Performance

Report

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| Name of service: | All Care Aged Care The Vales |
| Service address: | 60-66 States Road MORPHETT VALE SA 5162 |
| Commission ID: | 6933 |
| Approved provider: | Tickled Pink Aged Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 16 May 2023 to 19 May 2023 |
| Performance report date: | 15 August 2023 |

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 All Care Aged Care The Vales (**the service**) has been prepared by M Glenn 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; 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 11 July 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-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.

**Standard 2 requirement (3)(b)**

* Ensure care plans are reflective of consumers’ current and assessed needs and preferences and include risks to consumers’ health and well-being to enable staff to provide safe and quality care and services.

**Standard 3 requirement (3)(d)**

* Ensure staff have the skills and knowledge to recognise changes to consumers’ health and well-being, including clinical deterioration, implement appropriate monitoring and management strategies and initiate timely referrals, where indicated.
* Ensure policies, procedures and guidelines in relation to management of deterioration are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of deterioration.

# 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

The Quality Standard is assessed as compliant as all six of the specific requirements have been assessed as compliant. The Assessment Team recommended requirement (3)(d) in Standard 1 Consumer dignity and choice not met.

**Requirement (3)(d)**

The Assessment Team were not satisfied risk and choice assessment forms had been completed for consumers who required them or that all consumers taking risks were recorded. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

* A Risk and choice assessment completed in June 2019 identifies a lifestyle choice the consumer partakes in which includes an element of risk, and this assessment is reviewed six-monthly. There was no documentation to show that Consumer A or the General practitioner (GP) were involved in the initial consultation or any subsequent reviews or that Consumer A was consulted about the risks they choose to take and strategies to minimise the risks.
* A Risk and choice assessment relating to an activity Consumer B chooses to partake in which includes an element of risk had not been completed. There was no evidence of consultation with Consumer B to discuss their choice, risks or strategies to minimise the risks.
* Consumer C did not have a completed Risk and choice assessment to discuss impacts of food choices on their health.
* Consumer D refuses aspects of care, including Allied health dietary recommendations for wound healing. There was no evidence the possible consequences of refusing care had been explained to Consumer D.
* The policy document outlines some potential risks and review frequency for those risks. There is no supporting documentation about how risks are to be identified with consumers, consultation processes, how they are managed and who is responsible for completing documentation. Management recognised a deficiency in supporting documentation and stated a Consultant has been engaged to review current process and practices.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* A Risk assessment dated June 2019 relating to the activity and risks involved signed by Consumer A.
* State Consumer B no longer partakes in the activity.
* Acknowledge Consumer C did not have a Risk assessment in place until May 2023. Included progress notes from February 2020 and November 2021 relating to Dietitian reviews and notations demonstrating consultation with the consumer relating to risks involved in their choices.
* Progress notes dated November 2022 outlining a discussion with Consumer D relating to risks of not offloading pressure and notes from a Dietitian review in April 2023 demonstrating discussion with the consumer relating to nutritional support choices.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. For consumers highlighted, I find their wishes and preferences relating to risks they choose to take have been supported by the service and staff. In coming to my finding, I have placed weight on supporting documentation included in the provider’s response demonstrating discussions have been undertaken with Consumers A, C and D to help them understand the risks their choices pose to their health and well-being and strategies to manage those risks to support them to live the way they chose have been implemented.

I do note that dates of conversations with consumers range from June 2019 to April 2023. While supporting documentation provided for some of the highlighted consumers indicates ongoing review of related assessments, there does not appear to be a formalised process to undertake these reviews in consultation with consumers. Such consultation processes would ensure consumers’ understanding of risks related to their choices remains known and current, and management strategies remain effective and appropriate.

For the reasons detailed above, I find requirement (3)(d) in Standard 1 Consumer dignity and choice compliant.

**In relation to all other requirements in this Standard,** most consumers and representatives sampled considered consumers are treated with dignity and respect and their culture and diversity is valued. On entry, information about the consumer, their culture and life story is gathered and any needs or preferences regarding care and services are identified, with information used to develop care plans. Staff sampled provided examples of how they respect consumers’ identity, diversity and culture, and were observed interacting respectfully with consumers.

Consumers were from various backgrounds and said they felt care and services were culturally safe. Staff were knowledgeable of consumers’ cultural identity and described how they support consumers to meet their needs regarding care and services. Cultural days are celebrated throughout the year and are incorporated into the activities calendar, and care files and feedback from consumers and staff demonstrated consumers’ cultural safety is considered through provision of care and services.

