Performance

Report

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| Address: | Cnr Broadwater Boulevard & Bell Drive, Broadwater, BUSSELTON, Western Australia, 6280 |
| Activity type: | Site Audit |
| Activity date: | 14 May 2024 to 16 May 2024 |
| Performance report date: | 28 June 2024 |
| Service included in this assessment: | Provider: 1466 Aegis Aged Care Group Pty Ltd  Service: 6429 Aegis Ellenvale |

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 Aegis Ellenvale (**the service**) has been prepared by Katherine Richards, 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 consumers, representatives, staff, management, and others; and
* the provider’s response to the assessment team’s report received 12 June 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **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 3(3)(a):** The approved provider is to ensure staff are familiar with person-centred strategies to be used prior to administration of chemical restraint, and documentation clearly demonstrates their application and evaluation.

# 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 Quality Standard is compliant as 6 of the 6 Requirements have been assessed as compliant.

Consumers and representatives said staff understand their backgrounds and values, treating them with dignity and respect. Staff described information about consumer’s histories and life stories in line with care planning documentation and explained how this this influenced interactions and care. Staff receive training on diversity, respect, and dignity to ensure the service supports and includes all consumers.

Consumers and staff outlined how consumer’s cultural needs and preferences were understood and honoured. Cultural awareness and sensitivity were defined and reflected within governance processes, and staff practice informed through policies and procedures focused on person centred care.

Staff explained how they supported consumer decision making, acknowledging preferences, and familiarising themselves with choices outlined within the consumer’s care and services plan. Consumers explained how staff supported them to make decisions and maintain relationships of choice. Care planning documentation recorded consumer choices about how and when care was to be delivered, who was involved in their care, and supports to maintain relationships.

Consumers described how they were supported to take risks to meet their preferences. Care planning documentation demonstrated staff consultation with consumers and/or representatives on risks of choice, identifying the risks and responsive strategies. Staff were familiar with risks taken by consumers and the mitigating strategies used to optimise safety and well-being. Management explained the importance of supporting consumers to take risks to enhance independence.

Staff explained methods for providing information to consumers in line with communication needs and preferences. Consumers and representatives said they received sufficient information to make decisions, and staff are patient and take time to ensure consumers understand. Displayed information included the activities calendar and menu, with consumers saying verbal reminders provided.

Consumers outlined staff actions to respect and maintain their privacy, such as closing curtains and doors during care delivery. Staff explained how they sought permission to enter consumer rooms and were careful not to discuss consumer information in public areas, with documentation kept in computers that were password protected. The nurses’ station was secured when not in use, and computers locked when unattended, ensuring personal information was secured.

# 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. | 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. | 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. | Compliant |

Findings

This Quality Standard is compliant as 5 of the 5 Requirements have been assessed as compliant.

Staff outlined the initial and ongoing assessment processes to identify and inform needs, preferences, and risks associated with consumer care. Staff were guided through the assessment process through a checklist with expected timeframes to complete assessments. Care planning documentation identified risks and management strategies to inform consumer care.

Care planning documentation reflected current needs and preferences of consumers and included information relating to advance care and end of life planning. Staff were familiar with needs and preferences for consumers in line with care and services plans and consumer feedback. Staff explained approaches to discussing end of life planning, commencing during initial assessment and planning processes, and reviewed as required.

Consumers and representatives described their involvement within assessment and planning processes. Staff explained assessment and planning processes involved consultation with consumers and representatives, along with relevant providers and organisations. Policies and procedures reflected that assessment and planning practices were undertaken in partnership with consumers, representatives, and other providers.

Consumers and representatives said they received regular communication through case conferences or following identified changes to consumer condition or needs, and they could access a copy of the care and services plan. Care planning documentation included summary of discussions with consumers and representatives, with assessment and planning outcomes summarised into a care and services plan. Staff explained they updated consumers, representatives, and other providers of care and services with assessment and planning outcomes through verbal and written pathways.

