Uniting Hawkesbury Richmond

Performance Report

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**Commission ID:** 0222

**Provider name:** The Uniting Church in Australia Property Trust (NSW)

**Site Audit date:** 29 September 2020 to 1 October 2020

**Date of Performance Report:** 11 December 2020

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* The Assessment Team’s report for the 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 12 November 2020.

# STANDARD 1 NON-COMPLIANTConsumer 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Consumers and representatives interviewed said that generally consumers are treated with dignity and respect and make informed choices relating to the consumer. However, some representatives state that communication with staff is poor, that things are not always explained well, if at all, or the information can vary between staff.

Representatives and staff said that it is difficult for many consumers to understand staff from non-English speaking backgrounds, particularly if a consumer has dementia or is hearing impaired.

Feedback from consumers and representatives at the present time indicate that staff have a limited understanding of providing culturally safe services to consumers. However, the organisation has policies and procedures relating to cultural diversity and the organisation is working towards a consumer engagement framework.

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

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

The Assessment Team found generally during the site audit staff were observed to be treating consumers with dignity and respect. However, while some feedback provided by consumers and representatives supported this, others stated that care and services to consumers is not always provided in a respectful way and consumer dignity is not always maintained. Consumers and representatives provided a number of examples of staff interactions with consumers that were not respectful or where consumer dignity was compromised. This included poor engagement and communication, a lack of consideration of consumer needs and not consistently maintaining practices to support consumer privacy. Not all staff interviewed could demonstrate their understanding of consumer diversity, identity or culture. The service said it was providing further training in consumer dignity and respect.

In their response, the Approved Provider submitted information about the issues raised by the Assessment Team. In general, they do not accept the findings from the Assessment Team as being an accurate reflection of staff engagement with consumers. They believe it is contrary to their own observations and survey findings. They state they have not received any recent complaints that show consumers are not consistently treated with respect and their privacy maintained. They state significant staff training in managing consumer privacy and dignity has been undertaken over 2020 including by a work-place coach.

I have carefully considered the information provided. On balance I have given weight to the findings as reported by the Assessment Team based on a significant number of consumer and representative interviews conducted during this site audit. In particular that although staff at the service have undergone significant training in maintaining consumer privacy and dignity, consumers and representatives still raised issues with the Assessment Team to show this was not consistently occurring. It is my view the service has not demonstrated that consumers are consistently treated with dignity and respect in a way the shows consideration for their identity, culture and diversity.

Based on the information provided I find this requirement is non-compliant.

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

*Care and services are culturally safe.*

### Requirement 1(3)(c) Non-compliant

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

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

The Assessment Team found that consumers and representatives generally indicated they were not always supported to make decisions about their own care, or to make decisions about when family should be involved in their care and make connections with others. Although they recognised the need for restrictions due to the COVID-19 pandemic, they also identified the impact this had taken on their decision making, the activities provided in the service and the management of visits from or contact with families. The service manager advised that case conferences to improve communication with consumers and representatives and involve consumers more directly in their care and decision making, have been implemented and is now almost complete.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. I acknowledge they do not agree with the Assessment Team’s findings. They acknowledge the challenge that the COVID-19 pandemic has had on consumers and representatives in general, and specifically at the service. It is their view they have implemented an effective system and taken sufficient actions to manage and put in place sufficient systems to address the aspects of this requirement.

However, although the approved provider has almost completed case conferences that will support consumers to be actively participate in decision making around care and services, I find this was not reflected in consumer and representative feedback. It is my view the service requires further time to demonstrate the changes it has made will be effective in meeting this requirement. Likewise, I am not satisfied the issues raised by consumers regarding maintaining connections with family have been sufficiently addressed. The service should continue to review and monitor the systems it has in place to ensure they address the concerns raised.

Based on the information provided I find this requirement is non-compliant.

### 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) Non-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.*

The Assessment Team found that the service is not always providing timely and current information to support consumers and representatives in care and services. Some information is not clearly communicated to representatives and some representatives feel they are not getting enough information for them to make choices regarding consumers care. These included concerns regarding visiting protocols, quality of food and a lack of meaningful activities for consumers with dementia or sensory losses.

In their response, the Approved Provider submitted information about the issues raised by the Assessment Team. I acknowledge they do not agree with the Assessment Team’s findings. They are of a view that case-conferencing and the provision of copies to consumers of their updated care plan post case-conference has addressed most concerns raised. However, they identified without specific information they were unable to address some of the issues raised under this requirement by consumers and representatives.

I have given weight to some of the consumers and representatives interviewed who stated they did not always get the information they need to help them make decisions about the things the consumer wants and what they would like to do. I acknowledge the completion of case-conferences for all consumers will assist the service meet this requirement. However, it is my view the service requires further time to demonstrate that the information provided to consumers is current and communicated in a way that supports consumers to exercise choice.

Based on the information provided I find this requirement is non-compliant.

### 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Whilst many sampled consumers and/or representatives said they felt they were partners in assessment and planning, some consumers and representatives felt they had insufficient input into care and services.

However, the service was able to demonstrate it has a system to ensure initial and ongoing care assessments and planning are occurring. Overall this is conducted in partnership with the consumer and where appropriate their representative. The service has now provided all consumers with a copy of their updated care plan. Risk assessments and end of life planning documents were evidenced in the electronic information management system.

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

## 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 Assessment Team reported there is a process of assessment and planning for consumers at the service including risks. Relevant risk assessments were evidenced in the electronic information management system for most consumers sampled. Consumers where high impact high prevalence risks are identified are recorded in a risk register and the information supporting this incorporated into the consumer’s care plan.

Staff were able to speak to assessment and planning of risk and how this informs the delivery of safe and appropriate care. The service has policies, procedures and guidelines to assist staff to meet this requirement.