Most consumers and representatives felt involved in and supported to make decisions about the care and services consumers receive. Consumers said they are supported to make and maintain connections and relationships, both within and outside of the service, and are encouraged to participate in activities to keep them connected with others. For consumers sampled, staff described how they are supported to maintain relationships with people who are important to them, and consumers were observed spending time with their family members and participating in group and individual activities of their choosing.

Information is provided to consumers through a range of avenues, including daily verbal discussions, meeting forums, noticeboards and the Resident handbook. Focus meetings are run by the Chief executive officer to share information and seek feedback from consumers on a range of areas, including food, activities, cleaning, and laundry services. A consumer-run meeting is also conducted with no staff in attendance. On entry, consumers are provided with information regarding what information the service collects and why. Staff could explain how they respect consumer privacy and how information is kept confidential. All consumers and representatives felt staff respected consumers’ privacy.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

# 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. | Non-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

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied assessment and planning identifies and addresses consumers’ current needs, goals, and preferences. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

* Consumer C stated they wished to have a daily shower and had discussed this with staff in January 2023, however, this was not occurring. The care plan noted showering three times a week. Management stated Consumer C keeps changing their mind and that is why the care plan was not changed. The care plan was updated during the Site Audit to reflect the consumer’s wish and for staff to ask the consumer about their preference each day.
* The care plan did not include instructions relating to use of a piece of equipment for transfers, identified by the consumer as their preferred method, or Consumer C’s preference to not follow their recommended diet.
* A Self-medication form identifies Consumer B self-administers an injectable medication and decides the dose. Nursing staff stated they do not take Consumer B’s blood glucose levels and were not able to explain how they monitor and action high or low blood glucose levels. The care plan did not include information about self-administration of medication.
* Skin management interventions in Consumer D’s care plan are generic, not current, and do not consider refusal of care and current skin status. Recommendations from an external service in May 2023 had not been included in the care plan. The care plan was updated during the Site Audit following feedback by the Assessment Team.
* Falls management interventions in Consumer E’s care plan are generic, not current and do not consider impulsive behaviours and current needs.
* Staff stated they have been working at the service long term and are aware of consumer needs and do not necessarily refer to care plans while attending consumer needs.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, actions taken in response to issues identified and supporting documentation. The provider’s response included, but was not limited to:

* Consumer C receives exactly what they wish on any given day.
* Information relating to Consumer B’s diabetes management is located on and/or in the medication chart, accessible to registered staff. Progress notes, Diabetes management plan and medication chart were provided.
* In relation to Consumer D, those interventions relevant to care staff are in the care plan.
* While Consumer E’s impulsive behaviours and associated strategies had not been documented, numerous strategies had been documented, including use of a bed sensor mat which was physically in use at the time of the Site Audit.
* Indicated a long standing practice of providing only the information required by care staff being present in the care plan, with other key information in the areas that reflect service practices. Staff read care plans as needed, with changes listed on a whiteboard and discussed at handover.
* In relation to Consumers B, D and E a new care plan format has been adopted to avoid such information not being in the care plan.

I acknowledge the provider’s response. However, this requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences. I find, specifically for Consumers C, D and E, the evidence presented demonstrates care plans are not individualised and tailored to guide staff to provide care and services which are in line with each consumer’s needs and preferences and planned around what is important to them.

In relation to Consumers C and D, I have considered key information relating to choices they have made about care delivery, some which pose a risk to their health and well-being and are not in line with Allied health recommendations, has not been included in care planning documentation to guide delivery of care. For Consumer C, the care plan did not reflect preferences for transfer or frequency of hygiene needs. I also find for Consumer E, the care plan did not reflect current falls management strategies. I acknowledge Consumer C and D’s care plans were updated during the Site Audit, however, the updates were made in response to the Assessment Team’s feedback and not as a result of the service’s own monitoring and review processes. I acknowledge staff feedback indicating they have worked at the service a long time and are aware of consumer needs. However, I find the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers’ care and service needs.

While Consumer B’s care plan does not include information relating to self-management and administration of an injectable medication, I consider information included in the provider’s response demonstrates sufficient information is available to guide clinical staff in the management of Consumer B’s diabetes, including high and low blood glucose level readings.

