Performance

Report

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| Name of service: | Allanvale Private Nursing Home |
| Service address: | 38-40 Ascot Street South ALTONA MEADOWS VIC 3028 |
| Commission ID: | 4302 |
| Approved provider: | Carewest Group Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 25 July 2023 to 28 July 2023 |
| Performance report date: | 1 November 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 Allanvale Private Nursing Home (**the service**) has been prepared by J Howard, 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, conducted from 25 July 2023 to 28 July 2023. The site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The Approved Provider’s response to the site audit report, received 30 August 2023.
* Other relevant information and intelligence held by the Commission in relation to this service.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Non-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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

* ***Requirement 1(3)(d)* –** each consumer is supported to take risks to enable them to live the best life they can.
* ***Requirement 1(3)(f)* –** each consumer’s privacy is respected and personal information kept confidential.
* ***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.
* ***Requirement 2(3)(c) –*** assessment and planning:

i) 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

ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

* ***Requirement 2(3)(d)* –** the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available.
* ***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.
* ***Requirement 3(3)(a)*** **–** each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

i) is best practice; and

ii) tailored to their needs; and

iii) optimises their health and well-being.

* ***Requirement 3(3)(b) –*** effective management of high-impact or high-prevalence risks associated with the care of each consumer.
* ***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.
* ***Requirement 3(3)(f) –*** timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* ***Requirement 3(3)(g) –*** minimisation of infection-related risks through implementing:

i) standard and transmission-based precautions to prevent and control infection; and

ii) practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

* ***Requirement 4(3)(b)*** *–* services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.
* ***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.
* ***Requirement 4(3)(f) –***where meals are provided, they are varied and of suitable quality and quantity.
* ***Requirement 4(3)(g)* –** where equipment is provided, it is safe, suitable, clean and well maintained.
* ***Requirement 5(3)(b) –*** the service environment:

i) is safe, clean, well maintained and comfortable; and

ii) enables consumers to move freely, both indoors and outdoors.

* ***Requirement 5(3)(c)*** – furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.
* ***Requirement 6(3)(a)*** *–* consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.
* ***Requirement 6(3)(b) –***consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.
* ***Requirement 6(3)(c) –***appropriate action is taken in response to complaints and open disclosure is used when things go wrong.
* ***Requirement 6(3)(d) –*** feedback and complaints are reviewed and used to improve the quality of care and services.
* ***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.
* ***Requirement 7(3)(c)* –** the workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles.
* ***Requirement 7(3)(d)* –** the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* ***Requirement 7(3)(e)* –** regular assessment, monitoring and review of the performance of each member of the workforce.
* ***Requirement 8(3)(a)*** *–* consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* ***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.
* ***Requirement 8(3)(c)*** – effective organisation wide governance systems relating to the following:

i) information management

ii) continuous improvement

iii) financial governance

iv) workforce governance, including the assignment of clear responsibilities and accountabilities

v) regulatory compliance

vi) feedback and complaints.

* ***Requirement 8(3)(d)*** – effective risk management systems and practices, including but not limited to the following:

i) managing high-impact or high-prevalence risks associated with the care of consumers

ii) identifying and responding to abuse and neglect of consumers

iii) supporting consumers to live the best life they can

iv) managing and preventing incidents, including the use of an incident management system.

* ***Requirement 8(3)(e)*** – where clinical care is provided – a clinical governance framework, including but not limited to the following:

i) antimicrobial stewardship

ii) minimising the use of restraint

iii) open disclosure.

# Standard 1

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| Consumer dignity and choice | | Non-compliant |
| 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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 1(3)(d) and 1(3)(f).

*Requirement 1(3)(d):*

Consumers described how they were supported to live their best lives through taking risks, such as leaving the service to visit family and friends. Care and lifestyle staff described areas of consumer risk and applicable mitigation strategies. However, the site audit report noted consumers were observed taking risks of which staff were unaware, such as having electrical appliances in their rooms without a safety assessment having been conducted.

Consumers’ care plans showed staff had not conducted risk assessments for activities they wished to pursue, nor had the potential benefits and harms been discussed with them. In addition, consumer representatives had not been consulted regarding risks their loved ones wished to take.

During the site sudit, the Assessment Team shared its findings with management, who advised the issue would be raised with clinical staff. However, when the issue was investigated with management later in the site audit, no further comments were provided.

In its response of 30 August 2023 to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 1(3)(d), and advised it had taken steps to remedy the non-compliance. The response included a plan for continuous improvement (PCI) and actions taken after the site audit to remedy the non-compliance.

Planned actions to address the non-compliance included: a risk assessment will be conducted for consumers wishing to take risks; identify all consumers with electrical appliances in their rooms; offer consumers alternative options and discuss associated risks; regular review of consumers’ risk assessments; risks to consumers will be reviewed at ‘resident of the day’ meetings; and affected consumers’ care plans will be updated to include a privacy, dignity and choice authorisation form.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers were taking risks of which staff were unaware and required consumer supports were not in place. Therefore, I find the service was non-compliant with Requirement 1(3)(d) at the time of the site audit.

*Requirement 1(3)(f):*

The site audit report noted consumers’ privacy was not respected and their personal information was not kept confidential, which was confirmed through consumer and representative feedback, documentation reviews and observations made by the Assessment Team, all of which aligned.

Examples included in the site audit report included staff consistently entering consumers’ rooms without consent or announcing themselves; shift handovers occurring in a dining room where personal and clinical information was shared within earshot of consumers, along with staff gesturing toward consumers who were being discussed; nurses’ stations were left unlocked or unattended, whereby consumers’ personal and clinical information was visible to others; consumers’ files were not stored securely; and consumer representatives were seen accessing a staff communication book and adding information about their loved ones’ upcoming medical appointments.