Consumers and representatives confirmed care and services were reviewed regularly and as needed, such as when the consumer condition changed. Staff outlined the scheduled review process, with monitoring to identify changes of needs, and reviews undertaken following incidents. Care planning documentation verified review was undertaken annually or following an incident or change in consumer health.

# 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. | 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. | 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 Quality Standard is Not Compliant as one of the 7 Requirements has been assessed as Not Compliant.

The assessment team recommended Requirements 3(3)(a) and 3(3)(e) Not Met.

Requirement 3(3)(a)

The assessment team reported the service did not demonstrate they provided safe and effective personal and clinical care in line with organisation protocols, particularly in relation to use of restrictive practices, wound care documentation, pain management, and monitoring following consumer falls.

Care planning documentation for sampled consumers subject to chemical restraint met legislative requirements for consent and tailored behaviour support plans outlining alternate strategies. However, for 3 consumers the documentation did not consistently demonstrate the use of strategies within their behaviour support plan prior to administration of chemical restraint. Staff were observed to be effectively supporting consumer’s changed behaviours and were aware of requirements to consider and address their needs. However, during interviews staff described generic strategies rather than identifying the tailored management pathways outlined in behaviour support plans. Two representatives expressed concern that staff did not take a person-centred approach when responding to consumer’s changed behaviours, one citing they believed further training would be beneficial, however, neither representative had raised concerns with staff or management. Management advised they believed staff were using non-pharmacological strategies prior to use of chemical restraint but had not documented all information and commenced immediate toolbox training on the topic. Oversight of chemical restraint use was maintained by the Clinical manager to ensure strategies were reviewed for effectiveness.

Inconsistencies in documentation were also noted within wound charting, pain management, and monitoring of consumers following falls. Whilst staff described the importance of measuring wound sizes as best practice for monitoring, and regular charting included photographic updates, wound care records for one consumer did not always record measurements in line with policies and procedures. Documentation did not demonstrate use of identified non-pharmacological pain strategies for two consumers, although staff were familiar with strategies. Following consumer falls, neurological observations were not always undertaken in line with policies, and staff and management knowledge was inconsistent. Management believed these also were likely to be a documentation errors rather than lack of application, although added that staff are also able to use clinical judgement.

The approved provider has disputed the recommendation of Not Met. The response includes the following information and evidence to refute the assessment Team’s findings:

* An explanation of how restrictive practices were monitored and overseen at service and organisation levels, supported by policies, procedures, and work practices. Insight into the circumstances for use of chemical restraint for the named consumers, along with analysis of use for an extended period, demonstrated medication had been minimised and used as a last resort.
  + Whilst the assessment team reported non-pharmacological processes were not always being reported within the evaluation process following use of medication, this approved provider contends this does not show failure to ensure chemical restraint was a last resort action. Staff were recording individual strategies within charting and progress notes, evidenced within supporting documentation. The observations of staff supporting consumers with changed behaviours is also supportive in demonstrating tailored strategies were used.
  + As a commitment to ongoing improvement staff will be reminded to ensure this information is also reflective within the evaluation record, with continuous improvement activities including staff education, increased monitoring, and an audit to identify effectiveness. An organisational action has also been developed to include review of pro re nata (as required) psychotropic use within the Medication advisory committee and pharmacy cluster meetings.
* Corrections were made to information quoted about wound care, outlining wound monitoring and documentation requirements, and ensuring provision of best practice wound management through policies, procedures, and reference material. An investigation demonstrated wound measurements were documented in line with the policy, specifying frequency of records on initial/first assessment and at least every 4 weeks thereafter. Furthermore, the wound was demonstrated to be healing. However, as a commitment to ongoing improvement, education has been provided to clinical staff to ensure awareness.
* Information in the Site Audit related to pain management is inaccurate and at times contradictory. There is no obligation within policies to document use of non-pharmacological interventions prior to use of pain relief, however, evidence of use of the strategy of regular repositioning was available. Both named consumers had routine care outlined in their care and services plan as part of pain management strategies, for one this was routine repositioning which was documented in charting, the second had regular massage therapy charted. Neither consumer required regular administration of the pain relief, and when used, it was evaluated for effectiveness. The approved provider strongly refutes any comment was made about the service not always documenting effectiveness of medication, however, in response to the feedback has provided a reminder to all clinical staff.
* Only one consumer’s neurological observations following a fall was sampled but this was reflected as being generalised findings. Misquoted information on the frequency of monitoring was corrected during the Site Audit with reference to the policy. Staff practice is generally supported through the electronic care management system, which sets a workflow with prompts following incidents including for monitoring, and staff have access to policies to guide requirements to create the chart and undertake monitoring. A review of the consumer’s file included evidence of monitoring in line with the policy directives following other falls, and this was determined to be reflective of staff error, with counselling and education provided, and a reminder has been sent to all staff to ensure awareness of best practice in line with policies.

