Performance

Report

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| Name: | Adina Care Cootamundra |
| Commission ID: | 2743 |
| Address: | 121 Mackay Street, COOTAMUNDRA, New South Wales, 2590 |
| Activity type: | Site Audit |
| Activity date: | 2 July 2024 to 5 July 2024 |
| Performance report date: | 12 August 2024 |
| Service included in this assessment: | Provider: 1121 Cootamundra Health Care Co-operative Limited  Service: 1099 Adina Care Cootamundra |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Adina Care Cootamundra (**the service**) has been prepared by Therese Solomon, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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 Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for 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 assessment team’s report received 7 August 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# 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)

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

Requirement 2(3)(b)

* Ensure 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)(e)

* Ensure 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.

Requirement 3(3)(a)

* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, tailored to their needs and optimises their health and well-being.

Requirement 3(3)(b)

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

Requirement 3(3)(e)

* Ensure 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 4(3)(c)

* Ensure services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment and have social and personal relationships and do the things of interest to them.

Requirement 6(3)(c)

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

Requirement 6(3)(d)

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

Requirement 7(3)(a)

* Ensure 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)(d)

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

Requirement 7(3)(e)

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

Requirement 8(3)(b)

* Ensure 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)

* Ensure effective organisation wide governance systems relating to the following, information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance, feedback and complaints.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices, including but not limited to the following, managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, managing and preventing incidents, including the use of an incident management system.

Requirement 8(3)(e)

* Ensure where clinical care is provided—a clinical governance framework, including but not limited to the following, antimicrobial stewardship, minimising the use of restraint, open disclosure.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| 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. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| 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. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

This Standard has been assessed as compliant as six out of six Requirements have been assessed as compliant.

The service demonstrated that consumers are treated with dignity and respect and their culture and diversity valued. Consumers and/or representatives provided positive feedback regarding staff treatment and stated staff treat them with dignity and respect. Staff demonstrated familiarity with consumers’ cultural, personal, and family backgrounds, and consumers described how staff treat them with respect and kindness.

The organisation has diversity policies which stated what it means for the service and staff to treat consumer with dignity and respect. Clinical files document the consumer’s cultural diversity, background, and religious preferences. The Assessment Team observed staff interacting with the consumer in a caring, friendly, and respectful manner.

The service demonstrated that care and services are culturally safe. The organisation has a diversity and inclusion policy that informs the delivery of care and services. Consumers and/or representatives indicated staff is aware of consumer backgrounds and what is important to them, and they feel safe at the service. A review of consumer care plans identified they contained culturally specific information, and staff were able to describe consumer backgrounds and what is important to them.

The service demonstrated consumers are supported to exercise choice and independence. The service ensures each consumer and/or representative is provided with information upon entering the service to enable them to make informed decisions about the way they live and understand the care and service options available to them. Each consumer is provided with a resident handbook and agreement detailing life within the service.

The organisation has a choice and decision-making policy and procedure and an independence policy that guide staff on how to support consumers to enable decision making and independence. Consumers and/or representatives indicated consumers are supported to make decisions in relation to the care and services they receive and can choose who they want involved in their care planning process.

Staff described how each consumer is supported to make informed decisions related to their care and services, including who else to involve in the care planning process. Clinical notes include communication with the appointed representatives when required, and management indicated that case conferencing occurs yearly or as required. The service demonstrated ongoing communication occurs with the consumer and/or their representative through their resident of the day process and ongoing communication was documented in the progress notes.

The service demonstrated that each consumer is supported to take risks to enable them to live the best life they can. The service provided the dignity of risk policy and procedure evidencing the organisation’s process to support consumers to take risks. Management described how this would take effect through assessment and care planning. Consumers and/or representatives confirmed consumers are supported by the service to undertake activities of choice. Staff indicated activities of choice and the risk involved are discussed with the consumer and/or representatives.

The service demonstrated that information provided to each consumer is current, accurate and timely, and is communicated clearly, easy to understand and enables consumers to exercise choice. Consumers described information they receive to assist them with decision making, specifically related to activities they would like to participate in and meals. Staff described the different ways in which information is provided to consumers, including consumers with a cognitive deficit. The service provided evidence of choices being offered to consumers, including meals, lifestyle services and recreational activities.