During the site audit, the Assessment Team advised management of its findings and in particular, that a shift handover had occurred in public. Management stated the issue would be investigated and on day two of the site audit, a list was provided of staff who had attended a six-minute training session about consumer privacy. On day three of the site audit, staff were again observed conducting a shift handover in a dining room where consumers’ personal and clinical information was shared within earshot of other consumers. Staff who attended the shift handover advised the Assessment Team the process always occurred in the dining room and they had not been advised the process was to cease.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 1(3)(f), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: staff education on privacy and dignity; placing signs on consumers’ doors to remind staff to knock and wait; staff reminded to support a change in shift handover practices; all staff were sent a copy of the service’s privacy and dignity ‘standard’; staff were sent a copy of the service’s privacy and dignity policy, which they were required to sign; posters to be placed around the service which remind staff about consumer privacy and to close doors in nurses’ stations and the medication room; staff were reminded to lock computers and not leave documents in open areas; and orientation of nursing agency staff will be reviewed.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site sudit, consumers’ privacy was not respected and their personal information was not kept confidential. Therefore, I find the service was non-compliant with Requirement 1(3)(f) at the time of the Site Audit.

*The other Requirements:*

Consumers confirmed the service cared for them in a way which respected their culture and identity. Staff spoke of consumers with respect and understood their individual backgrounds, needs, preferences, cultures and identities, all of which were recorded in care plans. Consumers were supported to communicate decisions about their care and maintain relationships of choice.

Consumers’ care plans included information about how care should be delivered, who was involved in their care and how the service supported them to maintain personal relationships. Consumers confirmed the service provided information that was current and enabled them to make decision about their care and daily living preferences. For example, information was disseminated via resident meetings, verbally by staff, an activities calendar and a newsletter.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant, as I am satisfied the service is non-compliant with Requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e).

*Requirement 2(3)(a):*

Consumers provided mixed feedback about their sense of safety when receiving care and services. Specifically, consumers and representatives said the assessment and planning of care and services did not fully consider risks to consumers’ health and well-being, such as falls, pain management, behaviours of concern and restrictive practices.

Though clinical staff assessed consumers’ needs and planned their care after entry to the service, a review of care plans showed assessments were incomplete, risks to individual consumers were only partially documented and for the most part, behaviour support plans were absent. Consequently, risk mitigation strategies were incomplete and staff lacked guidance in how to deliver safe and effective care and services to consumers.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 2(3)(a), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: conducting a review of consumers’ restrictive practice and behaviour management care plans; conducting restrictive practice risk assessments and gaining consumer or representative consent; assigning a registered nurse to oversee care plan evaluations; developing a reporting template whereby clinical issues can be reported and trended; staff training in wound management and documentation; and reviewing risks to consumers at ‘resident of the day’ meetings.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service’s processes for assessment and planning of care and services did not fully consider risks to consumers’ health and well-being. Therefore, I find the service was non-compliant with Requirement 2(3)(a) at the time of the site audit.

*Requirement 2(3)(c):*

Consumers and representatives provided mixed feedback about their levels of involvement in the assessment and planning of care and services, though they confirmed other service providers were involved in the process. Specifically, consumers and representatives were not consistently involved in the assessment and planning of care and requests on behalf of consumers were mostly disregarded, which caused distress to some consumers.

Clinical staff said consumers’ family members were contacted during bi-monthly care evaluations or when changes occurred. However, no particular staff member was responsible for oversight of consumers’ bi-monthly care plan reviews, nor did staff ensure representatives were contacted when consumers’ circumstances changed. A review of care plans showed consumers and representatives were not involved in the assessment and planning of care, and evidence of other service providers’ input was scarce. The Assessment Team requested evidence that all consumers’ care evaluations had been completed as per the service’s schedule, but none was provided.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 2(3)(c), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: case conferences scheduled with affected consumers, their representatives, general practitioners and relevant staff; a consultant being engaged to support staff in care assessment and planning; use of a recruitment agency to employ a clinical care coordinator; care evaluation alerts to be included in the service’s electronic care management system; a registered nurse to ensure all care plan evaluations are conducted; and specific registered nurses will conduct regular reviews of consumers’ needs.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, assessment and planning was not consistently based on an ongoing partnership with consumers, representatives or other providers of care and services. Therefore, I find the service was non-compliant with Requirement 2(3)(c) at the time of the site audit.

*Requirement 2(3)(d):*

Consumers and representatives said they were consulted during formal care evaluations, but had not been provided with copy of the care plan, nor were they aware the document should be available on request. The Assessment Team advised management of consumer and representative feedback about the availability of care plans. Management stated care plans were available if consumers and representatives asked for a copy and no further comment was made.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 2(3)(d), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: sending an e-mail to consumers and representatives which apologised for not having previously offered a copy of care plans and advising a copy could be requested at any time; and offering a copy of care plans at care evaluations.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers’ care plans were not readily available to themselves or their representatives. Therefore, I find the service was non-compliant with Requirement 2(3)(d) at the time of the site audit.

*Requirement 2(3)(e):*

A review of consumers’ care documents showed the service did not regularly review consumers’ care and services for effectiveness, or when incidents impacted on their needs, goals and individual preferences. Specifically, consumers who experienced clinical incidents such as falls, unexplained weight loss or medication errors, were referred to one clinical staff member for review, follow-up and trend analysis. The staff member was only rostered to work two days per week and therefore, it took up to two weeks for clinical incidents to be reviewed.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 2(3)(e), and provided a PCI which set out how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: a review of 28 incidents which had been open since February 2023, to determine if they could be closed; all incidents to be reviewed and investigated within 48-hours of occurrence; the use of open disclosure when incidents occur; training for clinical and care staff in identifying, documenting, reporting, investigating, evaluating and closing incidents in a timely manner; and staff to be trained in updating care plans following reviews by allied health professionals.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service did not regularly review consumers’ care and services for effectiveness when incidents impacted on their needs, goals and individual preferences. Therefore, I find the service was non-compliant with Requirement 2(3)(e) at the time of the site audit.

*The other Requirement:*

Consumers and representatives confirmed they had discussed consumers’ end of life wishes with staff. Where consumers and representatives were not ready to discuss their end of life decisions, staff provided them with information to review and discuss again during care plan evaluations.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 3(3)(a), 3(3)(b), 3(3)(e), 3(3)(f) and 3(3)(g).