The assessment team also stated a consumer was not being monitored in line with specialist directives, however, later reported there was no evidence of the directive within documentation. The approved provider has also undertaken review and verified there was no evidence of any such directives, however, have increased monitoring in response to consumer feedback.

I acknowledge the approved provider’s comprehensive response, including the investigation undertaken, supportive evidence, and commitment to continuous improvement, demonstrated through actions within the Continuous improvement plan. I am satisfied the examples brought forward do not demonstrate significant or systemic issues in relation to pain assessment and management, or monitoring following a fall.

In relation to wound care for the named consumer, I have insufficient detail in front of me to determine monitoring and documentation was undertaken in line with the policy, as neither the Site Audit report nor approved provider’s response demonstrates photographs and measurements were taken every 4 weeks as a minimum. However, I have placed weight on the both the assessment team and approved provider reporting the wound was healing, along with evidence of best practice care relating to another consumer within the Site Audit report, and consider the service demonstrated effective wound care.

However, I am not satisfied the service has demonstrated chemical restraint was consistently used as a last resort. The approved provider has demonstrated policies and procedures available to guide staff use of restrictive practices, with oversight at service and organisational level. Documentation demonstrates consumers have tailored strategies for management of changed behaviours, and the service has reduced the frequency of administration of psychotropic medication for consumers. However, I find the service could not demonstrate strategies were used consistently prior to administering chemical restraint.

The approved provider believes the issue is concentrated on the record of medication administration, which triggers requirement to record non-pharmacological strategies, but other documentation such as progress reports and behaviour charting clearly outline use of other strategies. I do not find the submitted documentation supports this. Progress notes and behaviour charting has been provided for some, but not all, of the examples raised.

Inconsistencies in documentation practices have not been identified by the approved provider. Clinical staff use a template to prompt necessary documentation following use of chemical restraint. When non-pharmacological strategies are recorded, when comparing this information with behaviour charting there are inconsistencies in records reflecting a disconnect between the multi-layered documentation practices. This has not been identified by clinical staff or through monitoring processes. Documentation within consumer behaviour charts for one consumer with multiple examples of use of chemical restraint within the Site Audit report, had no behaviour charting done on 3 of the days chemical restraint was used, on one day the record showed no changed behaviour until 5 hours after use of medication, and on 2 occasions the non-pharmacological strategies were reported as effective without showing chemical restraint had been required.

The behaviour charting uses intervention codes to reflect what was undertaken, and I do not have full insight into what these all mean, or how they reflect upon strategies within the consumer’s behaviour support plans. However, there is an area to provide more detail, and I do not find this information reflective of information within the behaviour support plan. The provided behaviour support plan for one named consumer is lengthy, at 21 pages long, and the layout does not align triggers/needs/choices with strategies for ease of understanding or quick access and review by staff. The assessment team found staff interviewed were unable to describe the person-centred strategies they would use for the sampled consumers.

I do not find evidence within the documentation of use of the tailored strategies for the consumer, there is inconsistent information on what strategies were trialled dependent upon which document is reviewed, and staff demonstrated limited knowledge of person-centred care strategies to be used. Continuous improvement activities focus on education and oversight of clinical staff documentation, with monitoring for effectiveness, but not care staff activities to record information within the behaviour charting records. Accordingly, I am not satisfied the service has demonstrated use of best practice and tailored care for each consumer subject to chemical restraint.