Based on the information provided I find this requirement is 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.*

The Assessment Team found most care planning documents for the consumers sampled detail current needs, goals and preferences. Care plans were seen to be individualised and documenting personal preferences. All consumers sampled have advance care plans in place. End of life wishes are included in the document. The service gives all consumers and their representative a document called “Making an Advance Care Directive” when entering the service. This is also reviewed at the case conference and when applicable, such as deterioration or transfer to hospital. End of life care pathways are documented for relevant consumers.

Consumers expressed their satisfaction that their current needs and preferences were being addressed and met.

Based on the information provided I find this requirement is compliant.

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

*The organisation demonstrates that assessment and planning:*

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

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

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

The Assessment Team reported they found improvements in the service’s assessment and planning processes since the last assessment contact. This included the use of case conferencing to ensure care plans were current and contained information relevant to consumer needs and preferences. The service was able to demonstrate it is providing copies of updated care plans to consumers following a case-conference. However, some consumers and representatives said they were not satisfied this process was effective in communicating changes resulting from case conferences.

In their response the Approved Provider submitted information to address the issues raised by the Assessment Team. They state all consumers who have had a case conference have now received an updated copy of their care plan. These include changes which occurred through the case conference meeting. They provided documentation in support of this.

It is my view that the service should continue to monitor this requirement to ensure the system in place to manage care planning through regular case-management remains effective. While the outcomes from case conferences are documented in the care plan I am not satisfied that outcomes of assessment and planning are adequately communicated to the consumers and representatives involved in a meaningful way. I find that during this site audit the service was unable to demonstrate that overall consumers and representatives were being adequately informed of the outcomes of assessment and planning, based on significant feedback from consumers and representatives that they don’t understand the outcomes of assessment and planning.

On the balance of the information provided this requirement is non-compliant.

### 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.*

Overall, the Assessment Team reported regular review of care and services were seen to be occurring for most consumers when incidents impact on the needs of consumers. Care plans are reviewed every three months or when changes occur and the service has care plans evaluated and up to date for all consumers.

Most consumers said their care needs are discussed with them if for example when they return from hospital. They feel informed of changes in care. Other consumers said they are reviewed by the physiotherapist after all falls. Another consumer talked about the review the medical officer provided in relation to a change of medications.

Policies and procedures for review of care and services

Based on the information provided I find this requirement is compliant.

# 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Whilst many consumers said they receive personal care and clinical care that is safe and right for them several sampled consumers and/or representatives are not completely satisfied that this outcome is achieved.

The Assessment Team found high impact risks such as dehydration and weight loss had not been managed effectively at the service. COVID-19 preparedness at the service has not been effectively managed. Clinical practice does not reflect best practice as nebulisers are still being used at the service for consumers allowing possible aerosolization of COVID-19. Registered staff at the service were not aware of this risk. Behavioural monitoring is not always documented or evaluated consistently for some consumers. Pain is not always considered as a possible cause for behaviours, monitored consistently or evaluated for effectiveness.

The Quality Standard is assessed as non-compliant as two 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.*

The Assessment Team found that whilst most consumers and representatives interviewed were satisfied with the personal and clinical care consumers received, some consumers and representatives were not. In one instance, a representative raised that their consumer had lost significant weight over six-month period. They were also described as losing appetite and having reduced fluid intake. They had also experienced unwitnessed falls where staff did not consistently follow required neurological and other observations.

The Assessment Team reported clinical practice does not consistently reflect best practice. Some consumer records reviewed showed gaps in behavioural monitoring including documentation and evaluation. Pain management and pain documentation was not seen to be consistently effective or completed. They also reported interventions for managing challenging behaviours, were not seen to be consistently evaluated. Registered nurses and the deputy services manager confirmed nebulisers were still being used for consumers at the service and were unaware this was a potential risk in relation to the aerosolization of COVID-19.

The Assessment Team raised issues regarding the service’s application of restraint. They reported although some consumers have recently had psychotropics minimised or ceased they were not being consistently monitored for side effects following this. They reported there was not always an appropriate diagnosis to support the use of a psychotropic medication and pain was not consistently assessed as a consideration as a trigger for behaviours.

In their response, the approved provider submitted information regarding the issues raised by the Assessment Team. They outlined that actions had been taken prior to the site audit to address the weight loss of the consumer named in the report, including a dietitian review. They said the consumer was not dehydrated and has since increased their weight. The approved provider said nursing staff were aware of the risk associated with the use of nebulisers at the service in regard to the aerosolization of COVID-19. The approved provider states that none of the service’s consumers on as required (PRN) psychotropic medications have required such medication since May 2020. Therefore. they do not see a requirement to monitor consumers for any side effects due to cessation of such medication.

The approved provider acknowledged the service needs to improve its documentation in behavioural management, including the effectiveness of interventions and in pain management; and following up that when analgesics are used, that they are measured to ensure they are effective.

Overall, I have given consideration to the dissatisfaction expressed by consumers and representatives regarding the delivery of clinical care. I am not satisfied that the service has sufficiently demonstrated that clinical and personal care under this requirement is best practice or tailored to the needs of consumers. The deficiencies in documentation supporting pain management and behavioural management are also not best practice. I have also considered that the application of neurological and other observations were inconsistent with the service’s documented guidance following unwitnessed falls. Overall it is my view that on occasions inconsistent clinical practices and not completing required documentation has resulted in an impact on the health and well-being of consumers at the service.

Based on the information provided I find 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.*

The Assessment Team found that the service has a high risk, high prevalence register documenting risks for consumers. High impact and high prevalence risks associated with the care of sampled consumers were seen to be regularly reviewed and specialist input sought with recommendations implemented and evaluated. However, the Assessment Team reported some consumers they reviewed who were seen to be high risk (such as with falls and weight loss) appeared not to be recorded in this register.