*Requirement 3(3)(a):*

Consumers provided mixed feedback about their sense of safety when receiving personal and clinical care. Whilst some consumers and representatives said personal and clinical care was tailored to consumers’ needs, others said clinical care was not always appropriate and they did not feel safe when care was delivered. Specifically, consumers’ care plans reflected safe and effective care was provided; however, the Assessment Team identified deficiencies in relation to restrictive practices, behaviour support plans, the management of psychotropic medications and general medication management. Interviews with management, clinical and care staff identified significant deficiencies in their understanding of restrictive practices and the legislated processes which must be followed.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 3(3)(a), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: where consumers were subject to a restrictive practice, review the restrictive practice and behaviour management care plans and where none existed, develop both and gain consumer or representative consent; develop a reporting template whereby clinical issues can be reported and trended; use of a recruitment agency to employ a clinical care coordinator; review the audit process and create a schedule to review the delivery of clinical care and services; update all policies to ensure currency and best practice; staff to be trained in restrictive practices; consumers’ subject to a restrictive practice will be included in clinical review meetings; and review the psychotropic medication register.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, each consumer was not receiving safe and effective personal and clinical care. Therefore, I find the service was non-compliant with Requirement 3(3)(a) at the time of the site audit.

*Requirement 3(3)(b):*

Consumers and representatives provided mixed feedback about how high-impact and high-prevalence risks to consumers were managed. Whilst some consumers and representatives said falls risks and unexpected weight loss were well managed, others were dissatisfied. A review of consumers’ care plans who had experienced falls showed assessment and planning following a fall had involved allied health professionals, medical specialists and mitigation strategies were implemented.

Where consumers and representatives were dissatisfied with how falls risks were managed, they gave a specific example of three days in July 2023, where the service had no heating and some consumers with compromised mobility and therefore at risk of falls were also subject to a restrictive practice and had attempted to obtain blankets to stay warm. Those consumers who could not obtain blankets or use their call bells were found cold and without an alternate heat source in their rooms. One representative had advised staff of how cold their loved one was and requested additional blankets; however, none were provided. Consequently, the representative and another consumer’s family member took blankets from the linen cupboard and distributed them to consumers who were cold.

The Assessment Team raised consumer and representative feedback with management who said blankets and heaters had been provided to some consumers but otherwise, they did not realise others were cold. Management showed the Assessment Team an image taken during the heating outage, which confirmed temperatures within the service ranged between 15 and 21 degrees Celsius and therefore, consumers could not have been cold. Management further advised if another heating outage occurred, staff would adjust consumers’ reverse-cycle air conditioners to the heat function.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 3(3)(b), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: where consumers were subject to a restrictive practice, review the restrictive practice and behaviour management care plans and where none existed, develop both and gain consumer or representative consent; communication has been sent to consumers’ families to apologise for the heating outage; the business continuity plan was updated to include heating outages; additional blankets and space heaters were purchased; and a new restrictive practice policy will be developed.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, high-impact and high-prevalence risks to consumers were not being effectively managed. Therefore, I find the service was non-compliant with Requirement 3(3)(b) at the time of the site audit.

*Requirement 3(3)(e):*

Consumers and representatives were not satisfied with how information about consumers’ conditions, needs and preferences was documented and communicated within the organisation. A consumer representative said communication within the service is difficult as there was no clinical manager to speak with. Clinical and care staff said information about consumers’ care and services were communicated through verbal and written handovers and in individual progress notes, charts, assessments and care plans. However, a review of consumers’ care plans showed information about their conditions, needs and preferences were not well documented or communicated to otehr service providers. In addition, the service’s handover sheet did not include consumers’ medical conditions which affected the delivery of care and clinical staff said shift handovers were not assessed for effectiveness.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 3(3)(e), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: a review of the shift handover process; use of an electronic care management system to inform staff of changes to consumers’ conditions; review the ‘resident of the day’ care checklist; and staff to be trained in updating consumers’ care plans following reviews by allied health professionals.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, information about consumers’ conditions, needs and preferences were not effectively shared within the organisation, or with others where responsibility for care was shared. Therefore, I find the service was non-compliant with Requirement 3(3)(e) at the time of the site audit.

*Requirement 3(3)(f):*

Consumers and representatives said the service referred consumers to allied health professionals, medical specialists and external organisations. However, consumers and representatives said referrals to the service’s medical officer where not always timely, which was confirmed by a review of care plans. For example, representatives had limited opportunities and waited for prolonged periods to speak with the medical officer and either ask for blood tests to be conducted when consumers’ conditions changed, or to have the results of blood tests interpreted for them.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 3(3)(f), and presented a PCI for how it intended to remedy the non-compliance.

Planned action to address the non-compliance was offering affected consumers and representatives a case conference. No further actions were included in the response.

While I acknowledge the Approved Provider is taking some action to remedy the identified deficiencies, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, referrals to the service’s medical officer were not timely and this impacted consumers’ health and wellbeing. Therefore, I find the service was non-compliant with Requirement 3(3)(f) at the time of the site audit.

*Requirement 3(3)(g):*

Consumers, representatives, staff and management gave mixed feedback regarding the service’s infection control protocols, as well practices used to support the appropriate use of antibiotics. Specifically, the service did not have a dedicated infection prevention and control lead, staff were not adequately trained in infection control and antimicrobial stewardship, nor were there processes in place to monitor consumers receiving antibiotics.

With respect to infection control, staff were observed using personal protective equipment and sanitising their hands when attending to consumers, though they did not sanitise equipment shared by multiple consumers. Representatives said consumers’ personal equipment was dirty and had never been spot cleaned. The Assessment Team observed some consumers’ wheelchairs and mobility aids were soiled with food. The cleaning supervisor said care staff had responsibility for cleaning consumers’ personal mobility aids and shared equipment, such as lifting machines. The cleaning supervisor said cleaning staff would clean shared equipment when asked, though they could not recall the last time such a request was made.

With respect to antimicrobial stewardship, clinical staff and the service’s safety officer were asked to describe the control principles in place to promote antimicrobial stewardship. Staff said registered nurses were advised to contact consumers’ general practitioners and request ‘pathology slips’. Clinical staff further advised they followed general practitioners’ recommendations about antibiotic prescription. Management and staff were unsure of why some consumers were taking long-term antibiotics without any documented reason, nor were review processes in place for consumers for whom antibiotics were prescribed.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 3(3)(g), and presented a PCI for how it intended to remedy the non-compliance.