For these reasons, I have determined Requirement 3(3)(a) is Not Compliant.

Requirement 3(3)(e)

This Requirement was recommended as Not Met, with the assessment team identifying instances where documentation did not accurately reflect assessed needs of consumers, with provision of care impacted. Two consumers and one representative gave examples relating to consumer care needs and preferences that were not consistently reflected in care.

Staff were unaware of the dietary information for a consumer when assisting with meal orders, causing frustration to the consumer, and whilst care planning documentation reflected reported dietary intolerances it did not include the preferences. The consumer stated this was an isolated occurrence, and staff interviewed were aware of the consumer’s needs and preferences and could coordinate alternate meal options if needed. Management updated the care plan, stating they were unaware of the reported preferences prior to feedback.

One representative advised they had requested their family member was not offered a choice of meals, as it exacerbated confusion and caused distress. Whilst staff were aware of the confusion and frustration, they were unaware of the request, and this information was not recorded within care planning documentation.

The approved provider has disputed the recommendation of Not Met, stating most of the named consumers were able to advocate for themselves, were actively involved in assessment and planning processes, and had not previously shared this information. The response includes the following explanation and evidence to refute the assessment team’s findings:

* There was no evidence of any directives relating to 2 of the 3 named consumers who reported needs that were not being met. Both named consumers were able to self-advocate and raise concerns but had not done so.
  + In relation to feedback staff were not following specialist directives, there was no evidence of this requirement within discharge documentation or medical review outcomes. The Site Audit report evidence does not support a lack of information or communication about this matter.
  + Interviews with staff about the other consumer identified one staff suggested a trial to lessen reported symptoms, however, this was not a directive. A referral for assessment and evaluation of the symptom had already been requested prior to the Site Audit, and this had been communicated and was known by staff and has subsequently been undertaken.
* For the third identified consumer, the person providing feedback was not the recognised representative. The consumer was able to communicate their own care needs if dissatisfied but had not done so. When consulted, the consumer denied the need was as specific as reported by the assessment team, however, the care and services plan was updated with an amended strategy.
* Regarding consumers identified as being impacted through the meal ordering process, the approved provider acknowledges potential for improved staff communication with consumers. Although unaware of the reported preferences, and unable to investigate anonymous feedback from a representative, they have developed and undertaken improvement actions including training on the importance of supporting consumer choices and having effective communication practices.

I acknowledge the approved provider’s response, including the investigation undertaken, supportive evidence, and commitment to continuous improvement, demonstrated through actions within the Continuous improvement plan. I am satisfied that the examples brought forward do not demonstrate systemic issues within staff communication of consumer condition, needs, and preferences. If consumers and representatives state they have not communicated concerns, either within routine assessment and planning processes or to make change to needs and preferences, then it cannot be argued there are deficiencies in the processes. The observed matter was verified as an isolated incident, which suggests staff were generally aware of, and responsive to, the consumer’s needs and preferences.

For the consumer reporting staff were not following specialist directives, the approved provider has demonstrated there were no such directives within hospital discharge summaries or notes from the medical officer. Whilst additional monitoring following return from hospital would have reflected best practice, particularly given the consumer’s diagnosis, treatment, and medication changes; neither the assessment team nor provider has made comment or provided evidence on what monitoring was being undertaken prior to the Site Audit. Regardless, I would consider any absence of monitoring related to assessment and planning processes in Standard 2, rather than relating to ineffective communication practices.

The Site Audit report also contains evidence of effective communication practices between staff to understand consumer condition, needs, and preferences. This included representatives saying staff were aware of information about consumers and they didn’t need to repeat information, and staff could explain practices of sharing information through documentation, handover, and meetings. I find this evidence, combined with the information submitted by the approved provider, demonstrates information about each consumer is effectively communicated.

For these reasons, I am satisfied Requirement 3(3)(e) is Compliant.