The service demonstrated that each consumer has their privacy respected and personal information is kept confidential. The organisation has a privacy policy which includes processes for managing personal information, protecting personal information, security and retention of personal information and data breach responses. Consumers and/or representatives confirmed their personal privacy is respected by staff members.

Staff indicated they knock on consumer doors and wait for acknowledgement before entering, and nursing staff indicated consumer’s personal information is kept secured in the nurse’s stations and electronic care plans require a login and password to access.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Not Compliant |
| Requirement 2(3)(b) | 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. | Not Compliant |
| Requirement 2(3)(c) | 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. | Compliant |
| 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. | Compliant |
| Requirement 2(3)(e) | 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. | Not Compliant |

Findings

This Standard has been assessed as not compliant as three out of five Requirements have been assessed as not compliant.

The service was unable to demonstrate that assessment and planning for each consumer informed the delivery of safe and effective care. Risks to consumers were not consistently identified, and interventions were not always implemented to manage risks resulting in negative outcomes for consumers. Specifically related to skin integrity, pressure injury management and pain management.

Whilst staff were able to explain how they use assessment and planning for the delivery of safe and effective care and services, this was not demonstrated through review of clinical documentation. The service was unable to demonstrate that it has a schedule of clinical audits that monitor the effectiveness of the care and services provided and that assessments and care planning are completed within a timely period.

The organisation’s policy and procedures regarding care planning and assessments stipulates that all risks are identified upon entry and are documented by the registered nurse and incorporated into the consumer’s care plan. There was limited evidence to support that this is occurring.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system and clinical training for staff.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that 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 was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 2(3)(a) is found not compliant.

The service was able to demonstrate that advanced care planning occurs, and consumers and/or representatives confirmed their involvement with the process. However, the service was unable to demonstrate that assessment and planning for each consumer identified their current needs. This impacted consumers as interventions were not implemented to meet these specific needs, and staff were not consistently aware of each consumer’s individual care needs.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system and clinical training for staff.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that 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 service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 2(3)(b) is found not compliant.

The service was unable to demonstrate that care and services are reviewed regularly for effectiveness. Review of care assessments and care planning does not demonstrate that current interventions are evaluated for their effectiveness, or that further interventions are implemented to prevent incidents from re-occurring. Consumer care plans were not consistently reviewed for effectiveness when circumstances changed. A review of incidents relating to pressure injury development does not show investigation takes place to identify contributory factors, resulting in ongoing skin integrity concerns and unresolved pain.

Feedback from consumers and/or representatives was mostly positive, and clinical staff stated they were able to identify, manage and provide appropriate pressure injury care, however this was not supported by the deterioration of consumer wounds.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system and clinical training for staff.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 2(3)(e) is found not compliant.

The service demonstrated that assessment and planning is based on ongoing partnership with consumers and other individuals/providers the consumers wish to involve. Care planning documents reflect that consumers and others participate in assessment and planning. Consumers and/or representatives described how the consumer was involved in assessment and planning on an ongoing basis.

Staff described how they involve consumers and/or representatives in assessment and care planning and any others required. Staff described how allied health professionals, including the physiotherapist and dietitian contribute to assessment and care planning.

The service demonstrated it has processes in place to communicate information to consumers and/or representatives in relation to the outcomes of assessment and planning, and that the care and service plan is readily available. Consumers and/or representatives confirmed that discussions had occurred about the consumer’s care, and that a care plan had been offered to them.

Staff have access to the electronic clinical care system where they can readily access the care plans and charts, including agency staff. Incident documents had information about representatives being contacted and consumer representatives confirmed they had been contacted when incidents occurred and when changes occur in the health and well-being of consumers.

# Standard 3

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| Personal care and clinical care | |  |
| 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | 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. | Compliant |
| Requirement 3(3)(e) | 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. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | 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. | Compliant |

Findings

This Standard has been assessed as not compliant as three out of seven Requirements have been assessed as not compliant.

The service did not demonstrate that each consumers get safe and effective personal care and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being. A review of documentation, feedback from consumers, their representatives, and staff and the Assessment Team’s observations, identified deficits regarding consumer care needs, specifically in relation the management of pressure injuries, falls management and restrictive practices.