For the reasons detailed above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to all other requirements in this Standard**, care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are completed on entry and on an ongoing basis. A range of validated risk assessment tools are also used to inform care planning. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop a care plan which generally incorporates each consumer’s needs, preferences, goals and strategies to manage identified risks. Consumers and representatives were satisfied with the care consumers receive, and felt risks, such as falls and pressure injuries are identified and managed to promote their independence and safe care.

Care files sampled confirmed consumers and their representatives are involved in assessment and planning of care and services on entry and on an ongoing basis and demonstrated involvement of GPs and Allied health professionals in consumers’ care.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers, staff and others and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers. Care plans had been updated following regular review processes, in response to incidents and changes in consumers’ health and condition and recommendations from GPs or Allied health services had been incorporated into care plans, where required. Staff confirmed they are informed of changes to consumers' care needs and services, including through handover processes. Overall, consumers and representatives said the service regularly communicates with them about consumers’ care, they are offered a copy of the care plan, staff explain the care plan to them, and they consider the care plan meets consumers’ needs, goals, and preferences.

For the reasons detailed above, I find requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | 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. | Non-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

The Quality Standard is assessed as non-compliant as one of the seven specific requirements has been assessed as non-compliant. The Assessment Team recommended requirements (3)(b) and (3)(d) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied processes to manage high impact or high prevalence risks were effective. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

Consumer D

* Progress notes shows Consumer D has had multiple hospital admissions. Staff sampled said Consumer D prefers to take charge of their care and can be resistive to different nursing care interventions. Consumer D’s comorbidities and refusal of care have evidently impacted negatively on their health. Risks to Consumer D’s health have not been identified and considered and there are no effective risk management strategies to reduce risks to Consumer D’s well-being.
* Consumer D has four pressure injuries which have been attended to and regularly reviewed, and there is involvement of external Allied health services. Pain was noted to be well managed and regularly reviewed by the GP.
* Consumer D did not have any concerns with their care, stating wounds and pain are being managed as best they can be, and staff sampled were aware of Consumer D’s refusal of care and pressure care needs.

Consumer C

* Consumer C has a preferred method of transfer. Consumer C had an incident in January 2023 when staff did not place the transfer equipment appropriately resulting in a fall. Consumer C and their representative felt the fall was not investigated appropriately, nor adequate training relating to the piece of equipment provided to staff since the incident to further reduce the risk of reoccurrence.

Consumer E

* Consumer E is at high risk of falls and has had 18 falls with multiple injuries sustained since January 2023. Consumer E shows impulsive behaviours and does not wait for staff assistance. These risks have not been appropriately considered and interventions have not been reviewed or updated to reflect current risks and possible risk mitigation strategies.
* Falls have been managed appropriately, in line with the falls management protocol except for Physiotherapist reviews. Consumer E was not referred to or reviewed by a Physiotherapist after sustaining multiple falls in six-months, however, was reviewed by the Physiotherapist as part of the six-monthly care plan review process. Clinical staff said Physiotherapist referrals are initiated where consumers sustain a fracture or there is a change to mobility, noting Consumer E has not had a change in mobility following falls. The Falls prevention procedure and policy states a Physiotherapist referral must be completed if clinically indicated.
* Staff were aware of Consumer E’s compulsive behaviours, falls risk, causative factors and management strategies.

Consumer F

* Consumer F has had 14 falls since January 2023 with no injury. The GP has reviewed Consumer F in response to falls on multiple occasions in April 2023, stating falls are due to a medical condition, and not waiting for staff assistance.
* Physiotherapist reviews occurred at six-monthly care plan reviews, however, not in response to multiple falls. The care plan includes falls management strategies.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, actions taken in response to issues identified and supporting documentation. The provider’s response included, but was not limited to:

* Consumer D did not lack capacity and directed care they wished to receive and their wishes were respected and followed. Consumer D’s refusal of pressure care was documented and discussed, and while not using the recommended supplement, the consumer was taking a supplement of their choosing as noted by the Dietitian.
* Documentation demonstrating staff training was undertaken in relation to Consumer C’s preferred method of transfer.
* While Consumer E’s impulsive behaviours and associated strategies had not been documented, a sensor mat was physically in use and other management strategies were documented.
* A monthly Falls risk assessment is completed for all consumers, including Consumer F and Consumer F has been seen by the GP and Physiotherapist as stated in the report.
* Implementing new care plans to address concerns raised in the report; and amended the monthly falls document to ensure a prompt to consider and document referral to a Physiotherapist for incidents that result in more than minor injuries.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. In coming to my finding, I have considered the evidence presented in relation to the consumers highlighted does not demonstrate systemic deficiencies in the management of high impact or high prevalence risks related to care.