I am satisfied the other Requirements in Standard 3 Personal care and clinical care are Compliant.

Staff could identify high impact and/or high prevalence risks for consumers and how these were monitored and managed using person centred care strategies. Care planning documentation included strategies to manage and minimise risks. A representative said staff explained and implemented comprehensive risk management strategies.

Care planning documentation for a consumer receiving end-of-life care reflected consumer comfort, including pain, was addressed. Staff described actions taken to maximise comfort of consumers nearing end-of-life, including hygiene and regular, regular repositioning, management of pain, and meeting emotional and spiritual needs.

Staff outlined how they identified deterioration or change of consumer health through observations and monitoring and described pathways to communicate or escalate concerns. Responsive management of change or deterioration of consumer condition was guided through policies and procedures, with application evidenced within care planning documentation.

Consumers said referrals to providers to meet their needs were prompt. Staff explained referral processes for other providers, including through external organisations. Care planning documentation evidenced timely and appropriate referrals triggered prompt reviews.

Consumers reported they observed staff practicing infection prevention measures, such as practicing hand hygiene and wearing personal protective equipment. Staff described infection prevention and control measures in place and outlined how they followed best practice for antibiotic prescribing. The Infection prevention and control lead described their role in evaluating preparedness for outbreaks and monitoring staff practices. Policies, procedures, and outbreak management plans detailed assessment and actions for infection related risks.

# 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. | 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 Quality Standard is compliant as 7 of the 7 Requirements have been assessed as compliant.

Care planning documentation outlined preferences, dislikes, interests, and needs. Staff could describe how services and supports were used to support consumers do things of importance to them.

Consumers said staff provide emotional reassurance when required, and spiritual needs were supported through the available religious services. Staff explained indicators that reflected low mood in consumers and said when noticed they spend extra time listening to understand why they feel down. Care planning documentation outlined emotional and spiritual needs and strategies.

Consumers discussed their participation within the service and greater community to do things of interest and felt supported to stay connected with family and friends. Staff explained how the activities schedule was developed with consideration of consumer interests, identified within assessment and planning processes. Consumers were observed entertaining visitors or going out with family and friends.

Staff explained how information about consumer’s condition, needs, and preferences was shared with staff in various roles, including verbal and written handover practices and information within the care management system and dietary folders. Care planning documentation contained adequate information to inform staff.

Care planning documentation demonstrated timely and appropriate referrals to organisations and services to meet consumer needs. Consumers and representatives explained how needs were identified, and they were consulted on referrals made. Policies and procedures guided staff practices to make referrals to external organisations and providers.

Overall, consumers and representatives described provided meals as being of good quality and quantity, with enough variety to cater for preferences. Staff explained they can accommodate special requests for consumers, seeking meal choices daily and discussing consumer satisfaction during meals. Two consumers said meals were not always of their preference, but had not discussed this with staff, and management were responsive to the feedback and outlined actions they could take to make improvements for the named consumers. The seasonal menu was developed through consultation with consumers with Dietitian input.

Consumers described how personal equipment was cleaned and maintained by staff. Staff said they had sufficient access to equipment and supplies to support consumer needs, and described monitoring, cleaning, and maintenance processes. Equipment was observed to be suitable, clean, and in good condition.

# 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

This Quality Standard is compliant as 3 of the 3 Requirements have been assessed as compliant.

Consumers described the service environment as welcoming and easy to understand, and they were supported to personalise their rooms. Management described aspects of the service environment to welcome consumers and support their independence, such as signage and handrails. The environment had sufficient signage and lighting to support independent wayfinding and was clear of hazards and clutter.

Staff outlined cleaning and maintenance processes, with scheduled tasks and monitoring for hazards. Consumers and representatives said the service was clean and well maintained, and they could move freely through indoor and outdoor areas, including accessing the front door using a pass. Maintenance logs demonstrated prompt response to requests for service, and staff were observed undertaking daily environmental cleaning activities.