Planned action to address the non-compliance included: staff training in infection control with management to have oversight of the process; cleaning of consumers’ personal equipment to be included in ‘resident of the day’ meetings; deep cleaning of some consumers’ rooms, including their belongings; medication reviews for some consumers; antimicrobial stewardship to become a standing agenda item at staff meetings; staff to be trained in antimicrobial stewardship; infection control to be included in mandatory training and annual staff competency assessments; a registered nurse trained in infection control to be offered the position of infection prevention and control lead; and a review of policies and processes related to infection control and antimicrobial stewardship.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service had ineffective systems to manage infection control and antimicrobial stewardship. Therefore, I find the service was non-compliant with Requirement 3(3)(g) at the time of the site audit.

*The other Requirements:*

Consumers confirmed staff had discussed advanced care planning and end of life preferences with them, which were recorded in care plans. Staff who provided palliative care described how consumers nearing the end of life were supported. For example, staff made consumers comfortable by regular repositioning for comfort, pain monitoring and providing emotional support. The service responded to changes in consumers’ conditions and care needs in a timely manner, which was confirmed by consumers, representatives and a review of care plans.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-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. | Non-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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 4(3)(b), 4(3)(d), 4(3)(f) and 4(3)(g).

*Requirement 4(3)(b):*

Consumers and representatives said the service promoted consumers’ spiritual well-being, but did not always promote their emotional and psychological well-being. Though consumers’ care plans included their emotional and psychological needs, the Assessment Team identified staff were too busy to provide person-centred care or have meaningful engagement with consumers. For example, a consumer was visibly upset and staff spent two minutes with them before walking away without having provided meaningful emotional or psychological support. In addition, the Assessment Team reviewed a progress note from April 2023, which showed lifestyle staff spent one-on-one time with 50 consumers in a one-hour timeframe.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 4(3)(b), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: a review of the leisure and lifestyle calendar; staff to be trained in providing consumers with emotional and psychological support; a review of staff rosters; a review of the volunteer program to include one-on-one time with consumers; and seek consumer input to an activities calendar.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers did not receive supports for daily living which promoted their emotional and psychological well-being. Therefore, I find the service was non-compliant with Requirement 4(3)(b) at the time of the site audit.

*Requirement 4(3)(d):*

Consumers and representatives said they were not always satisfied consumers’ daily care and living preferences were effectively communicated between staff, and in particular, to nursing agency staff. For example, consumers said they often repeated themselves to agency staff who were unaware of their preferences, whilst representatives said clinical staff did not follow-up or consistently document their concerns. The service’s own staff said consumers provided feedback that nursing agency staff did not listen to them and information was not relayed between shifts.

The Assessment Team observed consumer representatives accessing a staff communication book and filling it themselves with information regarding their loved ones. When one representative was asked the reason behind this practice, they noted it was the only way to ensure staff were kept updated. When this feedback was shared with management, they said they were unaware communication between staff was an issue for consumers and representatives.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 4(3)(d), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: a review of orientation for nursing agency staff; a simplified handover sheet for staff; communication to be sent to all staff when changes occur at the service; staff surveys to commence with the aim of improving communication; and use of the electronic care management system to inform staff of changes.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers’ daily care and living preferences were not effectively communicated between staff and in particular, nursing agency staff. Therefore, I find the service was non-compliant with Requirement 4(3)(d) at the time of the site audit.

*Requirement 4(3)(f):*

Consumers’ dietary needs and preferences were recorded in their care plans and available to kitchen staff. Consumers and representatives were dissatisfied with meals offered by the service. Primary concerns included a lack of meal choices, food was often unpalatable, food temperatures were consistently cold, consumers had no input to the menu and there was a lack of staff attention for those consumers who needed assistance to eat. The head chef explained the service had a seasonal, weekly menu that repeated every four weeks and was developed with a dietician. Consumers chose between a hot or cold breakfast, with one hot meal choice at dinner or sandwiches and salad.

The Assessment Team observed meals being served in the dining room, as well as being delivered to consumers in their rooms. Consumers who required assistance were not treated with respect, nor were they afforded dignity by being offered napkins. Staff were further observed to have little time to help consumers, with some consumers unable to finish eating their meals as a consequence. Where some consumers found a meal unpalatable, they were not offered an alternative.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 4(3)(f), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: commencement of a consumer food focus group; food temperatures to be taken at the beginning and end of meal services; consumers to receive effective assistance at mealtimes; staff to be trained in ensuring consumers’ dignity during mealtimes; commencement of a daily catering survey; and management will supervise the dining service.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service was not providing varied meals of suitable quality or quantity. Therefore, I find the service was non-compliant with Requirement 4(3)(f) at the time of the site audit.

*Requirement 4(3)(g):*

Consumers said the equipment they used, such as mobility aids and activity resources, were not clean or well maintained. Representatives who regularly visited the service said they often cleaned their loved one’s equipment, rooms and bathrooms, particularly when their loved ones were unwell, as some staff would not enter due to the risk of infection. The cleaning supervisor said care staff had responsibility for cleaning consumers’ personal and shared equipment, such as wheelchairs and lifting machines. The cleaning supervisor said cleaning staff would clean shared equipment when asked, though they could not recall the last time such a request was made. The Assessment Team observed unsuitable, dirty and stained personal equipment throughout the service and in consumers’ rooms.

With respect to the maintenance of equipment, a review of the service’s reactive maintenance log showed 35 open requests since June 2021, of which 24 were recorded as moderate to high risks and one was an extreme risk, that being a broken building lift. The maintenance office was only onsite twice a week and jobs were prioritised according to urgency. Maintenance requests logged in the service’s electronic care management system were not always shared with the maintenance officer. The Assessment Team noted the service did not monitor equipment for safety, suitability and cleanliness.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 4(3)(g), and presented a PCI for how it intended to remedy the non-compliance.

Planned actions to address the non-compliance included: a review of cleaning duties and the service’s deep clean schedule; care staff to be reminded to clean equipment; and develop a register for monitoring the cleanliness of equipment.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, equipment provided by the service was not always safe, suitable, clean or well maintained. Therefore, I find the service was non-compliant with Requirement 4(3)(g) at the time of the site audit.

*The other Requirements:*

Consumers confirmed they were supported to participate in individual and group activities which interested them. Lifestyle staff collected information about consumers’ personal preferences and this aligned with information in care plans. Consumers confirmed they were supported to maintain relationships with family and friends and participate in the community. Lifestyle staff said they collaborated with external organisations to complement the service’s activities program. For example, Dementia Support Australia and community volunteers provided support which improved consumers’ wellbeing.