Behavioural monitoring is not always documented or evaluated consistently for some consumers. Pain is not always considered as a possible cause for behaviours. Pain monitoring is not consistent or evaluated for effectiveness.

In their response, the Approved Provider acknowledged there were gaps in behavioural and pain management documentation and they have taken steps to address this since the site audit. They submitted a range of information addressing the issues raised by the Assessment Team including updated pain assessment and behaviour plans and charts. Overall, they demonstrated that while their risk register is now current, it was not at the time of the site audit.

It is my view the service should continue to monitor and review behavioural and pain management documentation for the consumers identified under this requirement. They should ensure the gaps identified are closed and staff maintain effective documentation practices across the areas under this requirement.

Based on the information provided I find 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.*

The Assessment Team found the service has a system in place, including palliative care planning, to manage consumers on a palliative care trajectory. End of life wishes are recorded in advance care plans. Documentary review demonstrated appropriate end of life care is provided to consumers at the service, with comfort maximised and dignity preserved.

Registered nurses informed the Assessment Team to manage end of life care. Including that they ensure care staff report any distress or pain for the consumer at end of life. Medications are ordered and administered subcutaneously via an infusion pump if indicated and the effect always evaluated. A palliative care team is available and provides support if needed, or already involved. Family members are supported to be part of the end of life care of their consumer.

The service has policies, procedures and guidelines to support staff in the delivery of this aspect of care.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team found overall, the service could demonstrate it is identifying in consumers when there is a deterioration or change in condition. Action was seen to be appropriate and timely.

Most consumers said they are satisfied with the medical care provided when they become ill. Many consumers spoke about their confidence in their medical officer who visits them regularly at the service. Other consumers talked about the comfort they received from consultation with specialists.

Care staff were able to describe recent changes or deterioration in a consumer’s condition. They said they immediately report any concerns to the registered nurse. Staff said they reported consumers they found in pain or when they had fallen for immediate assessment by the registered nurse.

The service has a policy for identifying and managing the deterioration of consumers.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported care planning documents contain information from various health care providers. Handover folders communicate current changes for consumers. Diaries communicate relevant consumer appointments to allied health. Care files include specialist letters, entries from medical officers, speech pathologist, physiotherapists, dieticians, behavioural specialists and geriatricians.

Consumers expressed their satisfaction where shared responsibility of care is occurring.

A registered nurse informed the Assessment Team that all changes are documented in the progress notes, so all care providers are alerted to the changes. Changes for consumers are verbally handed over to the registered nurse, team leader and care staff and documented in the handover folder in the nurse station. Appointments for consumers are recorded in the nurses’ diary for easy reference.

The handover was observed by the Assessment Team. The registered nurse documented the salient points in a weekly handover document as a verbal handover was given to the registered nurse, team leaders and care staff on the oncoming shift.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported care planning documents for sampled consumers demonstrated evidence of appropriate referral to specialists and other health practitioners where required. The service demonstrated overall, timely referral to other providers of care and services was occurring when and as required.

Consumers said they have access to their medical officer and relevant specialists when needed. Many said this was one of the benefits of living at the service because this was arranged for them.

When a referral is required the registered nurse arranges appointments. Appointments are documented in the diary in nurse stations and in progress notes. Referrals are accompanied by letters from the medical officer about the nature of the referral

Based on the information provided I find this requirement is compliant.

### 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.*

The Assessment Team reported that staff demonstrated they understand antimicrobial stewardship and standard based precautions for outbreak management. However, they observed staff not adequately following infection control practices and found the service could not demonstrate it was COVID-19 prepared. This included findings such as: sufficiency and storage of personal protective equipment (PPE); staff not appropriately wearing face masks; the lack of hand sanitisers (including supporting consumers maintain hand hygiene practices) and the availability of signage and information to support maintaining a COVID-19 safe environment.

The assessment team also raised feedback from consumers regarding the cleanliness of rooms. And that although extra cleaning schedules had been implemented the Assessment Team did not observe cleaning staff cleaning recognised ‘touch’ points, nor commonly used surfaces being wiped before and after use.

In their response, the approved provider stated care staff have completed donning and doffing competencies. They acknowledged the wall mounted sanitisers were empty due to a lack of available inserts to replenish them. However, they stated there were sufficient bottles of hand sanitisers available and in use. They stated that the service is an organisation hub storage area for PPE and there are sufficient stocks on site in case of a potential outbreak. The approved provider said there is sufficient COVID-19 safe environment material visible throughout the service including donning and doffing instructions, cough etiquette, symptom alert and the requirement for influenza vaccination. Staff were sent a memo to remind them to use masks correctly, including donning and doffing. The approved provider included a detailed outline of the service’s COVID-19 preparedness.

The approved provider does not agree rooms were unclean as these are checked daily by the cleaning supervisor. High flow areas are cleaned daily. They have put in place a system to wipe commonly used surfaces.

Although the Assessment Team found this requirement non-compliant, I am satisfied overall, based on the information they submitted, that the approved provider has demonstrated that the service is effectively managing microbial stewardship and infection related risks.

Based on the information provided I find this requirement is compliant.

# STANDARD 4 NON-COMPLIANTServices and support 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The team also examined relevant documents.

Some sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enables them to do the things they want to do.

Consumers/representatives informed the Assessment Team that consumers receive support and services to promote their emotional, spiritual and psychological wellbeing. The onsite chaplain and pastoral care worker visit individual consumers, who require emotional, spiritual and psychological support. Consumers are supported to participate within the community, have social and personal relationships and do things of interest to them. The service can demonstrate sharing of information about the consumer’s condition and general needs.