In relation to Consumer D, I have considered evidence highlighted in Standard 1 requirement (3)(d) demonstrating refusal of aspects of care and Allied health recommendations were known by staff and care was provided to Consumer D in line with their choices. The Assessment Team’s report included evidence demonstrating effective management high impact or high prevalence risks for Consumer D, including wounds and pain, and involvement of the GP and Allied health services in the delivery of care. Consumer D stated while they have multiple health issues, staff look after them well. Consumer D did not have any concerns with their care and stated wounds and pain are being managed as best they can be.

While I acknowledge Consumer C felt appropriate action was not taken in response to an incident in January 2023, supporting documentation included in the provider’s response demonstrates training was provided to staff in relation to Consumer C’s preferred method of transfer. I have also considered there was no evidence demonstrating Consumer C had been involved in any further incidents of this nature.

While I acknowledge that since January 2023, Consumers E and F have had multiple falls, it is difficult to determine the effectiveness of falls management strategies with the evidence not outlining if the incidence of falls was trending up or down month to month. While falls sustained by Consumers E and F did not result in review by a Physiotherapist, staff were following the service’s falls management process where referrals are to be initiated where consumers sustain a fracture or experience a change to mobility. Both consumers were reviewed by the Physiotherapist as part of the care plan review process and there is no indication changes were made in relation to management strategies. There was evidence demonstrating Consumer F had been reviewed on multiple occasions by the GP in response to falls. I have considered information in the Assessment Team’s report indicating Consumer E’s recent falls were managed appropriately, in line with the falls management protocol and staff sampled were aware of Consumer E’s compulsive behaviours, falls risk, causative factors and preventative strategies and Consumer F’s care plan included falls management strategies.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied changes to consumers’ condition and care needs is recognised or responded to in a timely manner. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer C displayed signs of a cough in April 2023 with staff administering as-required medications over a five day period between April and May 2023. The following day, a notation was placed in the GP’s book for a visit, and a notation in progress notes two days post the entry indicates ‘in MOs (Medical officer’s) book for review’. A GP did not visit during this period despite several requests from Consumer C to see one. Consumer C was transferred to hospital directly from an outpatient’s appointment five days after the cough was identified and diagnosed with influenza. The GP visited the service on the day the consumer was admitted to hospital and prescribed antibiotics without assessment or review. Consumer C and their representative were dissatisfied with the delay in identification and response to deterioration which resulted in the hospital admission.
* Consumer D’s health slowly declined after return from hospital in April 2023. Staff did not identify and respond to signs of deterioration until Consumer D’s condition worsened 11 days later when they were taken to hospital and diagnosed with septic shock. Consumer D’s care file demonstrated bowel care was not effectively monitored or managed, the consumer refused meals and was feeling lethargic the day prior and day of hospital transfer.
* The Recognition of consumer deterioration procedure included generic information which lacked useful detail and did not provide specific guidance to staff.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, actions taken in response to issues identified and supporting documentation. The provider’s response included, but was not limited to:

* Commentary on the timeline of events for Consumer C and indicated Consumer C was booked to see the GP as part of a regular review, not because they were deteriorating. Consumer C was experiencing a dry irritating cough which was not uncommon. When Consumer C stated they felt worse, immediate action was suggested to the outpatient’s department.
* Progress notes for Consumer D for the period highlighted and indicated Consumer D’s deterioration was very much noted by clinical staff during the period raised and they were seen by the GP six times in the period noted.
* Adopted a new Health deterioration guide.

I acknowledge the provider’s response. However, I find for Consumers C and D, deterioration of condition was not effectively recognised or responded to in a timely manner resulting in negative impacts for both consumers.

I acknowledge Consumer C had a history of suffering a dry irritating cough. However, the provider asserts the consumer was booked to see the GP as part a regular review and not due to deterioration. However, in coming to my finding, I have placed weight on information in the Assessment Team’s report and consider timely action was not taken in response to a change in Consumer C’s condition. Progress notes indicate staff documented in the GP’s communication book the day after the cough was noted for the GP to visit. A further progress note two days later described Consumer C as ‘chesty and noted coughing’ and indicated Consumer C was in the GP’s book for review. While the evidence demonstrates staff were monitoring Consumer C and administering as required medication, notations referencing Consumer C as being documented in the GP communication book indicate there was some level of concern relating to Consumer C’s general condition. There is no indication attempts were made to contact the GP to request they review Consumer C. I have also considered while Consumer C was in hospital, antibiotics were prescribed by the GP without appropriate assessment and review of Consumer C.