Consumers said furniture, fitting, and equipment were clean and well-maintained. Furniture, equipment, and fittings were observed to be clean and in good condition, with updated records of service and maintenance where applicable. Staff explained the preventative maintenance schedule, and regular audits and observations were undertaken to ensure effectiveness of processes.

# 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

This Quality Standard is compliant as 4 of the 4 Requirements have been assessed as compliant.

Consumers and representatives confirmed they felt safe and comfortable to provide feedback or make a complaint and were aware of available feedback options. Staff said consumers and representatives were encouraged to provide feedback within meetings, using emails, or surveys, or could directly approach management or staff to discuss concerns. Feedback forms were available in reception, with a nearby secured box for lodgement.

Staff demonstrated awareness of advocacy and complaint services available for consumers, and management advised there are guidelines on coordinating language services if required. Consumers were aware of available support services for feedback and complaints but had not found need for use. Pamphlets and posters were displayed, and access pathways were outlined within the feedback and complaints policy.

Policies and procedures informed complaint management pathways, including use of open disclosure. Staff were provided training on application of open disclosure, and management explained the complaint and incident register prompted and recorded application of open disclosure. Feedback and complaint documentation demonstrated complaints were recorded, investigated, and acted upon in line with the open disclosure principles.

Documentation, including the Continuous improvement plan, meeting minutes, and feedback and complaints register, demonstrated how consumer input was used to make improvements. Management described how complaint trends were used to develop improvement actions, offering recent examples of responsive changes made.

# 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. | 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. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

This Quality Standard is compliant as 5 of the 5 Requirements have been assessed as compliant.

Some consumers, representatives, and staff reported there were occasions when there were not enough staff, particularly in the mornings, resulting in rushing of care, however, no consumers reported this as having impact on the provision of their care. Management explained there were ongoing recruitment strategies to ensure the workforce numbers were sufficient to meet consumer needs and legislative requirements and cover unplanned staff absences. Whilst rostering demonstrated unfilled shifts in the fortnight preceding the Site Audit, management explained they overbook staff, and also had a significant number of consumer rooms that were vacant, and demonstrated the service was meeting care minute requirements. Management also discussed monitoring practices to ensure consumer needs were met in a timely fashion, such as reviewing call bell reports for delays.

Consumers and representatives described staff interactions as kind, caring, respectful, and gentle. Staff practice and behaviour was informed through policies, training, and information in the employee handbook, and the organisational values, including the commitment to treating consumers with dignity and respect.

Management explained staff competency is considered through recruitment and onboarding processes, checking necessary qualifications, registrations, and security checks. The orientation process included mandatory training and competency assessment, and staff advised they could seek additional support if required. Staff could describe the requirements for their role in line with documented position descriptions, which detailed qualifications, experience, key duties, and responsibilities.

Consumers described staff as well trained and knowledgeable. Staff feedback reflected they felt supported and had sufficient access to training to deliver safe and quality care. Management explained how mandatory training topics were relevant to supporting quality outcomes, including infection control, the Serious Incident Response Scheme, and the Quality Standards, and additional training was provided where a need was identified. Monitoring practices ensured staff compliance with mandatory training.

Staff verified they underwent formal performance review through appraisals, during which they discussed progress, development, and goals. Management explained the formal performance review processes for staff, including those on probation. Documentation demonstrated actions were taken in response to deficits in staff performance.

# 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. | 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. | 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. | 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. | Compliant |

Findings

This Quality Standard is assessed as 5 of the 5 Requirements have been assessed as compliant.

The assessment team recommended Requirement 8(3)(e) Not Met.

Requirement 8(3)(e)

This assessment team found the service did not demonstrate best practice care in relation to use of restrictive practices, particularly use of psychotropic medication, and this was reflective of the clinical governance framework being ineffective in minimising use of restraint. Inconsistencies were identified in staff knowledge of elements of restrictive practices. Staff interviewed did not demonstrate understanding of restrictive practices, and chemical restraint was not consistently used as a last resort following use of tailored strategies. Changes to the clinical management team in the month preceding the Site Audit had impacted monitoring and oversight processes relied upon. However, management explained there had been organisational support during this period, and believed findings related to documentation rather than staff practice.