The organisation has a restraint minimisation policy and procedure and strives to provide a restraint free care environment wherever possible. The organisation’s policy and procedures reflect best practice and regulations. Management identified consumers subject to an environmental restrictive practice and all reside within the memory support unit. The service demonstrated the use of psychotropic medications for the purpose of chemical restrictive practice is being monitored and the consumers identified as being chemically restrained have the relevant consents and authorisations in place.

The service was unable to demonstrate they identify and monitor the development and deterioration of pressure injuries in alignment with best practice. Clinical staff described wound care to be provided once wounds had been identified, however, the service does not ensure that pressure injuries are prevented or identified at an early stage. Staff interviews and file reviews showed consumers’ pressure injuries were not identified in a timely manner and not managed appropriately to manage consumer’s assessed needs.

Some consumers and/or their representative raised concerns regarding the provision of personal care such as showering, stating that the lack of staff affected the delivery of personal care to consumers.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system, clinical training for staff, staff training in risk assessment, staff training for skin integrity and pressure injuries.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to their needs and optimises their health and well-being. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 3(3)(a) is found not compliant.

A review of consumers receiving care with high-impact, or high-prevalence risks shows a lack of clinical oversight in the management of their care. Deficits were identified in the management of consumers with a range of specialised care needs, including management of consumers at risk of choking, falls management and pressure injury care. The Assessment Team identified inconsistent reporting of incidents and monitoring charts were not routinely completed as directed.

The service was unable to demonstrate comprehensive investigations occur in relation to chocking incidents. The Assessment Team reviewed clinical documentation and incident reports and identified they had not been investigated adequately and that appropriate assessment and care planning had not been undertaken.

The service identified falls as one of their high-impact, high-prevalence risks. A review of care and services documentation related to falls showed staff are not consistently following the organisation’s policies and procedures. Consumers who have had falls are not consistently appropriately assessed after having a fall, neurological observations are not being attended as per the organisation’s policy and falls risk assessments are not consistently undertaken resulting in negative outcomes for consumers.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system, clinical training for staff, staff training in risk assessment, staff training for skin integrity and pressure injuries.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires effective management of high impact or high prevalence risks associated with the care of each consumer. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 3(3)(b) is found not compliant.

The service was unable to demonstrate 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.

While there are systems in place for communicating information about the care of consumers, these have not been effective for all consumers receiving aged care services. Sharing of information has not consistently occurred and information in the consumer’s care and service documentation is inconsistent. Information about the consumer’s condition is not always shared with the management team or medical officer.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system, and clinical training for staff.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that 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 service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 3(3)(e) is found not compliant.

The service has systems in place to ensure the comfort and dignity of consumers nearing end of life is maintained. Consumers and/or representatives are invited to participate in initial and ongoing case conferences and discussions including identifying the person’s end of life wishes as desired including the level of clinical intervention preferred. The outcomes of the case conference inform the development and ongoing review of an advanced care plan for consumers. Regular liaison occurs with doctors, staff, consumer representatives, and palliative care specialists are accessed as desired. Staff described a range of interventions they employ when caring for consumers during the end-of-life stage to ensure their pain is managed and their comfort and dignity maintained.

The service demonstrated deterioration or change of the consumer’s condition and well-being is recognised and responded to in a timely manner. Care and service documentation showed changes in consumer’s condition were identified and responded to in a timely manner. Consumers and/or representatives confirmed the service is responsive when consumers are unwell and notifies representative when changes occur. Staff could describe their actions if a consumer’s condition changed including informing the medical officer, referring to other health professionals or transferring the consumer to hospital.

The service demonstrated it has policies and system in place to ensure that timely and appropriate referrals to individuals, other organisations and providers of other care and services occur. Consumers and their representatives indicated they felt confident that referrals would be made if necessary and organised by the registered nurse.

Staff were able to articulate the service’s referral process. Management and registered nurses explained referrals are made through telephone calls, emails, and face to face referrals. They indicated there are doctor’s books for non-urgent items. These were observed in the registered nurse’s office. Management described the policy and procedural pathways to care for the consumers exhibiting changed behaviours including making referrals to the Older Persons Mental Health Team or Dementia Services Australia.

The service has policies and procedures in place for infection control and antimicrobial stewardship including the process to minimise the use of antibiotics. Staff demonstrated knowledge of infection prevention and antimicrobial stewardship and how this applies to them during their day-to-day practice. The service has implemented appropriate outbreak management plans and procedures.