However, the Assessment Team found consumer preferences and goals are not clearly and consistently identified and communicated. Representative feedback provided to the Assessment Team indicates, consumers who reside in the dementia unit (Blaxland) do not receive meaningful supports for daily living. Significant feedback was provided to indicate consumers in the hostel area were not satisfied with the quality of meals and overall, meals on the weekend at the service were inconsistent in quality and variety.

Consumer satisfaction with ‘meal quality’ indicates dissatisfaction for consumers residing in the hostel and for the weekend ‘meal quality’ for consumers residing in the nursing home.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-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.*

The Assessment Team reported care plans did not always show individualised consumer needs, goals and preferences to support daily living. They reported representative feedback consistently identified limited engagement and activities for consumers residing in the dementia unit (Blaxland) and particularly on weekends. The Assessment Team also received a significant amount of feedback from consumers and representatives expressing their concerns about the services engagement with consumers and the sufficiency and interest in the activities provided. A number commented there are insufficient one-on-one activities provided at the service. One consumer raised that due to a lack of activities they were lonely. One consumer’s care documentation showed they had five one-on-one activities recorded over August 2020 and four in September 2020.

Lifestyle staff said there had been a reduction in the Monday to Friday lifestyle roster from three positions to two. The service manager informed the team they were aware of the representative feedback regarding activities and engagement in the Blaxland unit. That all staff are expected to provide some activities in this area including over the weekend.

In their response, the approved provider submitted information about the issues raised by the Assessment Team. They believe regular care planning review ensures individual consumer needs, goals and preferences are in place and updated as required. There is a tool which does provide a choice from standard goals. The service manager met with consumers and representatives in Blaxland in May 2020 to discuss activities, but the meeting did not produce suggestions for other activities which could be introduced into this area. Lifestyle staff are now rostered to work seven days a week. All staff are expected to provide some form of activity or one-on-one engagement with consumers at the service. In some instances, there are more one-on-one engagements occurring than are recorded in consumer activity records. Activities will be closely monitored by the deputy services manager including on the weekends. Extra activity resources and equipment has been purchased for use at the service.

Although I acknowledge the approved provider’s submission and improvements made, I have given consideration to the weight of consumer and representative feedback under this requirement. This reflects that during this site audit a significant number of concerns were raised regarding the range and suitability of activities and engagement available to consumers. Although the service has taken steps to address this, it requires time for the service to demonstrate monitoring of activities across all areas of the service and particularly in the dementia unit, are sufficient and meet the needs, preferences and goals of consumers.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team reported consumers/representatives were satisfied consumers receive support and services to promote their emotional, spiritual and psychological wellbeing. The onsite chaplain and pastoral care worker visit individual consumers when they require emotional, spiritual and psychological support.

The Assessment Team found consumers care plans included information in relation to their emotional spiritual and psychological well-being.

The Assessment Team observed staff, the chaplain and the pastoral care worker interacting with the consumers in a supportive and caring manner.

Based on the information provided I find this requirement is compliant.

### 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.*

Overall, the Assessment Team found consumers are supported to participate within the community, have social and personal relationships and do things of interest to them. However, some consumers raised concerns regarding limited activities due to COVID-19 restrictions.

Overall, care plans sampled, included information about how consumers maintain their personal relationships and identify things of interest to them and their preferred activities. Lifestyle staff were able to explain how (pre COVID-19) consumers participate in the inner community and/or keep in touch with the people important to them. Since COVID-19, staff said they support consumers to keep in touch with family and friends. This includes; staff assisting consumers with emails, face time/skype/zoom and phone calls.

Lifestyle staff were observed facilitating group activities such as cooking and bingo which were well attended.

Based on the information provided I find this requirement is compliant.

### 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) Non-compliant

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

The Assessment Team reported that seven consumers based in the ‘hostel’ area of the service were overall dissatisfied with the quality of meals. In other areas, although consumers expressed satisfaction regarding meals, they did raise concerns this was not consistently the case over weekends. Consumers said although there are systems in place to address issues regarding food they were not seeing an overall improvement in the quality and choice available.The chef said they meet regularly with consumers to seek feedback and address concerns. They provided examples of individual meals made to meet individual consumer likes and dislikes. Service management expressed their disappointment with the feedback, however, they will continue to address the matters raised.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. They stated Uniting Hawksbury have undertaken significant improvements in this area. Daily food specific surveys have been conducted by the catering company with consumers and representatives from April to October 2020. This returned very little negative feedback on the quality and enjoyment of meals. They have followed up on the concerns raised by the consumers and representatives named in the report to ensure the matters raised are addressed and resolved. They are monitoring weekend meal services as they now understand this was a significant cause of dissatisfaction in the past to consumers. They believe with a new weekend chef this has improved and feedback they have received indicates this.

I acknowledge the approved provider is following up on the concerns raised and is acting to address these issues, however, although the approved provider is of the view the feedback on meals provided by consumers and representatives to the Assessment Team is historic, I am not persuaded this is so. Consumer feedback was provided during consumer interviews during the site audit about their current view. A significant number of consumers in the hostel area gave consistent feedback regarding their dissatisfaction with meals. Likewise, feedback was consistent regarding meals over the weekend not always being suitable or enjoyable. Although the approved provider has outlined the actions already in place to address this requirement, these were shown not to be effective at the time of the site audit.

Based on the information provided I find this requirement is non-compliant.

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The team also examined relevant documents.

Most sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. Some consumers interviewed said they feel at home and when their family can visit they are made to feel welcome. Consumers can decorate their rooms to their own taste, with personal items to make their home as comfortable as possible.

Overall the Assessment Team reported the service demonstrated a welcoming and easy to understand environment which can optimise each consumer’s sense of belonging, independence, interaction and function. They observed overall, the service was safe, clean and well maintained. They observed there was adequate lighting, heating and cooling, which contributes to a comfortable atmosphere.