In relation to Consumer D, I have considered bowel management was not effectively monitored or timely interventions undertaken which could have contributed to Consumer D’s change in condition. I acknowledge Consumer D was reviewed by the GP on five occasions in the 11 day period highlighted. However, progress notes included in the provider’s response do not demonstrate the GP was notified that Consumer D was possibly constipated, with the consumer not having a bowel motion for 10 days at the time of hospital transfer. The day prior to and of the transfer, the consumer was noted to have a diminished appetite, was refusing food, was consuming minimal amounts of fluid and was described as tired and lethargic. Progress notes indicate bowel management intervention was not considered until the consumer reported they had not had their bowels open for nine days, at which time intervention was refused by the consumer. Further intervention was not undertaken until approximately 24hours later, however, the effectiveness of the intervention is not noted.

For the reasons detailed above, I find requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**In relation to requirements to all other requirements in this Standard,** most consumers and representatives expressed satisfaction with the care consumers receive, including management of personal care, pain, diabetes and behaviours. Care files were reflective of consumers’ individualised personal care needs and demonstrated appropriate management of specific aspects of care, including pain, wounds, restrictive practices, diabetes and complex care needs, as well as involvement of GPs in consumers’ care. Updates from external governing bodies are followed to ensure currency of best practice is maintained.

Consumers and representatives were satisfied their wishes would be enacted and consumers’ comfort and dignity maintained during the end of life phase. Staff described how consumers are assisted to maintain their comfort and dignity during their end of life stage and provided examples of how they exercise and support end of life care, not only for the consumer, but also for representatives. Care files included consumers’ preferences in relation end of life care and advance care directives and end of life wishes were available and easily accessible to staff. Palliative care is provided onsite, with access to the GP and/or public health palliative care team, based on consumers’ needs.

Consumers and representatives were satisfied with how consumers’ information is documented, communicated and shared with others and felt consumers’ personal and clinical care was well coordinated and consistent. Care files demonstrated timely and appropriate referrals are initiated, where required. Where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff and care plans updated to reflect any changes to consumers’ care and service needs.

Infection related risks are minimised through implementation of transmission-based precautions and the antimicrobial stewardship program. Staff provided examples of infection prevention and control and clinical staff described preventative measures to minimise use of antibiotics. Policies are available to assist and guide staff practices, and staff are provided ongoing training relating to infection control, antimicrobial stewardship, and donning and doffing of personal protective equipment. Consumers and representatives said the service is clean, and staff practice good infection control.

For the reasons detailed above, I find requirements (3)(a), (3)(c), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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

Information reflected in care files sampled was tailored to each consumer’s needs, ensuring care and services provided optimised their independence, well-being, and quality of life. For consumers sampled, staff described what was important to them and activities they like to engage in, in alignment with care plan documentation. Consumers and representatives felt consumers are supported to do things they want to do and they feel safe in the way services and supports are delivered.

Consumers and representatives said consumers receive services that support and promote their emotional, spiritual, and psychological well-being. Where a negative change in a consumer’s demeanour is identified, this is addressed through one-on-one visits or referrals to a dedicated Resident liaison officer. The Resident liaison officer speaks to consumers who are feeling low and all new consumers on entry in order to identify their emotional, spiritual and psychological well-being needs. Volunteers are also available to provide one-on-one time to consumers for emotional and spiritual support.

Consumers and representatives felt consumers are supported to maintain contact and relationships with people who are important to them and to engage in activities, both inside and outside of the service, that are of interest to them. Lifestyle staff described how activities are tailored to meet and support consumers’ needs, goals, and preferences and review of the lifestyle and leisure schedule for the past two months demonstrated the schedule is updated regularly and activities adapted in response to consumer and representative feedback.

Information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely are referrals are initiated. Care staff described how they are kept up-to-date with consumers’ changing needs and preferences and consumers and representatives confirmed consumers are provided services consistent with their care needs.

