Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | BaptistCare Shalom Centre |
| Service address: | 159-164 Balaclava Road MACQUARIE PARK NSW 2113 |
| Commission ID: | 0608 |
| Approved provider: | BaptistCare NSW & ACT |
| Activity type: | Site Audit |
| Activity date: | 13 February 2023 to 16 February 2023 |
| Performance report date: | 31 March 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 BaptistCare Shalom Centre (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

The following information has been considered in preparing the Performance Report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment conducted 13 to 16 February 2023, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Team’s report received 15 March 2023
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances Determinations dated 21 April 2021; 27 October 2021; 28 April 2022; 28 October 2022.

**Assessment summary**

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

**Areas for improvement**

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 2(3)(b) The approved provider must demonstrate that care plans outline the consumer’s current condition, needs, and preferences. That information in relation to wound management and documentation of current behaviour management and mitigation strategies are effective and individualised for each consumer in care plans and behaviour care plans.
* Requirement 3(3)(a) The approved provider must demonstrate that all behaviours and management of behaviours including triggers, strategies reviewed and evaluated are incorporated into their behaviour care plans. Documentation for consumers subject to chemical and mechanical restraint demonstrates information about strategies to be implemented to avoid the use of chemical restraint. Environmental restraint consents and the indication for the use of the restraint is specific regarding the requirement for environmental restraint and is regularly reviewed.
* Requirement 3(3)(f) The approved provider must demonstrate that referrals occur in a timely manner to prevent the deterioration of wounds, behaviours and other incidents. Pressure injuries and wound management is consistent with the organisation policy and procedure in the delivery of wound care. Practices and documentation are reflective of best practice regarding directives or the recognition, management and documentation of wounds and pressure injuries.
* Requirement 8(3)(c) The approved provider must demonstrate that there are effective organisation wide governance systems relating to information management to provide sufficient, consistent and readily available information for staff and management to perform their roles effectively. Wound charting and wound care are effective in identifying the wound. Care plans and behaviour support plans including goals and interventions are individualised to the consumer.
* Requirement 8(3)(d) The approved provider must demonstrate that there are effective risk management systems and practices, to identify the effectiveness of intervention strategies and that they are analysed and evaluated for effectiveness.

**Standard 1**

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

**Findings**

The Quality Standard has been assessed as compliant as six of the six specific Requirements have been found to be compliant.

The Assessment Team interviewed consumers and representatives who overall said staff treat them with dignity and respect. Staff were observed treating consumers with dignity and respect and understood the consumers’ background and individual preferences. Care documentation was reviewed for several sampled consumers and reflected what is important to consumers to maintain their identity and demonstrated each consumer’s identity, culture, and diversity is recorded and valued. The organisation has documents and processes which outline consumers’ right to respect and dignity, including a diversity policy.

The Assessment Team found that the service demonstrated it provides culturally safe care and services. Care plans sampled contain information about consumers life history, cultural, religious, and spiritual needs. The service demonstrated an understanding of each consumer’s cultural identity, respecting diversity and how they provide inclusive care and support. Staff interviewed were able to describe how they become familiar with the details of a consumer’s culture and how they deliver care in accordance with the consumer’s cultural preferences.

The service was able to demonstrate consumers are supported to exercise choice and maintain their independence by making decisions about their care and services. Consumers are supported to nominate who they would like involved in their care, communicate their decisions, make connections with others, and maintain relationships of choice. The service has several couples that reside in the service. It was evident that the service enables these couples to maintain their relationships where they either share a room or have a room side by side where available.

The Assessment Team found that the service demonstrates consumers are supported to take risks to enable them to live the best life they can. The service has systems in place to identify, inform, support and review consumers to ensure dignity of risks are maintained when engaging in activities they prefer. Staff interviews, and care planning documentation reviewed by the Assessment Team identified that consumers are supported to undertake activities that may involve risk. There are policies and procedures in place to ensure care and services are delivered in line with consumer preferences.

The service was able to demonstrate current, accurate and timely information is provided to consumers and communication is clear, easy to understand, and supports consumers to exercise choice. Staff advise consumers of any changes to their appointments, and observations supported this. Posters and flyers of upcoming activities or other information (such as the site audit) were observed on noticeboards and in rooms.

The Assessment Team received feedback from consumers including that the staff are always asking the consumers to get their choices catered for and that staff are very good at providing information and including in relation to Covid-19. Staff were observed asking consumers for their meal choice from the options provided on the menu and offering other options if those were not sufficient.