However, they identified the hostel area and outdoor garden area was not welcoming or well maintained in appearance. External windows were not sufficiently cleaned and showed the presence of insect infestation. They also raised concerns from consumers and representatives regarding the impact from ongoing building works. Whereas overall furniture, fittings and equipment were observed to be clean, well maintained and suitable for the consumers, some furniture in the hostel area was stained and not clean.

The hostel environment is not safe, well maintained and/or clean.

The Quality Standard is assessed as non-compliant as one of the three specific requirements have been assessed as non-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) Non-compliant

*The service environment:*

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

The Assessment Team reported the service demonstrated overall, the environment was clean, well maintained and welcoming. They did however, observe areas such as the hostel and garden were not clean, well-maintained or welcoming. They also raised concerns from consumers and representatives regarding the impact from ongoing building works. Consumers also commented on lack of cleaning of external windows, the poor quality of flooring and surfaces including in Blaxland and that the garden areas needed tidying up. Issues were raised by the Assessment Team with the service regarding keeping fire certification processes current and maintaining smoke seals on consumer doors.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. They stated some observations were due to consumer use of the environment (such as scuffing on walls). These have since been repaired. Flooring issues are being reviewed to best identify actions as to repair or replace. External window cleaning is completed by a contractor on an annual basis and was last done in January 2020. The approved provider stated that the ongoing building works makes it a challenge to keep windows clean but an additional clean has just been carried out. The gardening contractors, who attend fortnightly, have been instructed to complete additional garden maintenance work to address the issues raised. The approved provider states their fire certification process was current and that smoke seals are in place where required. The service is currently upgrading its environment and safety across several areas.

I acknowledge the response from the approved provider and the actions taken to address the matters raised, including future plans to upgrade the environment. However, I have given consideration to the issue that during the site audit the Assessment Team identified a range of concerns in this requirement which had not been identified or addressed by the provider and which impacted on consumers enjoyment of their environment. It is my view the system in place to maintain garden areas, the cleaning of external windows and refurbishment of internal walls and floors is not effective. The service should continue to monitor this to ensure the changes made are effective and can be sustained.

Based on the information provided I find this requirement is non-complaint.

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

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

The Assessment Team reported overall furniture, fittings and equipment were observed to be clean, well maintained and suitable for consumers. However, they noted some of the furnishings in the hostel area was not clean. Likewise, feedback from consumers indicated whereas most consumers were satisfied cleaning and the maintenance of the environment was satisfactory, some were not.

Cleaning staff said they have cleaning schedules and can mostly complete their work. The cleaning manager advised that if it is needed they will send an additional cleaner to support the workload.

Based on the balance of the information provided I find this requirement is compliant.

# STANDARD 6 COMPLIANTFeedback 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Most sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Consumers and representatives have access to advocates and other methods for raising and resolving complaints. The service management was found to apply open disclosure in managing complaints.

However, two consumers and two representatives said they were disappointed that some of their complaints regarding quality of food did not result in beneficial changes for consumers. Although the Assessment Team found the service was unable to demonstrate how feedback from the consumers/representative is used to implement improvements in the quality of care, I found they were able to demonstrate this aspect of the Standard.

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

Overall, the assessment team reported the service could demonstrate it actively encourages consumers and other interested parties to provide feedback and complaints. Consumers and representatives said they are able to raise issues with the service. This includes through residents’ relative meetings, feedback forms, emails and in one-to-one conversation with the manager. Consumers and representatives advised the manager responds to their concerns/complaints.

Staff said they are aware they can encourage consumers to raise their concerns with the manager. They advised they would assist consumers to fill out the feedback form if asked. The organisation has feedback forms accessible to consumers and other interested parties.

Based on the information provided I find this requirement is compliant.

### 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.*

The Assessment Team reported consumers/representatives provided mixed feedback about this requirement. Some consumers did say they have never had to raise a complaint to the service. Two consumers and two representatives said they were disappointed that some of their complaints regarding quality of food did not result in beneficial changes for consumers. However, consumers/representatives indicated the service was applying an open disclosure process in their management of complaints.

The service was able to demonstrate that open disclosure is used in relation to feedback received by the service manager from consumers and representatives. The register and complaint feedback forms and confirmation from representative confirmed the service manager practices open disclosure when addressing complaints.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team found that the service has a compliments, complaints and feedback register and a complaints management and process system in place. However, they found the service could not demonstrate the analysis of complaints data to identify patterns and trends. For example, there were patterns of complaints raised by consumers and representatives about some of the staff working at the service on the weekend which had not been identified by the service. Some staff had language issues which impacted on their communication with consumers and representatives. Likewise, complaints had been raised regarding meal quality on the weekends as being inconsistent. Consumers and representatives said they did not think these concerns had been adequately addressed by the service or organisation.

In response to the Assessment Team findings under this requirement the service ran a generic deep dive organisational report on complaints. However, the Assessment Team found this did not adequately analyse complaints specific to Uniting Hawkesbury.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. They provided several examples of actions they have taken to address issues raised by consumers and representatives. These include: an action catering plan to address meal quality across the service; an environmental review; the purchase of additional activity resources and changes to rostering. They have reviewed weekend staffing and weekend meal quality. A deputy service manager will be working across the weekend to monitor staff practices. The Approved provider states the deep dive regarding complaints was specific to Uniting Hawkesbury and involved the previous eighteen months of data.

I acknowledge the response by the approved provider and the actions taken by them to address most issues raised from the site audit report. It is my view this demonstrates their proactive approach to the management of complaints. However, I remain concerned that consumers and representatives gave feedback that some issues are not resolved to their satisfaction. The approved provider should continue to monitor and address the concerns raised in a timely way including monitoring consumer/representative satisfaction with the outcome.

Although the Assessment Team found this requirement was not compliant, I find based on the information provided the approved provider, they have demonstrated that feedback and complaints are reviewed by the service and used to improve the quality of care and services.