Staff demonstrated appropriate infection control practices and could describe practices and procedures to minimise transmission of infections. Staff understood the importance of infection control and described that infection related risks are minimised at the service through handwashing, environmental cleaning and use of infection control precautions when required. Staff were observed regularly washing their hands and using hand sanitising gel after attending to consumer’s needs.

Registered nurses and care staff were familiar with antimicrobial stewardship terminology and could describe how to reduce the risk of increasing resistance to antibiotics. Management advised they review the use of antibiotics monthly, will investigate why the antibiotics were prescribed and ensure an appropriate infection report is documented in the electronic clinical care system.

# Standard 4

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| Services and supports for daily living | |  |
| 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. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | 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. | Not Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Standard has been assessed as not compliant as one out of seven Requirements have been assessed as not compliant.

The service supports consumers to have social and personal relationships and has a program of activities which consumers are invited to. However, the service does not ensure that consumers who are unable or uninterested in the group programs provided by the service are supported to have stimulation and engagement. The service does not have a system to ensure consumers requiring individual supports are identified, and suitable interventions implemented to engage and support the consumers.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system and clinical training for staff.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment and have social and personal relationships and do the things of interest to them. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 4(3)(c) is found not compliant.

Consumers and/or representative reported satisfaction with their experience living at the service. Specifically in relation to support consumers receive for their cultural, spiritual and emotional needs, support for their relationships and having things to do. Staff know consumers well, are aware of consumer needs and preferences as it relates to their daily living and most care plan documentation generally provides information about consumer needs.

Consumers and/or representatives indicated consumers emotional and spiritual needs are met, and they consistently expressed satisfaction with the caring and supportive attitude of staff. The service has systems to support consumers spiritual needs and refers to appropriate services for psychological and other supports if needed. Information about consumers spiritual and emotional supports is captured in their care and services documentation.

The service demonstrated that information about the consumer’s condition, needs and preferences is communicated within the organisation, and with other where responsibility for care is shared. The service has systems in place to ensure information on the consumer’s condition, needs and preferences is communicated effectively, this includes information in relation to the consumer’s spiritual needs and meals. Staff were familiar with consumer’s needs and preferences in relation to supports for daily living.

The clinical care manager and the care staff confirmed the service uses a message board on their electronic care system to communicate the consumer’s appointments, messages from their representatives or a change in care needs. The staff are provided handover after each shift from the registered nurse on duty.

The service demonstrated that appropriate referrals are made to other organisations and providers of care. The lifestyle staff stated they are trying to organise volunteers to return to the service again to spend time with consumers and assist with group activities. A volunteer was observed by the Assessment Team to be working with the lifestyle staff at the service on the first day of the Site Audit.

Consumers and/or representatives provided mixed feedback about the quality of meals provided. Whilst some consumers indicated the meals were not tasty, other consumers provided very positive feedback about the meals.

The hospitality manager reported the service is currently training in the Maggie Beer program for the next twelve-months. Part of the program includes adding protein to each meal, however some of the consumers do not like the recipes. The hospitality manager stated they are working collaboratively with consumers and/or representatives to find a recipe balance that meets the dietary requirements and consumer preferences.

The hospitality manager explained how catering services receive information about new consumers entering the service or any changes in consumers’ dietary needs from the registered nurses. This is entered into the electronic management system, and updated information is printed out for the catering staff. An updated dietary needs list was observed by the Assessment Team at the servery after a new consumer entered the service.

Consumers and/or representatives confirmed they felt safe when using the service’s equipment and said it was easily accessible and suitable for their needs. Consumers stated they were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items were replaced when necessary. Equipment used for activities of daily living were observed to be safe, suitable, clean and well-maintained.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Standard is assessed as compliant as three of the three Requirements were assessed as compliant.

The service environment was observed to be welcoming and comfortable. Consumers living at the service stated there are adequate private areas, both indoors and outdoors for them to utilise when socialising. Each consumer has their own bedroom which they are able to furnish with their own personal items. The bedrooms have an ensuite. Some bedrooms have a small veranda where the consumers can sit and have some potted plants if they chose.

The service demonstrated there are processes in place for a well-maintained, safe and comfortable environment. The Assessment Team observed the environment appears safe, well-maintained and comfortable for consumers and is clean. Consumers are able to move around freely, both indoors and outdoors and consumer and/or representative feedback was positive in relation to the environment.