Requirement 1(3)(f) was found to be not met by the Assessment Team as the team found that the service was unable to demonstrate consumer’s privacy is respected. While staff confirmed all consumers’ personal information is kept confidential and is not discussed in front of others, it was observed that several consumers were often located in staff only areas such as the nurse’s stations while staff were on computers and talking with each other.

The Assessment Team were undertaking an interview with the consumer and the representative and observed a staff member knock and enter a consumer’s room prior to acceptance, and without regard to the privacy of the interview, proceeded to conduct their business with the consumer before retreating once completed. At no stage did the staff member ask permission to see this as a consumer’s preference.

The approved provider responded to the Assessment Team’s report and advised that the consumers who were observed to be in the nurse’s station had responsive behaviours, and this is an alternative strategy to chemical restraint. The service advised the consumers that are in the nurse’s station are not at risk of understanding any documents or conversations about current matters, however based on the Assessment Team’s feedback, that handover is no longer being held in the nurse’s station where consumers want to join the group. Staff go to another office where the consumers cannot see or hear handover, whilst care staff are in attendance with the consumers during this time. The service also advised that they were unable to identify the staff member who did not wait for consent prior to entering the consumer’s room and interrupting the interview without asking, as this was not raised during the site assessment, however they have initiated training for all staff to remind them of waiting for a response before entering a consumer’s room.

Based on the information that the approved provider has submitted; I find that the provider is compliant with this Requirement 1(3)(f).

**Standard 2**

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

**Findings**

The Quality Standard has been assessed as non-compliant as one of the five specific Requirements have been found to be non-compliant.

The following Requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e) have been found to be compliant.

The Assessment Team found that the organisation has policies and procedures which guide staff practice when conducting assessments and developing consumer care plans. Documentation reviewed reflected these policies and procedures are consistently adhered to. Sampled consumers have risk care plans that address specific risks to the consumer’s health and well-being. These risk care plans are used to inform the delivery of safe and effective care and services.

The Assessment Team interviewed consumers and representatives who provided mixed feedback relating to their partnership in assessment and care planning. Most interviewed consumers and/or representatives said they had not been involved in a care conference at the service in recent memory. When asked about care conferencing and involvement of consumers and/or their representatives in assessment and care planning, management said they are currently working to catch up on care conferences. The management team acknowledged most consumers had not had a care conference for some time. Since the current care team managers commenced at the service in January 2023, at least 30 care conferences have been completed. The care team managers said they have been actively attempting to contact consumers and their representatives to complete the care conferences. The recommendations of specialist providers such as wound consultants, dieticians, speech pathologists, the local mental health team and dementia support Australia were generally observed incorporated into consumer care plans. When not incorporated, directions were provided in the care plan to inform staff where to find the consultation notes.

The Assessment Team found that the service ensures all consumers care and services are reviewed with each monthly ‘resident of the day’ assessment. The organisation’s clinical documentation policy outlines the requirements for clinical documentation, care planning and assessment. The policy requires complete evaluation of consumer care plans and at a minimum of every 6 months with a care conference scheduled annually or when care and service needs change. Care planning and documentation for sampled consumers was reviewed with evidence observed of adjustments made to care planning after changes in condition or preferences.

The Assessment Team interviewed consumers and representatives who mostly did not recall receiving or being offered a copy of their most up to date and current care plan.

One representative when asked if they had been offered a copy or discussed their consumer’s care plan said they had made decisions relating to end of life and advanced care planning. The representative required explanation as to the general care planning documents in order to advise they had not received a copy. Review of care conferencing documentation reflects staff have an option to check a box to indicate a copy of the care plan has been offered during the process. The Assessment Team found that there was insufficient evidence to support compliance with this Requirement.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and a copy of minutes from the January minutes of the resident and relatives meeting where the Facility Manager advised consumers and representatives that if anyone wants to know about their care plan it can be discussed, I have considered the information that has been provided and find that the approved provider is compliant with Requirement.

The following Requirement 2(3)(b) was found to be non-compliant.

The Assessment Team identified that the service did not demonstrate assessment and planning identifies each consumer’s current needs, goals and preferences. However, it was demonstrated advance care planning and end of life planning are considered for the sampled consumers.