On the balance of the information provided I find this requirement is compliant.

# STANDARD 7 NON-COMPLIANTHuman 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

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Some consumers and representatives interviewed indicated that the consumer gets quality care and services when they need them and from people who are knowledgeable, capable and caring. Most consumers and representatives said staff are kind, caring and gentle when providing care to the consumer.

However, most consumers and representatives said they thought the service could do with more staff.

Overall it has been demonstrated the workforce are completing competencies and have the qualifications and knowledge to perform their roles however some staff have not had recent education/training in the Quality Standards.

The monitoring and review of the performance of each member of the workforce has not been undertaken on a regular basis.

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

## Assessment of Standard 7 Requirements

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

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

The Assessment Team reported that overall consumers and representatives were complimentary regarding staff at the service. Saying they are hard working. Overall, they said they did see improvements in staffing levels. Several consumers and representatives said they were happy with the new acting service manager. However, a significant number of consumers, representatives and staff raised concerns about the adequacy of staff numbers and spoke about the impact it has on consumers. This included wait times for services. They identified it is worse on weekends. Staff said they are not always able to complete all their duties. Staff were observed each day of the site audit to be rushed during meal times. Other staff said they work long or additional shifts or time.

The service identified there has been in 2020, a significant turnover in staff. Including key staff and registered nursing staff. Roster review has led to an increase in staff in specific shifts and areas. Call bell response times are monitored, and management said recent reviews do not show extended waiting times are occurring.

In their response, the approved provider submitted information to address the issues raised by the Assessment Team. They responded to the significant number of concerns raised by consumers and representatives about waiting times. The approved provider stated this is not supported by a review of call bell waiting times; which do not show extended waiting times for assistance. They strongly refute some of the findings that show consequences to waiting for assistance, stating these are not being captured through documentation. The approved provider said a supervisor has been appointed to oversee staff on the weekend and the acting service manager has accepted the permanent role of service manager. The service continues to review and adjust the roster based on consumer need.

I have carefully considered the information provided. I have given weight to the large number of interviews with consumers, representatives and staff which provide a consistent overview that the service is not adequately staffed to meet the needs and preferences of consumers for care and services. Although I acknowledge the approved provider’s response and the actions taken to address the issues raised, I am not satisfied it has demonstrated the service’s workforce has sufficient numbers to ensure the delivery and management of safe and quality care and services.

Based on the information provided I find this requirement is not compliant.

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

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

The Assessment Team reported most consumers and representatives said that staff are kind, caring and respectful in their engagement with consumers. Staff said they are aware of the importance of treating consumers with respect and were observed doing so when observed during this site audit. However, feedback was received about staff sometimes being overworked, rushed and sometimes abrupt in their duties.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported some concerns were identified regarding the turnover in staff and recruitment of new RNs. The service has recently recruited six new RNs and a new deputy service manager. However, overall the service could demonstrate its workforce is competent and have the qualifications and knowledge to perform their roles.

The service manager advised that staff qualifications and skill sets are checked on recruitment and that mandatory training is part of orientation for staff prior to commencement of their duties. The service manager and administration staff are responsible for checking that all employees have their qualifications and registration, including criminal checks and health checks current at the time of employment and as determined by legislation.

The organisation has identified core competencies and capabilities for different roles. Competency training records reviewed for 2020 indicate that relevant staff have completed education including hand washing, medication, PPE skills and manual handling assessments. Documentation showed that 100% of staff currently working have completed competencies relevant to their work role.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team found that consumers, representatives and staffsaid that some staff were not sufficientlytrained or supported to effectively carry out their roles. Feedback included that while the consumer’s cultural safety is generally respected, staff particularly from a non-English speaking backgrounds, have a limited understanding of providing culturally safe services to some consumers. Representatives said not all staff have a good understanding of how to communicate to consumers with dementia or consumers with hearing and eyesight impediments.

It appeared some staff training was on hold due to COVID-19 restrictions. Some staff said they felt they could have more training, with newer staff saying they have yet to have training in the Standards. However, the service has recently employed many new staff and training for them is still underway. The service manager said some clinical staff need more training in clinical oversight for example wounds training. This training is being sourced.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. A three-day workshop ‘Becoming a more confident communicator’ will be run to assist staff including those where English is a second language. It includes a component ‘Australian Expressions’. A clinical excellence program will run for 2021.

I am satisfied the approved provider has addressed the issues raised by the Assessment Team. In particular, they were aware of and were planning education and training to address the gaps raised by the Assessment Team. Although the Assessment Team found this requirement was non-compliant, I find on the balance of information provided it is compliant. However, it is my view the service should continue to monitor staff education to ensure its workforce is sufficiently trained and supported to deliver the outcomes required across the Standards.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment team found that feedback from staff and management and documentation reviewed shows that regular assessment, monitoring and review of the performance of each member of the workforce has not been undertaken on a regular basis and is currently overdue. Most staff interviewed stated they had not had a performance appraisal in the last 12 months. The service manager advised that they have commenced a process of continuous conversations as part of performance management. An annual schedule is currently being developed to undertake continuous conversations with all staff over a 12-month cycle, but it is yet to be implemented. Documentation reviewed indicated six staff appraisals had been completed in 2020. The service manager said they plan to have 33% completed by end September 2020.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. They advised that there has been a significant focus at Uniting Hawksbury to change the staff culture. This has led to a number of staff being performance managed and leaving. The approved provider said at the time of the site audit 37 staff have had their performance appraisal completed and the other long-term staff are on track to do so. They state there has been a turn-over of staff over 2020 and an influx of new staff in the same period including ten new RNs. Performance appraisals for 15 new staff are not due until 2021. However, the service manager has regular engagement with new staff as part of the on-boarding process.