# Standard 5

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| Organisation’s service environment | | Non-compliant |
| 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 5(3)(b) and 5(3)(c).

*Requirement 5(3)(b):*

Cleaning staff described the schedule they follow which included cleaning consumers’ rooms and common spaces. The Assessment Team reviewed the daily cleaning log which was up to date. However, the service environment was observed to be unsafe, unsanitary and one area had a malodour. On days three and four of the site audit, rubbish bins were full and gloves used by staff were laying outside of the bin. In addition, storerooms were left open, whereby anyone could access linen, towels, lifting equipment, oxygen tanks, soiled equipment and hazardous waste.

Consumers said they could not move freely, both indoors and outdoors. Specifically, for seven months consumers had not had access to the outdoor courtyard as it was full of gravel and unused building materials, surrounded by metal fencing. The maintenance officer could not provide a completion date for the courtyard’s construction.

Consumers could not freely enter and exit the service as the keypad system did not operate and instead, a fob key was required. There were only five consumers and their representatives with a fob key. For those without a fob key, staff had to respond to a doorbell when people wanted to enter or exit the building. A receptionist is employed two days per week, which left the front door unmonitored for the remaining five days. Consumers and representatives expressed frustration at the availability of staff to assist entry and exit to the building.

The Assessment Team noted the doors to balconies were locked and a door to the smoking area was kept ajar by a magazine. The issue was raised with management, who advised it would be investigated and added to the service’s continuous improvement plan. On day four of the site audit, a copy of the continuous improvement plan had not been provided as requested and the door to the smoking area was left ajar using a chair. Access to the smoking area was facilitated by railing and a ramp, which led to a locked, chipped and splintered gate. Cigarette butts were all around the floor of the smoking area. The cleaning supervisor said they only swept outdoor areas if requested.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 5(3)(b), and presented a PCI for how it intended to remedy the non-compliance.

Actions take to address the non-compliance included: reviewing open maintenance requests and attending to urgent entries; allowing maintenance staff access to the service’s electronic management system and providing training on how to use it; reviewing cleaning duties and the service’s deep clean schedule; installing a keypad for entry and exit to the building and balconies; and providing consumers’ families with a fob key to allow entry and exit of the building.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers could not move freely, both indoors and outdoors. Therefore, I find the service was non-compliant with Requirement 5(3)(b) at the time of the site audit.

*Requirement 5(3)(c):*

Consumers and representatives were dissatisfied with the cleanliness of furniture, fittings and equipment at the service. Staff described how they ensure the service environment, furniture and equipment were kept clean, safe, well-maintained and suitable for consumer use. However, the Assessment Team noted furniture and equipment was unclean, soiled with food and poorly maintained. A review of maintenance documents showed reactive requests were not actioned in a timely manner. For example, the laundry tumble dryer had been broken since November 2022 and in July 2023, the service’s heating system was inoperative for three days. Staff confirmed management were aware of maintenance issues at the service.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 5(3)(c), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: a review of cleaning duties and the service’s deep clean schedule; care staff to be reminded to clean equipment; develop a register for monitoring the cleanliness of equipment; laundry staff to audit all blankets at the service and dispose of any which were damaged; and establish a bi-annual audit of all linen.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service environment was not safe, clean, well maintained and consumers could not move freely, both indoors and outdoors. Therefore, I find the service was non-compliant with Requirement 5(3)(c) at the time of the site audit.

*The other Requirement:*

The service environment was welcoming, easy to understand and promoted a sense of belonging. Consumers felt at home within the service, particularly as they personalised their rooms with possessions of their choosing. Corridors and common areas were spacious, well-organised and staff supported consumers to move throughout the service. There were multiple signs throughout the building which assisted consumers to navigate the service.

# Standard 6

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| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Non-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. | Non-compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d).

*Requirement 6(3)(a):*

Consumers and representatives were dissatisfied with how management responded to their feedback and complaints, which left them discouraged with the process. Some consumer representatives were frustrated with management’s lack of response to multiple complaints about their loved ones’ care and services. The service had a feedback and complaints guide which included mechanisms for receiving information, however, staff and management practice did not align with the guide. Though the service conducted an annual resident survey, there was no evidence the data was analysed and used. The Assessment Team observed minimal information about how to provide feedback and make complaints and there was no feedback box, whereby feedback forms could be kept confidential.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 6(3)(a), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: resident enquiry and welcome packs now contain information on advocacy services and how to make complaints; feedback to be interpreted; provide consumers with information on how to submit a complaint with the Commission; consumer satisfaction surveys will be completed on an electronic management system; and management and staff to be trained in feedback and complaints processes.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service’s feedback and complaints process was ineffective and consumers and representatives were discouraged from providing feedback and making complaints. Therefore, I find the service was non-compliant with Requirement 6(3)(a) at the time of the site audit.

*Requirement 6(3)(b):*

Consumers were generally unaware of how to access interpreter services, advocates and other methods for raising and resolving complaints. Clinical staff were aware of advocacy, social work and interpreter services but were uncertain of how to support consumers to access these services. The service’s unmanned reception area had a small brochure about an advocacy service, general information about the Commission and no information about interpreter services. When the general lack of information was raised with management, they thought the brochures were sufficient.

Management said the resident handbook contained information about advocacy, social work and interpreter services, along with the Charter of Aged Care Rights and internal and external avenues for raising complaints. The Assessment Team asked management to provide a copy of the resident handbook so it could be reviewed, however, one was not provided.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 6(3)(b), and presented a PCI for how it intended to remedy the non-compliance.

Actions taken to address the non-compliance included: resident enquiry and welcome packs now contain information on advocacy services and how to make complaints; information about advocacy and interpreter services is now available at reception and nurse stations; and staff to be trained in advocacy, feedback and complaints processes.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers were generally unaware of how to access interpreter services, advocates and other methods for raising and resolving complaints. Therefore, I find the service was non-compliant with Requirement 6(3)(b) at the time of the site audit.