The Assessment Team reviewed care plans and found that they did not always outline the consumer’s current condition, needs, and preferences. This includes for example the incorporation of information about wounds being managed in the skin domain and documentation of current behaviours and management and mitigation strategies that are effective and individualised for each consumer in behaviour care plans. In addition, conflicting information was observed recorded in some care plans relating to food and nutrition consistency or whether restrictive practices are in use currently.

The Assessment Team found that behaviour and restrictive practice care plans were observed to not include current or easily accessible information about management and mitigation of behaviours or avoidance of restrictive practices. Goals for care are not consistently outlined in the sampled care plans. For some consumers, their specific goals are broadly stated in the ‘all about me’ section of the care plan. Where domain specific goals are included, they are not consumer specific and generic. This was discussed with management who said this is a restriction of the electronic care management system and not currently able to be remedied. The management team said all consumer specific goals for care should be recorded in the ‘all about me’ section of the care plans. Management said there are plans in place to implement a new system across the organisation with timeframes for implementation for this service between one and 6 months from the completion of the site audit.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and attachments relating to the team’s report. Whist there was some evidence provide to demonstrate the service is responding to consumer’s needs, goal and preferences, it was not evident that that behaviour and restrictive practice care plans include current or easily accessible information about management and mitigation of behaviours or avoidance of restrictive practices.

I am not satisfied that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences and find that the approved provider is non-compliant with Requirement 2(3)(b).

**Standard 3**

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | 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. | Compliant |

**Findings**

The Quality Standard has been assessed as non-compliant as two of the seven specific Requirements have been found to be non-compliant.

The following Requirements 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e) and 3(3)(g) have been found to be compliant.

The Assessment Team found that the service has tracking tools to identify individual consumer risks. In addition, regular ‘10 at 10’ meetings are held to discuss consumers who are of concern and fortnightly clinical meetings are held which focus on high impact and high prevalence risks at the service.

Management said they are currently developing an audit tool to assist in identifying who their high impact and high prevalence risk consumers are and more accurately track the risks. Clinical reporting sent to the board currently only provides information about consumers who experience falls and are considered high risk. The report did not provide detailed information regarding any other high impact and high prevalence risks such as pressure injuries and infections, with only overall numbers provided in the report.

The Assessment Team observed for those consumers on a palliative trajectory to have planned care in place that is appropriate for their level of need. Observations of consumers considered palliative reflected they are treated with respect and have their comfort maximised.

Documentation reviewed reflected when an advance care directive has been completed the wishes of the consumer are input to the electronic care management system for ease of access.

As a consumer’s condition deteriorates, palliative care plans are developed in consultation with the consumer and/or their representative to describe their needs and wishes for end-of-life care. Consumers who are assessed as approaching end of life are commenced on a palliative care pathway in consultation with a palliative care clinical nurse consultant. This pathway, (based on the Queensland health palliative care pathway) directs staff regarding care needs of the consumer including but not limited to pain monitoring and assessment, skin care, oral care, and nutrition and hydration. Documentation of care provided is recorded primarily in the paper-based comfort care chart as well as the electronic system.

The Assessment Team found that the service demonstrated for the sampled consumers, recognition of change or deterioration in a consumer’s cognitive, mental or physical health, function and capacity is generally recognised and responded to in a timely manner.

Overall, consumers and representatives indicated staff at the service are responsive to their needs, with representatives also confirming they are kept well informed about their loved one’s condition when changes or deterioration are observed. Review of care planning and clinical documentation reflected that changes in consumer’s condition when identified, received timely assessment and response.

The Assessment Team interviewed consumers and representatives who provided positive feedback regarding the communication of their needs between themselves and staff, explaining they did not need to repeat their wishes on a regular basis.

Observations of communication channels including handover sheets, communication books and inter-staff communication demonstrated information was effectively shared to ensure safe and quality care and services for consumers.

Care staff and registered nurses interviewed said they are confident in the communication procedures at the service. Care staff said they are kept well informed of changes that occur through their shift as well as at handover. Registered nurses said they escort medical practitioners and some specialist providers during their visits to ensure their recommendations are passed on to staff.