Consumers and/or representatives stated they feel at home in the service environment and that it is a nice place to live. Representatives reported they feel welcomed by staff members and there are sufficient indoor and outdoor areas to spend time with their loved ones.

The maintenance manager was able to demonstrate preventative maintenance is being attended within the required timeframes including legionella testing, regular pest control, electrical tests and grease traps. The maintenance manager stated responsive maintenance is attended to promptly and the staff can notify the maintenance team of any maintenance issues via the services electronic management system. Staff confirmed they can raise a maintenance issue via the electronic management system and the maintenance team attend to the issue promptly.

The Assessment Team observed the furniture, fittings and equipment to be safe, clean, well-maintained and suitable for consumers. Consumers and/or representatives were satisfied with the furniture, fittings and equipment. Management and staff demonstrated effective systems in place for the cleaning and regular maintenance of the furniture, fittings, and equipment.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

This Standard has been assessed as not compliant as two out of four Requirements have been assessed as not compliant.

Consumers and/or representatives were generally satisfied the service will address and resolve any complaints or issues they raise. Staff described how they assist consumers to resolve their concerns. However, the complaints reviewed had very limited evidence of an open disclosure process used.

The electronic complaints and feedback register contained very limited evidence of follow up occurring in response to complaints. None of the complaint’s reports reviewed demonstrated an apology had been provided, a factual explanation of what happened, a discussion of potential consequences of the adverse event or an explanation of steps being taken to manage the event and prevent reoccurrence. In other words, an open disclosure process was not evidenced.

Whilst there is evidence that appropriate action was taken for some of the complaints reviewed, it has not been demonstrated for all complaints reviewed and an open disclosure process has not been consistently demonstrated.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 6(3)(c) is found not compliant.

Consumers and/or representatives provided mixed feedback in relation to feedback and complaints, with some consumers stating they are satisfied their feedback is used to improve the quality of care and services. However, documentation reviewed indicates the service does not record all their feedback into their electronic complaints system.

Interviews with consumers and representatives, staff and management suggest that most complaints are managed informally. This informal process makes it difficult for the service to analyse and identify complaint trends and feed into the service’s continuous improvement plan.

The Assessment Team reviewed the continuous improvement plan and noted none of the entries have feedback/complaint as the source of the improvement initiative and none reflect improvements are being made in response to consumer feedback and complaints. The service did not demonstrate that they monitor feedback and complaints and utilise feedback to improve care and services for consumers.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that feedback and complaints are reviewed and used to improve the quality of care and services. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 6(3)(d) is found not compliant.

Consumers and/or representatives stated they understand how to give feedback and would feel comfortable to provide feedback or make a complaint. Consumers and/or representatives stated if they need to provide feedback, they will talk to the staff informally and it will be addressed.

Staff described how they would resolve complaints immediately whenever possible or escalate complaints to a registered nurse. Resident meeting minutes show the consumer’s voice in the minutes, and that consumers raise concerns in the meetings on a regular basis.

Consumers and/or representatives stated they are aware of how to access advocacy services and feel comfortable in doing so. The Assessment Team observed advocacy service information displayed on the electronic boards and posters displayed throughout the service, and staff indicated they are aware of how to access language and advocacy services for consumers if required.

# Standard 7

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| Human resources | |  |
| 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. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

This Standard has been assessed as not compliant as three of the five Requirements have been assessed as not compliant.

The service did not demonstrate that 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. Consumers and/or representatives provided mixed feedback about the care they receive, with consumers reporting the lack of staff impact their care and services.

Management reported the service previously covered the staffing shortfall with agency staff, however the financial cost of employing agency staff was not sustainable for the service. The board made the decision to reduce the number of consumers living at the service to enable sufficient staff coverage of consumer care and service needs whilst the service recruits more staff.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that 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 service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 7(3)(a) is found not compliant.

The service did not demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Consumers and/or representatives reported satisfaction in relation to staff knowledge, and said staff know what they are doing. Staff and management reported the service offers education and training through a combination of face to face learning and online learning modules.