*Requirement 6(3)(c):*

Consumers and representatives were dissatisfied with how the service responded to their multiple complaints. Management and clinical staff had a poor understanding of the service’s complaints management process, such as apologising when things go wrong, as well as documenting, analysing and trending complaints to support a resolution between parties. As a consequence, consumer feedback and complaints were not documented in a way which allowed response actions to be recorded.

Management advised they investigated every complaint but due to the COVID-19 pandemic, had fallen behind and not documented the actions taken in response to consumer feedback. Notwithstanding, consumers and representatives indicated multiple complaints had been raised about the same issues, without having received an apology and appropriate action had not been taken. In support of consumer and representative comments made to the Assessment Team, a review of the feedback folder held no evidence to show complaints were recorded, analysed, trended and therefore, resolved.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 6(3)(c), and presented a PCI for how it intended to remedy the non-compliance.

Actions taken to address the non-compliance included: resident welcome packs now contain information about how to make complaints to the Commission; posters about complaints mechanisms will be displayed at service reception and nurses’ stations; a consumer satisfaction survey will be completing electronically moving forward; and staff to be trained in feedback and complaints processes.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, appropriate action was not taken in response to complaints and open disclosure was not used when things went wrong. Therefore, I find the service was non-compliant with Requirement 6(3)(c) at the time of the site audit.

*Requirement 6(3)(d):*

The service did not review feedback and complaints to improve the quality of care and services. For example, consumers and representatives made multiple complaints about food quality and cold temperatures since January 2023, which were recorded in successive monthly resident meeting minutes up to July 2023. The meeting minutes showed no evidence of improvements to food quality and temperature, though management advised they were trialling ways to improve the meals experience. However, when the Assessment Team asked management to provide the service’s plan for continuous improvement (PCI), nothing was provided, despite having been asked several times during the Site Audit.

The Assessment Team noted two general complaints were recorded in an electronic management system, both of which were received in February 2023, and neither were actioned. The feedback folder detailed seven complaints received in July 2023, though there were no complaints recorded prior to July 2023. There was no evidence of actions taken in response to the seven complaints, though management said they had spoken to all complainants.

Management further advised that complaints received prior to July 2023, had been transferred to the PCI ‘working folder’, which the Assessment Team reviewed. The review showed no evidence of actions taken in response to the complaints and each complaint was kept in an individual plastic pocket with handwritten notes kept on adhesive note paper. Therefore, management was unable to identify, analyse and trend complaints in order to improve the quality of consumers’ care and services.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 6(3)(d), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: creating an action plan to identify deficits in the quality of consumers’ care and services; management to develop a report to include complaints analysis and trends which will inform continuous improvement and future staff training; staff welcome pack will include information about open disclosure; and management and staff to be trained in the use of open disclosure.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, feedback and complaints were not reviewed and used to improve the quality of care and services. Therefore, I find the service was non-compliant with Requirement 6(3)(d) at the time of the site audit.

# Standard 7

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| Human resources | | Non-compliant |
| 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. | Non-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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant, as I am satisfied the service is non-compliant with Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e).

*Requirement 7(3)(a):*

Consumers and representatives reported daily staff shortages and a high use of nursing agency staff (agency staff). Consumers further reported poor response times to their call bells, which adversely impacted the quality of care and services they received. For example, consumers who required assistance with personal care often tried to mobilise on their own, which in turn put them at risk of falls and episodes of incontinence. Management advised the call bell system had been ineffective since June 2021, and they could not access or analyse staff response times. Management were unaware consumers waited up to 40 minutes for staff to respond to their call bells.

Management could not provide evidence of workforce planning and the staff member responsible for developing the roster was uncertain of how to identify the number of agency staff who filled vacant shifts. Management confirmed a high use of agency staff as there was an insufficient pool of the service’s own staff to fill vacant shifts. Management attempted to request the same agency staff to ensure continuity of care for consumers, however, this was not always possible and due to time pressures, new agency staff were not well oriented to the service.

The Assessment Team observed staff did not respond to consumers’ calls bells in a timely way. Call bells were programmed to go to an annunciator panel and digital enhanced cordless telecommunications (DECT) phones carried by staff, which management said all staff carried. However, only nurses were observed carrying DECT phones and care staff said they did not carry them, as they were broken. The Assessment Team noted a drawer in the nurses’ station was full of broken DECT phones and management was unaware care staff were not carrying DECT phones. Management were aware some DECT phones were broken, but said all had been fixed and were available to staff.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 7(3)(a), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: ongoing recruitment efforts for the service’s own staff; the agency staff orientation process will be improved with consideration of consumer feedback; training in continence management for staff; continence audits to be conducted; management will review the call bell report and require an explanation of wait times in excess of 10 minutes; staff to be issued with clear roles and responsibilities; staff responsible for developing the roster will be trained in how to access data about the number of agency staff being used; and a new staff pager system is being trialled and is due to be installed in September 2023.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the workforce was not planned to enable the delivery and management of safe and quality care and services. Therefore, I find the service was non-compliant with Requirement 7(3)(a) at the time of the site audit.

*Requirement 7(3)(c):*

Consumers and representatives said staff were not competent or effective in their roles. Consumers said when staff attend to them, they did not appear confident to meet their individual care needs and as a result, consumers often directed staff in how to meet their needs. When raised with management, they advised staff were supposed to read consumers’ care plans and deliver care accordingly. The service’s own clinical and care staff said they had knowledge to perform their roles, however, they often worked with agency staff who were ill-equipped and ineffective in supporting consumers and the wider staff team.

Staff could not recall when they last received training, other than a six-minute-intensive-training (SMIT) session, which was how the service mitigated risk. A SMIT was printed for staff to read and sign, though staff said it was an ineffective approach to training. Management thought the SMIT was an effective way to ensure staff competency in their roles; however, they had not sought feedback from staff as to the effectiveness of this training method. Senior staff considered themselves responsible for tasks outside of their scope and they did not have time to complete the tasks for which they were responsible. Management disagreed with this statement and said senior staff were ‘rostered accordingly’.

The service’s one administration staff was interviewed as they were responsible for maintaining workforce registers related to national police checks, mandatory annual vaccinations and for clinical and allied health staff, their registrations with the Australian Health Practitioner Regulation Agency (AHPRA). The administration officer had to review the registers each month but had fallen behind as they were only rostered to work two days per week.