The Assessment Team identified that the service has documented policies, procedures, and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control and for the management of a COVID-19 outbreak as well as an outbreak policy which directs management of outbreaks of any infectious disease (such as gastroenteritis and influenza). The service has an influenza and COVID-19 vaccination program for staff and consumers and has appointed an Infection prevention and control (IPC) lead. The previous IPC lead left the week prior to the Site Audit, with one of the care team managers now appointed as IPC lead. This care team manager has already completed the IPC training and been an IPC lead at another service previously. The other care team manager is enrolling in the IPC course, and another registered nurse, also IPC qualified, is available for redundancy. Staff provided examples of practices to prevent and control infections such as hand hygiene, encouraging fluids, the use of personal protective equipment (PPE) and obtaining pathology results prior to commencing antibiotics.

The following Requirements 3(3)(a) and 3(3)(f) were found to be non-compliant.

The Assessment Team found that the service was not able to demonstrate they are consistently providing safe and effective personal and clinical care that is best practice, tailored to each consumer’s needs and optimises their health and well-being.

Most consumers and representatives interviewed said they were happy with the care and service provided to them. One representative raised concern about the consumer’s skin being damaged during provision of personal care and turning by staff.

Staff interviewed demonstrated they know their consumers and their preferences, as well as triggers for their behaviours and what helps to minimise them. The care staff said they have received training in how to redirect consumers when they are showing reactive behaviours, which includes for specific consumers. However, it was identified that the strategies discussed by staff regarding the management of behaviours for the sampled consumers were not always observed incorporated into their behaviour care plans.

Documentation for consumers subject to chemical and mechanical restraint did not demonstrate information about strategies to be implemented to avoid the use of chemical restraint were recorded. The consent forms indicated the medications are not routinely reviewed by the consumer’s medical practitioner or discussed with representatives on a regular basis to ensure their ongoing consent. Environmental restraint consents were reviewed for consumers subject to this type of restraint and the indication for the use of the restraint is listed as ‘consumer lives in a dementia support unit with a coded door’. No consumer specific indication regarding the requirement for environmental restraint is recorded.

Behaviour charting is not completed for all expressive behaviours occurring at the service, only when behaviours are being evaluated for consultation purposes or if the behaviour is out of character for the consumer. This results in an inconsistent record of each consumer’s behaviours and the effectiveness of behaviour management strategies employed cannot be easily reviewed. In addition, behaviour and restrictive practice care plans were observed to not contain individualised management strategies or consistently identify potential triggers or the current expressive behaviours displayed by consumers.

The Assessment Team observed the application of potential physical restraint for a consumer during the lunch meal service. The consumer was resistive to having a milkshake and the Assessment Team observed the care staff member then holding the consumer’s right hand down trying to make the consumer consume the milkshake. The care staff member proceeded trying to forcibly make the consumer drink the milkshake. After a few unsuccessful attempts, the care staff member put the milkshake down and attempted feeding the main meal instead. The consumer was agitated at that point and was resistive to eat. The Assessment Team provided this feedback to Management who investigated it with the relevant care staff member and said they will also enter this as a SIRS (serious incident response scheme) incident within 28 days. The consumer’s representative was also contacted by management who also requested the consumers representative speak to the Assessment Team. The Assessment Team interviewed the representative who said ‘staff have got to do what they need to do’ in order to get some food into the consumer. The representative was not concerned and said staff can hold the consumer’s hand down if needed. The representative was happy with the care and services provided by the service.

The Assessment Team reviewed information relating to 3 consumers and their pressure injuries and noted it reflected inconsistent application of organisation policy and procedure in the delivery of wound care. In addition, the Assessment Team observed practices and documentation were not reflective of best practice regarding directives or the recognition, management and documentation of wounds and pressure injuries.

The Assessment Team found that generally, consumers are referred to individuals, other organisations and providers of other care and services when needs are identified. However, the Assessment Team observed a lack of follow up for a referral made to a wound consultant for one consumer which ultimately contributed to a deterioration of a wound to the consumer’s leg.

The Assessment Team identified in speaking with consumers and/or representatives there are some consumers at the service who are accessing private physiotherapy due to their belief the service’s physiotherapist is not available for any more than pain management.

The approved provider responded to the Assessment Team’s report with a copy of the Plan for Continuous Improvement and attachments to support compliance with these Requirements. Whilst extensive documentation was provided including training for all Registered Nurses on Wound Care and training for Restrictive Practices for care staff, the information provided does not satisfy me that documentation for individualised triggers and strategies for behavioural concerns are recognised and trialled or that investigation and responsiveness to an incident for a consumer who received a skin injury following personal care occurred despite this being reported by the representative. There has also been a lack of immediate wound charting and referral for a consumer with a deteriorating wound. I acknowledge the actions that have been taken, however understand that it will take some time to reflect compliance with these Requirements.