Consumers and representatives said meals provided are of a suitable variety, quality, and quantity. Consumers confirmed they are involved menu planning, can order outside of the menu if they choose and said the service is always open to feedback and suggestions. Meals are prepared in line with a four-week rotating menu, which has been reviewed and approved by a Dietitian, and a selection of alternative options are available. Informal feedback about the food is sought from consumers and reported back to management for possible improvements or changes. Consumers also provide feedback regarding meals during monthly consumer meetings. In response to feedback provided, changes are made to the menu in consultation with consumers to ensure their needs and preferences are met.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Equipment available is specific to consumer needs and preferences and additional equipment is purchased if specifically required. Staff are provided training on the use of equipment required for consumer use. Maintenance processes ensure equipment is maintained in a safe and suitable condition. Most consumers said they feel safe when using the equipment and they know how to report any concerns they have, which are attended to quickly and efficiently.

For the reasons detailed above, I find all requirements in Standard 4 Services and supports for daily living compliant.

# 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 service environment was observed to be welcoming and easy to navigate, encouraging a sense of belonging. The service is a single storey building with multiple courtyards, communal spaces and several areas which promote consumer interaction with others and spaces for quiet reflection. Outdoor gardens were observed to be well manicured, with pathways that were clear and wide for easy access for consumers. Consumers are encouraged to bring in personal items and furniture to add personal character, feel, and familiarity to their individual spaces. Consumers said they feel at home in the service environment and the service optimises their sense of belonging.

The service environment was safe, clean, and well maintained with consumers able to move freely both indoors and outdoors. Consumer rooms are large, well-lit, and spacious with their own air conditioning and heating system that consumers can regulate to ensure it meets their personal preference. Regular cleaning is undertaken and reactive and preventative maintenance processes, supported by contracted services, are in place. All consumers said the service is clean and well-maintained and they can move freely, both indoors and outdoors, if they wish. Additionally, consumers and representatives said equipment and furniture is safe, well-maintained, and suitable for consumers’ needs.

For the reasons detailed above, I find all requirements in Standard 5 Organisation’s service environment compliant.

# 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

The Quality Standard is assessed as compliant as all four of the specific requirements have been assessed as compliant. The Assessment Team recommended requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied the manner in which complaints and open disclosure are managed was consistent with the service’s policies and procedures. The Assessment Team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Some consumers and representatives felt the service considered, investigated, and responded to complaints.
* A consumer and their representative stated they had verbally raised concerns with management regarding the consumer not feeling safe following an incident, continence management and not having complaints heard or actioned.
* A representative said they had raised verbal concerns relating to clothing and was unsure of what had happened as a result. Management contacted the representative during the Site Audit.
* A consumer stated they made a complaint in January 2023 relating to wound management and the competence of staff completing the task. They stated they had not received an explanation from management or staff following the complaint but noted the nurse no longer attended to them. An apology was not provided.
  + Complaints raised by these consumers were not evident in records sampled nor was there indication that open disclosure was applied in response to issues raised. Management could not provide an explanation as to why these complaints were not recorded.
* There is no formal policy or procedure to assist staff in managing feedback or complaints.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* The provider refuted statements made by one consumer and their representative and provided evidence to demonstrate staff training had been arranged and undertaken following the incident described.
* Stated the consumer did not raise concerns relating to wound management with the head nurse and had they been aware of the feedback, open disclosure would have been followed.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. While I acknowledge the feedback provided by four consumers and/or representatives, I do not consider this demonstrates systemic issues with the overall feedback and complaints system as it relates to actioning feedback and complaints and open disclosure. For one of the consumers highlighted, the provider’s response demonstrated appropriate actions were initiated in response to an incident, and for another the provider asserts the issues were not raised with them to be able to respond. While I acknowledge that the feedback from these consumers was not noted in feedback documentation sampled by the Assessment Team, 419 entries of feedback were included.