When the Assessment Team asked management how many staff were in the service’s workforce, they were initially told there were 75 employees. However, a printout from the service’s electronic register showed 57 employees. On the final day of the site audit, administration staff confirmed 65 staff were employed at the service. A review of the workforce register showed all clinical and allied health staff had valid registrations with AHPRA, though mandatory staff vaccinations and national police check data was not 100% current, as required by aged care legislation.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 7(3)(c), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: ongoing recruitment efforts for the service’s own staff; a review of staff roles, responsibilities and times allocated for each; staff to be issued with clear position descriptions; and national police checks will be managed on an electronic system.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the workforce was not always competent when providing care, nor did they have knowledge to effectively perform their roles. Therefore, I find the service was non-compliant with Requirement 7(3)(c) at the time of the site audit.

*Requirement 7(3)(d):*

The service’s workforce was not adequately trained, equipped and supported to deliver the outcomes required by the Quality Standards. Consumers and representatives said staff were poorly trained and ill-equipped to perform their roles and deliver quality care and services. Clinical staff considered their training adequate to perform their duties, though they were unable to demonstrate knowledge of restrictive practices, antimicrobial stewardship, infection control and the Quality Standards.

Management advised staff were trained and equipped to deliver care in line with the Quality Standards, via online learning and in-person training. New employees participated in an orientation program and worked buddy shifts. However, management was unable to confirm how many staff were employed at the service, nor provide documented evidence to show the workforce was satisfactorily trained, equipped and supported to deliver outcomes required by the Quality Standards. The Assessment Team asked management to provide staff files so training records could be verified, however, none were provided.

The service’s safety officer monitored mandatory staff training in infection control, the Serious Incident Response Scheme (SIRS), discrimination, bullying and harassment, fire safety awareness and the Quality Standards. Training in restrictive practices, infection control and the Quality Standards was last provided in 2021, February 2022 and July 2022, respectively. The safety officer advised the service had not provided training in antimicrobial stewardship and the appropriate prescribing of antibiotics. A review of mandatory training records showed the workforce was not satisfactorily trained in line with the Quality Standards.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 7(3)(d), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: providing training in advocacy; a new learning system to be installed in August 2023, with all staff to complete mandatory training within four months; all records related to workforce management and regulatory compliance will be kept in one system; training in restrictive practices and antimicrobial stewardship to be scheduled and included in an annual training calendar; staff competency in infection control to be assessed with education provided for those yet to be trained; infection control to be included in annual training; catheter care to be included in annual training; and a review of the infection control and antimicrobial stewardship policy.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the workforce was not adequately trained, equipped and supported to deliver the outcomes required by the Quality Standards. Therefore, I find the service was non-compliant with Requirement 7(3)(d) at the time of the site audit.

*Requirement 7(3)(e):*

The service had a human resources and development policy which required staff to participate in an annual performance appraisal. Management described the performance appraisal process and said it was used to identify staff training needs. However, staff could not recall when they last had a performance appraisal, nor could management provide evidence of performance appraisals having occurred.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 7(3)(e). However, although its PCI mentioned Requirement 7(3)(e) in some sections, the PCI did not contain any discernible information about how the Approved Provider intended to remedy the non-compliance concerning the lack of staff performance appraisals.

At the time of the site audit, the performance of each member of the workforce was not being assessed, monitored or reviewed. Therefore, I find the service was non-compliant with Requirement 7(3)(e) at the time of the site audit.

*The other Requirement:*

Consumers confirmed permanent staff were kind, caring and respectful of their cultural backgrounds when providing care and services. Clinical staff were observed addressing consumers by their preferred names and using respectful language when assistance was provided.

# Standard 8

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| Organisational governance | | Non-compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

*Requirement 8(3)(a):*

Management advised the service had mechanisms to engage consumers in the development, delivery and evaluation of care and services, and were supported in that engagement. For example, management said consumers and representatives were engaged through resident meetings, surveys and feedback forms. However, consumers and representatives said they were not engaged in the development, delivery and evaluation of care and services, nor did management listen to concerns they had raised. Management provided minimal evidence to show consumers were supported to provide input about the care and services they received.

Consumers and representatives gave examples of input they had provided to improve the quality of their care and services. For example, multiple complaints were made about food quality and the cold temperature of food since January 2023, which were recorded in successive monthly resident meeting minutes up to July 2023. The meeting minutes showed no evidence of improvements to food quality and temperature, though management advised they were trialling ways to improve the meals experience. However, when the Assessment Team asked management to substantiate actions taken to address consumers’ ongoing concerns about food temperature, no evidence was provided.

Consumer representatives were dissatisfied with how the service responded to their efforts to improve the quality of care and services received by their loved ones. Representatives said multiple formal complaints had been made, whereby they were disappointed with the lack of response from the service, or no action was taken at all.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(a), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: engaging a dietician to listen to consumer feedback about their overall menu and meals experience, and establishing a food focus group with consumers; trialling food ‘hot boxes’, pending a review and potential purchase; placing microwaves in meal areas; inviting members of the board of directors (the board) to meet with consumers; reviewing the organisational structure; recording board meeting minutes; including consumers and stakeholders in a new board meeting schedule; and reviewing the PCI to ensure consumer concerns were included.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, consumers and representatives were not engaged in the development, delivery and evaluation of care and services. Therefore, I find the service was non-compliant with Requirement 8(3)(a) at the time of the site audit.

*Requirement 8(3)(b):*

The service did not demonstrate the organisation’s board promoted a culture of safe, inclusive and quality care and services for which it was accountable. Consumers and representatives were unaware of the board’s existence. The board comprised two members, one of whom was the chief executive officer (CEO). The CEO described how the board was involved with, and accountable for, care and services provided to consumers. Though the service had an organisational governance framework, feedback provided to the Assessment Team indicated consumers’ day-to-day experiences were not safe, inclusive and of suitable quality.

The CEO provided an organisation chart which detailed clear lines of reporting to the board, which the document showed had four members. However, the CEO said there had never been four members. The CEO said the service had a quality committee which comprised the CEO, facility manager, three registered nurses, the safety officer and a project officer. The quality committee had responsibility for reviewing clinical governance and risk, general operations and infection control, however, meeting minutes were not taken and there was no evidence of how information was recorded, trended and shared with the board. Similarly, the CEO advised board meetings were not formally scheduled and minutes were not kept.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(b), and presented a PCI for how it intended to remedy the non-compliance.