Staff reported they have received training in several training modules including the Serious Incident Response Scheme, and the Quality Standards through their online training platform. Staff stated they have completed their manual handling training face to face with the service’s onsite physiotherapist. Whilst there is training facilitated for staff such as manual handling, understanding and managing behaviours, and Serious Incident Response Scheme, there is limited evidence that effective monitoring and review of staff application of this knowledge occurs.

Whilst there is evidence that training is provided to staff, there is limited evidence to demonstrate there is effective oversight of staff application of this knowledge and whether they have embedded this knowledge into their daily practice. There is limited evidence to indicate education is responsive to clinical indicators and risk identified at the service.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including ongoing staff training in documentation within the electronic case management system and clinical training.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 7(3)(d) is found not compliant.

The service did not demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The service has not demonstrated that all staff have up to date annual appraisals and there was no evidence of performance reviews of staff. None of the care staff or registered staff could confirm they had a performance review or have one scheduled. The clinical care manager reported they have had not had an opportunity to complete performance assessments of staff.

The service could not demonstrate how they use staff performance reviews to work out staff training needs, review duties list, and maintain the staff’s overall ability to provide safe care and services.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires the regular assessment, monitoring and review of the performance of each member of the workforce. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 7(3)(e) is found not compliant.

The service demonstrated that the workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Consumers and/or representatives stated staff engage with them in a respectful and caring manner and are gentle when providing care. Staff demonstrated an in depth understanding of consumers and this information aligned with care plan documentation.

The service demonstrated that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Consumers and/or representatives stated the staff are competent in their roles and know what they are doing. The Assessment Team observed staff to be competent in their roles and consumers expressed satisfaction with care and services provided.

Competencies are role specific, and management reported competency reviews of care staff are conducted by registered nurses. The clinical care manager overseas the registered and enrolled nurse competencies.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not Compliant |
| 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. | Not Compliant |
| Requirement 8(3)(d) | 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. | Not Compliant |
| Requirement 8(3)(e) | 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. | Not Compliant |

Findings

This Standard has been assessed as not compliant as four of the five Requirements have been assessed as not compliant.

The organisation’s governing body does not promote a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The chair of the board stated oversight and accountability of the service is achieved by the board meeting every 3 months and through 3 monthly reporting by the CEO. The board also has several sub committees including, quality and risk committee, asset committee, marketing and fundraising and the finance committee. The sub committees are active in discussing and taking actions in relation to matters which may present a risk to each area of focus.

The CEO reports to the board reflect the national quality indicator data and information about Serious Incident Response Scheme and workforce planning. However, the review of documentation across Standard 2 and Standard 3 indicate a lack of clear clinical oversight, including deficiencies in capturing clinical data, lack of analysis and deficiencies in using this data for quality improvements.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 8(3)(b) is found not compliant.

Review of the organisation’s documentation, interviews with the governing body, staff and consumers indicated that whilst some improvements have been made there are still gaps in effective wide governance systems.

In relation to information management, the service has transitioned to a new electronic care management system that will manage all care plan documentation. The system went live in July 2023 and since this time the service has been gradually transferring information into the system.

Each time a staff member starts an assessment, the electronic care management system has internal prompts for the staff to follow and complete each task to ensure all aspects of the assessment process is completed. A review of uncompleted tasks is completed each morning. However, the service is not consistently undertaking appropriate assessments to inform the delivery of care and services, hence information is not populating the electronic care management system and the care plan documentation to guide staff with current information about each consumer.

Staff stated they cannot readily access information they need when they need it and said finding and accessing organisational policy and procedure to assist in guiding their practice is difficult. Management confirmed there are policies and procedures that are still to be uploaded into the service’s electronic care management system.

The organisation has a continuous improvement system which includes audits, feedback and observations which are fed into their continuous improvement plan for all services within the organisation. The plan for continuous improvement is regularly reviewed by the governing body.

The Assessment Team found the organisation has effective systems for financial governance and has a system of delegated authorities. Management stated in relation to staff coverage, there is a financial commitment to provide adequate staffing levels. The CEO has access to funds to purchase items and make commitments when there has been a need to support the consumer’s care and service delivery. Staff advised they have access to equipment and supplies to support consumer care and service delivery. The consumer and representatives interviewed advised that equipment and supplies are available to support person care and service delivery.

The Assessment Team discussed the organisations workforce strategy plan which includes strategies for workforce recruitment, retention, accountability, training, and career pathways. Along with a review of other documentation provided, there is evidence of an awareness of local workforce challenges and actions have been taken and are being taken to address this.