In coming to my finding, I have considered information in the Assessment Team’s report indicating some consumers and representatives felt the service considered, investigated, and responded to complaints. I note 21 consumers and/or representatives provided feedback during the Site Audit. I have also considered evidence in other Standards and requirements indicating the service supports a culture where consumers are encouraged and supported to provide feedback and complaints. This included a consumer-run committee of which meeting minutes demonstrated consumers provided verbal feedback and suggestions on what was important to them and actions taken in response; engagement of a Resident liaison officer whose role it is to meet with consumers on a one-on-one basis to discuss their concerns; and the engagement of two Continual service improvement staff who speak directly with consumers to obtain their feedback. One representative stated they had raised concerns relating to a consumer’s care and was pleased with actions taken in response. I have also considered care and clinical staff sampled demonstrated an understanding of open disclosure principles and described how they apply them in practice.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied there were processes to review and analyse trends in complaints and feedback to improve the quality of care and services. The Assessment Team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Management were unable to demonstrate processes to review and analyse trends in complaints and feedback to improve the quality of care and services.
* A Resident liaison officer is engaged to meet with consumers on a one-on-one basis to discuss their concerns and there are two Continual service improvement staff whose job it is to speak directly with consumers to obtain their feedback. One of the three staff stated they were unable to provide adequate support services for consumers as they are only available three hours each day and much of the visitation is welcoming new admissions to the service.
* Feedback records included 419 entries from December 2022 to May 2023. The information was focused more on interviews and meeting notes from the Resident liaison officer about the general physical and psychological well-being of consumers as opposed to complaints. The Resident liaison officer’s handwritten feedback notebook entries were not consistent with the service’s feedback records.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* The Resident liaison officer records what is raised in the meetings. Entries missed in the log is human error and did not result in negative outcomes.
* Written feedback is minimal compared to verbal feedback and we will go around and speak with consumers all the time for this reason.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. While the Assessment Team asserts processes to review and analyse trends in complaints and feedback were not demonstrated, further evidence to support this assertion has not been provided. As such, I do not consider the evidence presented demonstrates systemic issues with the overall feedback and complaints system as it relates to monitoring, reviewing and using data to improve the quality of care and services provided to consumers.

In coming to my finding, I have considered information in the Assessment Team’s report demonstrating some consumers and representatives felt the service endeavoured to make improvements to the service which was principally done through verbal feedback and complaints raised directly with staff and management. I have also considered evidence in other Standards and requirements indicating feedback and complaints are used to improve the quality of care and services. This included minutes of consumer and representative meeting forums demonstrating feedback from consumers being actioned; regular updates made to the lifestyle and leisure schedule and adaption of activities in response to consumer feedback; and changes to the menu in consultation with consumers to ensure it meets their needs and preferences. I have also considered the Continuous improvement plan, included in the provider’s response, included improvement initiatives derived from consumer feedback and complaints, including those from external avenues. Furthermore, organisational meeting minutes, also included in the provider’s response, included consideration and monitoring of complaints data and focus group discussions.

For the reasons detailed above, I find requirement (3)(d) in Standard 6 Feedback and complaints compliant.

**In relation to requirements (3)(a) and (3)(b)**, consumers said they are encouraged to provide feedback and complaints verbally. Consumers and representatives are provided information relating to lodgement of formal complaints through newsletters and pamphlets. Consumers and representatives said they feel able to provide verbal feedback and reported they have not needed advocates or external support when discussing feedback or complaints with the service. Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry and ongoing. Information brochures relating to advocacy and translation services were observed throughout the service.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints compliant.

# 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

Adequate staffing levels across the service were demonstrated and rosters for the four weeks preceding the Site Audit confirmed all shifts were covered to maintain quality care and services. A Registered nurse is rostered on every shift every day and there are sufficient Registered nurses available to cover shifts. Staff stated there were enough staff and they did not appear rushed when carrying out their duties. Consumers said staff are good, and there are enough staff to provide care and services. Most consumers felt staffing levels were sufficient to meet their care and service needs and said call bells are responded to in a timely manner on most occasions.

All consumers and representatives said staff were kind, caring and respectful in their interactions. Staff were knowledgeable and respectful of consumers’ needs and preferences and were observed interacting with consumers in a kind and caring manner.

There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles. New staff are provided an orientation to the service, participate in buddy shifts, and are assigned a trained mentor. Role descriptions are available and were noted to be consistent with staff understanding of their roles and required performance. Staff competency is monitored through review of clinical data, feedback and workforce turnover to obtain visibility on where and how care and service delivery is being provided. Consumers and representatives felt staff were well trained to provide the support and care needed.

Staff said they receive training provided by the Chief executive officer and specialists in designated areas. Staff undertake mandatory and elective training components, with mandatory training monitored for completion. The Continuous improvement plan evidenced additional training had been implemented and provided to staff in response to an external complaint. Consumers and representatives said staff are well trained to provide the support and care consumers needed.

The service has a staff performance framework which ensures staff performance is regularly assessed, monitored and reviewed. Audits, consumers’ clinical needs, competencies, trending results, observations and legislative changes are used to review, assess, and monitor each staff member's performance. Prior to discussions with the management team relating to performance, staff members have an opportunity to self-assess their performance, review their practices, and identify areas for development and training.