Action take to address the non-compliance included: a range of meetings to be scheduled and minutes taken, which include consumers, all staff, clinical staff and leadership meetings; terms of reference, standard meeting agendas and reporting templates to be developed for reporting to the CEO and board; weekly update and review of the service’s continuous improvement plan; review board composition and constitution; implement governance reforms in accordance with aged care legislation; consider conflict of interest for the CEO who has an operational and governance role; and additional board members are being sought to ensure compliance with the board’s constitution.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the board was not promoting a culture of safe, inclusive and quality care and services for which it was accountable. Therefore, I find the service was non-compliant with Requirement 8(3)(b) at the time of the site audit.

*Requirement 8(3)(c):*

The service did not demonstrate it had effective, organisation-wide governance systems for information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team identified all governance systems were ineffective and inconsistently maintained as some were paper-based and others were electronic. The CEO, who was responsible for reporting to the board and providing direction and support to management and staff, advised the board was satisfied the service met all requirements of the Quality Standards.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(c), and presented a PCI for how it intended to remedy the non-compliance.

Actions taken to address the non-compliance included: reviewing the current PCI and trending all findings, concerns, audit outcomes, survey results, outcomes of meetings and quality indicators; including governance across all areas as a standing agenda item at meetings; reviewing workforce governance policies; reviewing the service’s internal audit schedule; reviewing the internal audit system for currency and relevance; reviewing and updating all policies to reflect current best practice; recommencing a medication advisory committee; and staff training in use of the electronic care management system.

While I acknowledge the Approved Provider is taking steps to remedy the deficiencies identified in the site audit report, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service did not have effective, organisation-wide governance systems for information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Therefore, I find the service was non-compliant with Requirement 8(3)(c) at the time of the site audit.

*Requirement 8(3)(d):*

The service did not have a risk management plan and its risk management systems and practices were ineffective in: mitigating high-impact or high-prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live their best lives; and the management and prevention of incidents, through the use of an incident management system.

The CEO said risks were monitored and discussed at the medication advisory committee and quality committee meetings, following which steps were taken to mitigate risks. However, the CEO could not provide meeting minutes as none were taken or available handwritten notes were illegible. Management and staff described the processes for identifying and managing risk; however, the Assessment Team noted systems and staff practices did not align with the service’s policies.

The Assessment Team reviewed the service’s incident management system and noted: 28 unresolved incidents relating to consumers, which dated back to February 2023; 25 unresolved workforce incidents, dated back to October 2021; and 35 unresolved maintenance requests, dated back to June 2021, of which 24 were marked moderate a high risk and one was considered an extreme risk. The CEO was unaware of the unresolved incidents in the service’s management system and could not provide evidence of how risks were monitored in line with the Quality Standards.

Clinical staff described the service’s process for reporting incidents such as consumer falls, abuse and neglect of consumers, restrictive practices and the SIRS. Clinical staff said they reported SIRS incidents to the CEO, who completed the reporting process in line with the service’s SIRS policy. However, staff practice was inconsistent with an Approved Provider’s responsibilities under aged care legislation. For example, a review of the SIRS records showed it was a ‘working’ folder and each incident was kept in a plastic pocket with handwritten notes on pieces of paper. There was no evidence the service had a formal SIRS register, nor was there evidence the incidents had been reported to the Commission, as required by aged care legislation.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(d), and presented a PCI for how it intended to remedy the non-compliance.

Actions taken to address the non-compliance included: identifying risks to consumers and discussing risks with them and their representatives; reviewing consumer risks daily; reviewing and updating all policies to reflect current best practice; clinical and quality meetings to be scheduled and minutes taken; incidents under the SIRS to be managed electronically once staff have been trained; archiving documents no longer in use; establishing and maintaining a new SIRS folder; and advising relevant staff of where to access the service’s SIRS register and how to use it.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service’s risk management systems were ineffective. Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the site audit.

*Requirement 8(3)(e):*

The service’s clinical governance framework included policies, procedures, service delivery practices and staff training requirements relating to antimicrobial stewardship, restrictive practices and open disclosure. However, staff practices did not reflect the service’s clinical governance framework.

With respect to antimicrobial stewardship, the service had never provided training for its workforce. Infection control training in the context of antimicrobial stewardship was last provided in February 2022. A registered nurse who had qualified as the service’s infection and prevention control (IPC) lead refused to undertake the associated duties, so a personal care assistant who was not a qualified IPC lead, was responsible for infection control practices at the service.

With respect to minimising the use of restraint, the Assessment Team identified deficiencies in relation to restrictive practices, behaviour support plans and the management of psychotropic medications. The service could not show where restrictive practices had been applied to the care of consumers only as a last resort. Interviews with management, clinical and care staff identified significant deficiencies in their understanding of restrictive practices and the legislated processes which must be followed. Training for the workforce in restrictive practices was last provided in 2021, and management had not identified deficits in staff practice.

With respect to the use of open disclosure, management and clinical staff had a poor understanding of the service’s complaints management process, such as apologising to consumers when things go wrong. As a consequence, consumers and representatives were dissatisfied and frustrated following feedback and complaints made about the care and services provided.

In its response to the issues raised in the site audit report, the Approved Provider acknowledged the ‘not met’ finding for Requirement 8(3)(e), and presented a PCI for how it intended to remedy the non-compliance.

Actions taken to address the non-compliance included: review and update all policies to reflect current best practice in antimicrobial stewardship, infection control and open disclosure; management and staff to be trained in antimicrobial stewardship, infection control and open disclosure; the position of IPC lead to be offered to a registered nurse with a second IPC lead to be trained; open disclosure will be included in ‘staff packs’; clinical review meeting to be scheduled and minutes taken; antimicrobial stewardship will be a standing agenda item at the medication advisory committee meetings; and ongoing staff competency assessments in infection control will be introduced.

While I acknowledge the Approved Provider is taking steps to remedy the deficiency, it will take time to fully implement the required steps and to assess their effectiveness once the actions have been implemented. At the time of the site audit, the service’s risk management systems were ineffective. Therefore, I find the service was non-compliant with Requirement 8(3)(e) at the time of the site audit.

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)