Although the Assessment Team found the service does not comply with this requirement, I am of a different view. In particular, I am satisfied with the information from the approved provider showing they have a large cohort of new staff who are not due for appraisal until 2021 and for other longer-term staff appraisals are occurring and will be completed by a set schedule.

Therefore, based on the balance of the information provided I find this requirement is compliant.

# STANDARD 8 NON-COMPLIANTOrganisational 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

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Overall sampled consumers said they did not consider that the organisation is well run and that they can partner in improving the delivery of care and services. Consumers and representatives interviewed said they have not been effectively consulted about or had input into the development, delivery and evaluation of care and services at service level.

Whereas significant Improvements had been made and were in progress, a number of these had not yet been evaluated and the service could not demonstrate they had been effective. Feedback from consumers, representatives and staff identified dissatisfaction with the management of information and information systems and workforce governance around the sufficiency 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 8 Requirements

### Requirement 8(3)(a) Non-compliant

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

The Assessment Team found there have been improvements to care and services since February 2020. However, they reported that some consumers and representatives interviewed, while acknowledging improvements, said they feel there is still more to be done regarding engaging consumers in the development, delivery and evaluation of care and services.

Consumers/representatives raised concerns regarding the falling away of monthly consumer advocacy forums; consumers no longer being involved in recruitment; the delays in case conferencing, the belief that although communication to consumers and representatives had improved (particularly under the new service manager), it was still not proactive and consistently clear in areas such as the ongoing building works and visiting restrictions.

In discussion with the Assessment Team the service manager acknowledged that “programs are not where they need to be, and we need to individualise the activities to what suits individuals or small groups and their interests.” The service manager also advised that the organisation identified the need for new staff to have a better understanding of the need for consumers to be engaged in the development and delivery of care and services and how staff can support them in this regard. The service’s continuous improvement plan identified a workplace coach will work with staff to increase consumer engagement.

In their response, the approved provider submitted information to address the issues raised by the Assessment Team. The approved provider does not believe the Assessment Team’s findings under this Standard reflect where the service is currently. However, they did acknowledge they were still on an improvement journey that has been impacted by COVID-19 requirements.

They stated the consumer advocacy forums are still meeting monthly and consumers are involved in the recruitment process. They state they work with any issues raised by representatives to ensure lines of communication remain clear. They believe the impact of COVID-19 has impacted on the range of external activities available to consumers and this has resulted in some of the issues raised. However, they have increased resources to allow a broader range of activities to take place within the service. They acknowledge the building works have impacted on consumers but have consistently addressed this as issues have been identified or raised. They believe communication on the progress of the building works have been consistently communicated such as through newsletters and meetings. The approved provider also indicated that the service is working on completing an engagement map with consumers, representatives and staff to identify unique engagement needs and mechanisms,

While I acknowledge the organisation has made significant improvements to ensuring consumers are engaged in the development, delivery and evaluation of care and services, I am not satisfied they have demonstrated consumers have been sufficiently supported in this process. Although the approved provider has provided a range of information to demonstrate the improvements made, I have given weight to the consistency of consumer and representative feedback showing how they perceive they are still not being sufficiently actively engaged in the development, delivery and evaluation of care and services. I also give weight to this being acknowledged by staff in the assessment report. In my view, the organisation need to continue to monitor and review its systems for how it engages with consumers and representatives and demonstrate the changes and improvements it is implementing such as the engagement map. are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

### 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) 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 Assessment Team found that while staff interviewed advised they can generally readily access information they need when they need it, this was not consistent. Consumers and representatives said they were not always able to access information about consumers’ condition and care needs. Issues were identified regarding pain management and behavioural management documentation being completed and demonstrating care processes were being adequately followed. (See Standard 3 Requirement (3)(a) for information regarding this). The continuous improvement plan was seen to identify improvements to the service that reflect non-compliance issues from the Review Audit of February 2020 at an organisation level. It was identified that most actions are still to be fully implemented and evaluated. Human resource governance (see Standard 7 Requirement (3)(a)) identified a gap in adequacy of staff. Other aspects of this Standard identified a need for improvements in training and support for staff and review of staff performance. The Assessment Team found the service could not adequately demonstrate it has a clearly defined consolidated record. The Assessment Team also identified issues as regards to whether complaints were being sufficiently addressed to the satisfaction of complainants, analysed and trended to support ongoing continuous improvement processes.

In their response, the Approved Provider submitted information to address the issues raised by the Assessment Team. The approved provider stated that the majority of case conferences have been completed and updated care plans provided to consumers or relevant representatives. They state clear systems are in place to inform representatives of any issues that occur such as through incident reports and progress notes. The approved provider acknowledged issues regarding some aspects of documentation can be improved, and work to address this through staff education and training has commenced. The continuous improvement plan has been updated and includes issues raised from this assessment contact site audit. The service does have a consolidated register and is using a standard organisational system in managing this. The approved provider said this has not previously raised issues elsewhere in its other of its services. The approved provider (under Standard 7) said a deep dive of complaints included Uniting Hawkesbury and was used to analyse complaints trends.

Although I acknowledge some of the points raised by the approved provider, I am not satisfied that their response has sufficiently addressed the issues raised. In particular, that many of the issues raised was consistent feedback from a significant number of consumers, representatives and staff during the site audit. The approved provider said they believed significant improvements had been made across all areas under this requirement. Whereas feedback did indicate this was the case, it also identified dissatisfaction with the management of information and information systems and workforce governance around the sufficiency of staff. Although the approved provider and service are addressing these matters, it is my view that during the site audit they could not demonstrate the systems supporting these areas were working effectively. The organisation and service requires further time to demonstrate the changes and improvements being made are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

### 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.*

The Assessment Team found that whilst a documented risk framework is in place, it has not been effective in identifying high impact or high prevalence risks associated with the care of consumers. However, they also found staff had generally been educated about the risk management policies and were able to provide examples of their relevance to their work. The Assessment Team reported that representatives raised issues regarding in the service supporting them to access consumers during restrictive visiting requirements.