I find that the approved provider is non-compliant with Requirements 3(3)(a) and 3(3)(f).

**Standard 4**

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

The Quality Standard has been assessed as compliant as seven of the seven specific Requirements have been found to be compliant.

The Assessment Team interviewed consumers and representatives who consistently reported satisfaction with their experiences living in the service. This included in relation to support for their cultural, spiritual and emotional needs, support for their relationships and having things to do. Care planning documentation provides information about the consumer’s needs in relation to their daily living and staff are aware of these Requirements. Consumers provided feedback of the service supporting relationships which allows them to follow their preferred routines as they wish with their preferences included in care plans.

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

The service has a chaplain who provides emotional and spiritual support. Some consumers receive regular ongoing support from the chaplain, others receive the support upon referral or when their circumstances change.

The Assessment Team spoke with staff who explained how they support consumers to participate in things of interest to them and to connect with others outside the service as much as possible. Documentation demonstrates that consumer needs are identified in relation to their interests. Consumers and representatives spoke positively about consumers opportunities to participate in activities provided at the service. Consumers and representatives interviewed said there was enough support available in the lifestyle program for consumers to be able to do things of interest to them, both within the service and provided by the community. All consumers interviewed said activities which occur in their relevant wings meets their interests and they participate in almost all the activities available.

Consumers who have functional or cognitive impairment were observed routinely participating in activities and were not left in their rooms for long periods. Their activity participation records indicated they consistently received either one on one support or joined group activities such as sing a longs and sensory stimulation.

The service has systems to ensure that information on the consumer’s condition, needs and preferences is communicated effectively. This included in relation to consumers’ spiritual, emotional, lifestyle needs and in relation to meals. Review of consumer documentation demonstrated that these systems are effective, and staff were familiar with consumers’ needs.

The service demonstrated that appropriate referrals are made to other organisations and providers of care. The service has referred consumers to a psychologist service and continues to do so when needed. Several consumers have been referred to the Community Visitors Program for regular or one-off visits. Deliveries from the local library were observed arriving at the service for consumers.

The Assessment Team interviewed consumers who provided positive feedback about the quality and quantity of the food. The service provides opportunities for consumers to give feedback about the food, and the feedback is used to adjust the meals to reflect the consumers’ needs and preferences. Most care plan documentation is consistent with consumer preferences and dietary needs. The Assessment Team observed during lunch service on the first day of the Site Audit, consumers were waiting for over 15 minutes at their table before they received their meals. The care staff were still gathering other consumers to the dining tables at the time, although it was past the time where meals were supposed to start being served to consumers that were already waiting (which management advised was 12:00pm). Some dining tables were observed to have inconsistent set-up within individual dining areas with some tables having coloured place mats whereas others did not, and some had a flower in the middle where many did not. The Assessment Team provided this feedback to management who said they would ensure meals were being served on time and consumers were not kept waiting for long periods. Observations of subsequent meal services indicated this had been attended with consumers being provided their lunches on time.

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

Consumers reported having access to mobility aids, which are suitable and clean, to assist them with their daily living activities. Lifestyle staff said they have access to equipment and supplies to support the activities calendar. Lifestyle equipment was readily available across all wings for consumers to safely use. The maintenance staff described the preventative and reactive maintenance schedule and how they ensure equipment is safe, clean, and well maintained. The Assessment Team’s observations of the kitchen confirmed they have areas to complete work safely. The kitchen and food storage areas were clean and tidy. There were sufficient storage areas in the kitchen to store food safely. Cleaning staff said they have access to equipment and sufficient cleaning supplies to meet their needs adequately.

**Standard 5**

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

**Findings**

The Quality Standard has been assessed as compliant as three of the three specific Requirements have been found to be compliant.

The Assessment Team observed the service environment to be welcoming and comfortable. Consumers said there is adequate private areas, both indoors and outdoors for consumers and visitors to utilise when socialising. All consumers have their own bedroom with ensuite, which they were able to furnish with their personal items. There is a chapel set up for religious reflection, which is used by consumers for church services and personal reflection. Several consumers with language barriers, have wayfinding signs in their native tongue at various parts of the service to assist them in navigating their environment. In the memory support units, the consumers have individually coloured doors that also assist in finding their way.