The service has stopped advance booking agency staff to reduce the excessive expense of hiring agency staff. The service has reduced the numbers of consumers to manage staff coverage, and the service is supporting current staff who would like to further their qualifications.

The organisation has actively been working at improving their understanding of the Quality Standards. Training has been completed by all staff, management and board members; however, it has not ensured the service complies with some of the Quality Standards.

The organisation has a complaints and feedback register however not all complaints and feedback are recorded on the register. The CEO stated complaints are on his email and have not been transferred across to the complaints register. Verbal complaints are not recorded in the complaints register. This informal process makes it difficult for the service to analyse and identify complaint trends and feed into the service’s continuous improvement plan to actively improve results for the consumer.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The service was unable to demonstrate that this occurs consistently, therefore Requirement 8(3)(c) is found not compliant.

The organisation has a risk management framework and associated risk management policies which detail the process to identify, assess and manage risk, however these are not always being followed by the service. Management and staff were not able to demonstrate a knowledge of their responsibilities in relation to these policies and the accompanying legislative reporting requirements.

The service has developed a high-impact high-prevalence register for monitoring the top high-impact high-prevalence risks, however, effective assessments, monitoring and evaluation to identify and respond to high-impact high-prevalence risks are not always occurring.

There was limited evidence to demonstrate how the organisation can identify and address systemic issues in the quality of care they provide and how they use this information to provide feedback and training to staff about preventing and managing incidents.

The service has not demonstrated they are effectively managing high-impact high-prevalence risk, understand their responsibilities when it comes to responding to abuse and neglect and do not have an effective incident management system in place.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires effective risk management systems and practices. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 8(3)(d) is found not compliant.

There is a documented clinical governance framework which is composed of governance, leadership and culture, resident safety and quality improvement systems, clinical performance and effectiveness, safe environment for the delivery of care and partnering with the consumer. The clinical governance framework includes policies on antimicrobial stewardship, minimising the use of restraint and open disclosure.

However, there are deficiencies identified in Standard 2 and Standard 3 that demonstrate the organisation’s clinical governance systems have not been effective at the service level. The deficiencies indicate a lack of clear clinical oversight, including deficiencies in capturing clinical data, lack of analysis and deficiencies in utilising this data for quality improvements.

The service was able to demonstrate they were using antibiotics appropriately and are following antimicrobial stewardship principles such as obtaining pathology prior to commencing antibiotics. Registered nurses demonstrated a sound knowledge of antimicrobial stewardship and confirmed they had recent training to improve the assessment and management of urinary tract infections.

There is limited evidence action was taken in relation to some of the complaints on the complaints and feedback register, however the service was not able to demonstrate an open disclosure process is consistency applied. In relation to accidents and incidents, it has not been demonstrated that open disclosure is consistently applied. Accident/incidents are often not investigated to understand what occurred and why, so that an explanation can be provided to the consumer and/or their representative.

The Approved Provider responded and acknowledged some of the findings identified during the site audit. The Approved Provider’s response included additional documentation and a plan for continuous improvement containing actions to address the non-compliance.

In coming to my decision, I have considered the information provided by the Assessment Team as well as the information provided by the Approved Provider. Whilst the Approved Provider demonstrated some compliance with this Requirement, this Requirement requires that where clinical care is provided, a clinical governance framework including but not limited to the following, antimicrobial stewardship, minimising the use of restraint and open disclosure. The service was unable to demonstrate that this occurs consistently for all consumers, therefore Requirement 8(3)(e) is found not compliant.

The organisation has implemented processes to engage with consumers and representatives in the development, delivery and evaluation of person-centred care and services. The service has established a consumer advisory body to provide feedback to the service’s governing body about the quality of care and services they deliver. The consumer advisory body is run without involvement from the service. They maintain their own minutes and their own terms of reference.

The management team reported that currently the consumer advisory body mainly consist of consumer representatives, however the organisation is encouraging consumers to join the consumer advisory body. The service promotes the consumer advisory body through their newsletters and residents’ meetings as well as individual conversations with consumers and representatives.

Consumer representatives that form part of the consumer advisory body advised they are satisfied with the opportunity the consumer advisory body has created to let them share their concerns and ideas to the management team.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)