For the reasons detailed above, I find all requirements in Standard 7 Human resources compliant.

# 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

The Quality Standard is assessed as compliant as all five of the specific requirements have been assessed as compliant. The Assessment Team recommended requirement (3)(c) in Standard 8 Organisational governance not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied effective organisation wide governance systems relating to information management, continuous improvement, and feedback and complaints were demonstrated. The Assessment Team’s report provided the following evidence gathered through interviews, and documentation relevant to my finding:

* Some care plans were basic, with several deficits around consumer information not being available, and were not consistently reflective of consumers’ current conditions. Not all consumers at high risk of falls or taking risks had this information recorded.
  + Clinical and care staff sampled were unable to locate policies and/or procedure manuals or instructions.
  + There is limited structure around policies and procedures and evidence of how staff were trained in the awareness and implementation of policies and procedures was not provided.
* While the Continuous improvement plan included some examples of continuous improvement, information in the Continuous improvement register was inconsistent with the Feedback and complaints register, often lacking reference to several consumers’ feedback, requests and suggestions.
* A framework for encouraging, accepting, analysing, and responding to feedback and complaints using open disclosure protocols was not demonstrated, and evidence of staff training in managing feedback and suggestions was not provided.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation of not met. The response included commentary relating to the information presented in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* Assert high risk or high impact risks were managed effectively.
* The policy and procedure system is long standing and while improvements have been made to Dignity of risk and Feedback and suggestions policies, the remainder remain sound. During the Site Audit, policy and procedures had been removed from the nurses station to the Assessment Team’s room.
* There are macro and micro continuous improvements captured, consumer and organisation lead. Consumers drive their own improvements through the consumer run committee.
* Feedback is logged and actioned and the complaints log is tabled at meetings.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service compliant with this requirement. I find effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were demonstrated.

In relation to information management, while I acknowledge deficiencies in consumer care planning documentation, I find this evidence is more aligned to requirement (3)(b) in Standard 2 and have considered this information in my finding for that requirement. While clinical and care staff were unable to locate policy and procedure manuals, there is no further evidence to indicate if this was an ongoing issue, or as the provider asserts, just during the Site Audit. I have also considered that while there was no evidence relating to staff training in policy and procedure documents, the evidence presented in the Assessment Team’s report across the eight Quality Standards does not demonstrate systemic issues relating to staffs’ understanding and application of policy and procedures in the delivery of care and services. I acknowledge the provider’s response indicating improvements made to the Dignity of risk and Feedback and suggestions policies.

In relation to continuous improvement, I have placed weight on supporting documentation included in the provider’s response demonstrating a Continuous improvement plan is maintained. The plan provided was current, included a range of improvement initiatives across all eight Quality Standards, and noted progress and evaluation of initiatives implemented. The plan also included improvement initiatives derived from consumer feedback and complaints made through external avenues. Organisation meeting minutes provided also evidence monitoring of the plan and continuous improvement initiatives. I have considered the evidence presented relating to consumer feedback and suggestions in my finding for requirement (3)(d) in Standard 6.

I do not consider the evidence presented relating to feedback and complaints demonstrates systemic issues with the service’s related processes. In coming to my finding, I have considered information in the Assessment Team’s report and the provider’s response demonstrating the service has adapted the way they gather and action feedback to reflect the consumer cohort. The findings of the four requirements in Standard 6 demonstrates feedback and complaints systems and related processes are actively applied to seek consumer feedback and identify ways to improve care and services provided. While evidence of staff training was not provided, there is no evidence presented to suggest staff were not aware of the service’s feedback and complaints processes.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance compliant.

**In relation to all other requirements in this Standard,** consumers are engaged in the development, delivery and evaluation of care and services through one-on-one communication, feedback processes and meeting forums. The Chief executive officer said resident and representative meetings provide important input into the service and consumers and representatives felt consumer meeting forums were an important way to provide feedback and learn about happenings in the service.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The service is a family-run business, with the Chief executive officer holding the position as the sole member of the governing body. Information gathered through feedback, incident reporting, risk assessment and consumer experience surveys inform the organisation’s executive management and the governing body, and quality, risk and continuous improvement reporting is shared within the organisation and is monitored by the governing body.

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including use of an incident management system. A clinical governance framework is in place, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Management and staff awareness of processes relating to clinical governance was further demonstrated through evidence presented in other Standards.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 8 Organisational governance compliant.

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