While consumers and their representatives were observed moving freely both indoors and outdoors of the service, issues were identified in relation to supervision of contractors whilst works were underway. Issues in relation to the service environment which requires cleaning or maintenance were raised with management.

The Assessment Team observed equipment including full lifters remaining in the hallways, not in use and not stored safely in the service. Contractors were undertaking work throughout the site audit with ladders and cables running across common hallways without appropriate caution signs in place. It was observed they were using fire doors as alerts although the ladders came to the edge of the door, and they were also blocking access to consumer rooms. Several chairs inside the meeting room and café had large stains on them. One wall was noted to require patching to be done of approximately 30 centimetres in size. Several consumers doors had deep scrapes running across the doors caused by staff using equipment whilst assisting residents. The scrapes appear to have been there for a long period. The Assessment Team was walking into the administration area door, and a heavy stopper from the top of the door fell and almost hit the assessor in the face. This was subsequently removed by maintenance staff.

The Assessment Team observed the furniture, fittings and equipment to be safe, clean, well maintained and suitable for consumers. Consumers interviewed were satisfied with the furniture, fittings and equipment. Management and staff demonstrated effective systems in place for the cleaning and regular maintenance of the furniture, fittings, and equipment. Furniture in communal areas were observed to be clean, in good condition and in plentiful supply. The cleaners were observed cleaning consumers rooms and other common areas. Consumers interviewed expressed satisfaction with the cleaning and maintenance systems at the service.

Requirement 5(3)(b) was found to be Not Met by the Assessment Team, however the approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement and copies of the Contractor’s induction checklist, management procedures and induction manual. The Plan for Continuous Improvement included actions for patchwork to be brought forward for painting to commence 13 March 2023 with completion by 30 June 2023.

I have considered the actions that the provider has taken in relation to the gaps identified by the Assessment Team and have found that based on the evidence provided and the Plan for Continuous Improvement that Requirement 5(3)(b) is compliant.

**Standard 6**

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

**Findings**

The Quality Standard has been assessed as compliant as four of the four specific Requirements have been found to be compliant.

The Assessment Team interviewed consumers and representatives who said they are supported to give feedback or make a complaint and said they feel comfortable doing so. Management and staff were able to describe processes in place to encourage and support feedback and complaints. Complaint forms are available from reception, visibly located in each area of the service and are also available from any of the lifestyle staff.

Consumers sampled were aware of the advocacy services and other methods for raising and resolving complaints. Every notice board checked around the service had a flyer about the Older Persons Advocacy Network (OPAN) and other advocacy services. They also had flyers with contact details if they required interpreters. Lifts and the front foyer had Commission flyers with a contact number to call if they wanted to make a complaint. Overall, consumers said they did not require an advocacy service as they are confident management will resolve any complaints.

The Assessment Team interviewed staff who were able to describe how they would assist consumers who have a cognitive impairment or difficulty communicating to raise a complaint or provide feedback. Methods described by staff included assisting them in completing a feedback form, utilising multilingual staff, using communication aids or contacting the consumers’ representative for assistance.

Staff demonstrated a shared understanding of the internal and external complaints and feedback avenues, and advocacy and translation services, available for consumers and/or representatives. One registered nurse said that they have used an interpreter service to enable communication with one of the consumers who was having some clinical issues, and their representative was unavailable, and said it was helpful for understanding the consumer's discomfort.

Consumers and/or representatives were confident management will address and resolve any concerns which are raised. Staff demonstrated an understanding of the principles of open disclosure, explaining how they would apologise to a consumer in the event of something going wrong. None of the consumers, expressed any concerns that management would not address complaints and attempt to resolve any concerns in a timely manner. One consumer who recently made a complaint said they have confidence in approaching staff and management, as their complaint was handled excellently. Management and staff demonstrated a shared understanding of the process that is followed when feedback or a complaint is received. Staff confirmed the principles of open disclosure stating they will apologise and explain to consumers and/or representatives if anything goes or is done wrong.

The Assessment Team noted the services complaints register was incomplete, did not contain all feedback, for example from recent resident meetings, had little detail, outcomes developed, or how or if, reviews are completed. This was addressed with management who assured the Assessment Team that they take all feedback seriously and deal with any concerns efficiently and in accordance with policies. As the Assessment Team was provided evidence and feedback that missing feedback from the register had been appropriately dealt with; this Requirement was found to be met by the Assessment Team and addressed in the below Requirement.