The approved provider has disputed the recommendation of Not Met, explaining the Clinical Governance Framework includes robust processes for management and oversight. The response includes the following information and evidence to refute the assessment team’s findings:

* The governance framework guides management and staff through processes and procedures reflective of legislative requirements and best practice. The processes are mature, having been enhanced over time with additional information, and significant changes have been supported through staff training. Staff have access to this information through the electronic information management system.
* Comprehensive systems and processes are in place to ensure compliance with restrictive practice legislation, and management and staff have received ongoing training. Copies of documents relevant to use of restrictive practices have been supplied with the response, reflective of assessment and application procedures, work practices with tools and checklists, flowcharts, training case summaries, monitoring practices including the register, and toolbox training undertaken. The supporting documents within the framework for open disclosure and antimicrobial stewardship have also been submitted.
* Expectations of staff knowledge varied by roles, and it is unclear whether questions were structured suitably for staff understanding relevant to their position.
* Evidence in the Site Audit report is contradictory at times, suggesting deficiencies within staff knowledge of open disclosure practices but then reflecting feedback from consumers and representatives confirming use and management and staff could describe application of an open disclosure process. Similarly, positive feedback has been provided relating to infection control and antimicrobial stewardship.
* As a commitment to providing quality care, they have also developed and undertaken improvement actions including provision of antimicrobial stewardship education to clinical staff and sending a bulleting to all services within the organisation on the principles of open disclosure and supporting policies.

I acknowledge the approved provider’s response, including the investigation undertaken, supportive evidence, and commitment to continuous improvement. I consider it reasonable for staff to hold differing levels of understanding relating to matters of clinical care or response to incidents and complaints dependent upon their roles and responsibilities, although I did not find this was routinely reflected within the provided documentation. I find that the Site Audit report has included sufficient positive evidence relating to antimicrobial stewardship and application of open disclosure reflective of an effective governance system.

Whilst there is potential for improvement of practices relating to the application of chemical restraint, particularly around documentation, I do not find the evidence before me demonstrates this arises from an ineffective clinical governance framework. The organisation has established policies, procedures, guidance materials, training, and monitoring practices, overseen by the clinical governance committee which reports to the Board. The effectiveness of this is demonstrated within other Requirements and Standards, including practices and accountability for the quality of care and services outlined in Requirement 8(3)(b) of the Site Audit report.

For these reasons, I am satisfied Requirement 8(3)(e) is Compliant.

I am satisfied the other Requirements in Standard 8 Organisational governance are compliant.

Consumers and representatives verified their involvement in the development of care and services through feedback and partnering in their care. Management outlined methods to engage consumers and representatives through meetings, feedback, surveys, and within care plan reviews, as well as the organisational consumer advisory body. Meeting minutes demonstrated consumer input on items such as food quality, staffing arrangements, and continuous improvement.

Management described the organisational structure and hierarchy, including reporting and communication practices between different levels of management. Reporting and audit outcomes were submitted regularly to the Board for review, with discussion evidenced within meeting minutes. The Board make up included executive and non-executive members, with relevant skills and clinical experience to ensure the promotion of safe, inclusive, and quality care and services.

The organisation’s governance systems included processes and mechanisms for key management areas and were understood by staff. Financial governance included allocation and management of budgets, detailing spending authorities and processes to seek approval for additional purchases to meet consumer or service needs. Information management systems enabled staff access to consumer information, policies, procedures, training, and incident reporting. Changes to regulatory compliance were monitored and managed at organisational level.

The risk management system included policies, procedures, and monitoring through clinical indicators, audits, and reporting. High impact and high prevalence risks were identified within reporting and known by staff. Staff were aware of their responsibilities for reporting incidents, including through the Serious Incident Response Scheme, and systems supported escalation of serious incidents through to the governing body, and analysis for trends. Consumers were supported to live their best lives through making choices, including where this entailed risk. Staff received training on recognising and responding to elder abuse and neglect.

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)