In their response, the approved provider submitted information to address the issues raised by the Assessment Team. In response to findings they have adopted a more stringent approach to monitoring weight loss. However, the approved provider states the service is effectively managing high prevalence risk for consumers and has comprehensive systems in place to identify, address and respond to abuse and neglect in consumers. They also stated they implemented a range of mechanisms to support representatives to engage with consumers during the restricted visiting requirements. These included social media platforms, purchased more electronic notebooks and headphones and increased visibility visiting areas for families to meet their loved ones.

Although the Assessment team found this requirement was non-compliant I have come to a different view. I am satisfied the information provided by the approved provider has addressed the issues raised under this requirement. This includes a current risk-register for consumers at the service. The consolidated record showing documentation of incidents where alleged abuse has occurred.

Based on the information provided I find this requirement is compliant.

### 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.*

The Assessment Team asked staff whether policies under this requirement had been discussed with them and how they apply them in their work roles and practices. Staff had generally been educated about the policies and were generally able to provide examples of their relevance to their work, for example several staff described recent education for restraint minimisation and the need for risk assessments to be undertaken and consent to be obtained if restraints were to be used.

Management were asked what changes had been made to the way that care and service were planned, delivered or evaluated as a result of the implementation of policies under this requirement. They said the service has implemented monthly clinical governance and quality meetings; a weekly clinical review meeting to follow up clinical care/concerns and update risk registers and psychotropic self-assessments; a daily review of electronic consumer records and incident register is undertaken and shift huddles have been implemented with care staff to identify and communicate any clinical/care concerns that need immediate follow up.

However, the Assessment Team reported the actions listed above were not always effective (Refer to Standard 3 for further information regarding this). They also found that although a documented clinical governance framework is in place, it has not been effective in ensuring that clinical needs are assessed or that clinical needs are met.

In their response, the approved provider submitted information to address the issues raised by the Assessment Team. In response to findings they

Although the Assessment team found this requirement was non-compliant I have come to a different view. I am satisfied the information provided by the approved provider has addressed the issues raised under this requirement.

# 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 1(3)(a)

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

The Approved Provider must demonstrate that:

* Care and services to consumers is always provided in a respectful way and consumer dignity is always maintained.
* All staff have an understanding and training in consumer dignity, respect, identity and culture and can demonstrate this consistently in their work practices and engagement with consumers.

### Requirement 1(3)(c)

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

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

The Approved Provider must demonstrate that:

* Consumers and representatives’ feedback indicates consumers are supported to make decisions about their own care, make decisions about when family should be involved in their care and make connections with others.

###  Requirement 1(3)(e)

*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.*

The Approved Provider must demonstrate that:

* The service is providing timely and current information to support consumers and representatives in care and services.
* Information is clearly communicated to representatives.
* All consumers and representatives feel they are getting enough information for them to make choices regarding consumers care.

### Requirement 2(3)(d)

*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 Approved Provider must demonstrate that:

* Consumers and/or representatives continue to have regular case conferences to discuss their care and services plan.
* Representatives are satisfied with the communication of outcomes of assessment of care and services.
* There is documentary evidence at the service of when a care plan is offered or given to a consumer or representative.

### Requirement 3(3)(a)

*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 Approved Provider must demonstrate that:

* Consumers and representatives are satisfied with the personal and clinical care provided.
* Behavioural monitoring is documented and evaluated consistently for consumers.
* Pain is considered as a possible cause for behaviours and evaluated for effectiveness.
* Pain monitoring documentation is consistent.

### Requirement 3(3)(b)

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

The Approved Provider must demonstrate that:

* Consumers and representatives are satisfied that high impact risks are managed effectively at the service.
* Behavioural monitoring is documented and evaluated consistently for consumers.
* Pain is considered as a possible cause for behaviours.
* Pain monitoring is consistent and evaluated for effectiveness.

### Requirement 4(3)(a)

*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.*

The Approved Provider must demonstrate that:

* Representative feedback indicates consumers who reside in the dementia unit (Blaxland) receive meaningful supports for daily living.
* Information within the consumer survey indicates consumers get effective services and supports for daily living that meets consumer’s needs, goals, preferences and/or optimises wellbeing and quality of life.

### Requirement 4(3)(f)

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

The Approved Provider must demonstrate that:

* There is a majority of positive feedback regarding quality of meals from consumers residing in the hostel.
* Weekend meals receive consistent positive feedback from consumers.

### Requirement 5(3)(b)

*The service environment:*

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

The Approved Provider must demonstrate that:

* The hostel is clean, well maintained and safe.

### Requirement 7(3)(a)

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

The Approved Provider must demonstrate that:

* Consumers, representatives and staff do not have any concerns about the adequacy of staff numbers.
* Consumer feedback confirms that there are no adverse impacts on consumers as a result of insufficient staff numbers.
* Staff can report that they’re able to complete all of their or duties in a timely way.

### Requirement 8(3)(a)

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

The Approved Provider must demonstrate that:

* Consumers and representatives are satisfied with improvements regarding engaging consumers in the development, delivery and evaluation of care and services.
* The service can describe specific examples of how consumers are being supported to participate in the development, delivery and evaluation of care and services.

### Requirement 8(3)(c)

*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 Approved Provider must demonstrate that:

* Staff, consumers and representatives can readily access information about consumers’ condition and care needs when they need it.
* Effectiveness of the continuous improvement system is improved, by the service reviewing trends in complaints to input into the continuous improvement plan.
* Human resource governance requires systemic improvement in the areas of adequacy of staff, training and support for staff and review of staff performance.