Requirement 6(3)(d) was originally found to be not met by the Assessment Team, as the Assessment Team found that the service was unable to demonstrate that it monitors all feedback, conducts appropriate reviews, and ensure ongoing compliance to agreed outcomes. As comprehensive monitoring is not occurring, management are not able to conduct effective analysis of their feedback systems and trending patterns.

The complaints register provided to the Assessment Team was incomplete, had the date feedback provided, brief detail of issue, related standard, and closure date. This closure date was not necessarily the date the issue was resolved and competed, but could be the date it was filed, or handed to another person to deal with. Management was not aware of the benefit of reviewing any changes made, post outcome; to ensure compliance is maintained. Management was also unaware of how potential improvements can be incorporated to provide positive improvement for other consumers. Feedback systems at the service such as the incident register, staff and resident meeting minutes and audits, did not all feed into the complaints register, or then into continuous improvement.

The Assessment Team also notes that individual improvements for consumers have been developed, all feedback acted upon, and improvements to the service was also observed.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement and advised that the service is aware of trends in relation to food complaints and have undertaken improvements with an action plan for individualised menus and it was noted earlier in the report that the consumers are satisfied with their meals. The service manager has also ensured that actions from meeting minutes were entered into the feedback register and added to the Plan for Continuous Improvement. These actions have been completed.

I have considered the immediate actions taken by the service and have found that the approved provider is compliant with this Requirement.

**Standard 7**

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

The Quality Standard has been assessed as compliant as five of the five specific Requirements have been found to be compliant.

The Assessment Team observed workforce interactions with consumers are overall kind, caring and respectful. Most consumers and representatives have praised the staff for the care they provide to consumers. Representatives provided feedback that the staff are very attentive, very obliging and wonderful. The representative said the lifestyle officer has been wonderful and understands their parents.

The organisation ensures the workforce is competent and have qualifications and knowledge to effectively perform their roles. The educator described the suite of mandatory staff competency assessments to ensure staff meet the correct criteria to effectively perform their roles. Records show staff are completing these and staff interviews generally confirmed this.

Staff qualifications are monitored by the roster clerk at the service prior to staff employment for new staff and ongoing clinical registrations. Head office monitor police checks, visa checks and staff and allied health registrations. Consumers and representatives generally felt confident staff members have the skills, knowledge and expertise to support their clinical and personal care needs and preferences. Consumers said most care staff know what they are doing, and registered nurses are competent in providing required medication and clinical care.

The Assessment Team sighted documentation showing staff qualifications, mandatory training, position descriptions and current registrations. The service has recently commenced training Certificate III care staff in medication administration.

The Assessment Team found that staff were knowledgeable with regard to individual consumers care needs such as consumers who require behaviour management, wound dressing, those who had current infections and consumers using restrictive practices and how often that consumers are reviewed.

The Assessment Team found that staff at the service are recruited and trained by the service to assist consumers with their personal and clinical care. Staff training records indicate that staff have received or completed training and education to deliver required care and services to consumers.

Mandatory training is provided online and through toolbox talks. Competencies are monitored monthly through head office and are managed via a manual spreadsheet of staff training due to be completed. This is provided weekly to the service educator for actioning with a copy to the residential manager. Registered nurses’ complete annual medication incidents and reassessment and more recently have been provided with syringe driver training.

Requirements 7(3)(a) an 7(3)(e) were originally found to be Not Met by the Assessment Team.

The Assessment Team identified that the organisation does not have sufficient staff numbers at the service to ensure the delivery and management of safe quality care and services. The residential manager advised that there has been a high turnover of staff over the past few months including management and clinical staff. Consumers and representatives have commented that there is a shortage of staff at the service, and this was impacting on consumers care and safety.

Consumer and representative feedback included that that staff are too busy to check in on consumers regularly to make sure they are okay, and clean. One representative advised the Assessment Team that staff struggle sometimes because of the ‘nature of the consumers’, with some consumers having verbal and aggressive behaviours, and others are trying to get out of their chair, and they require 2 people to assist them. The representative said that staff numbers was an issue and that on 2 occasions their consumer has tried to get up by themselves and nearly fell out of their chair. Another representative advised that their consumer is dependent on staff for everything, the representative comes most days and assists with mealtimes as it takes a long time for the consumer to have a meal and feels that staff don’t have time to do it.

One representative provided feedback commenting there are staff shortages, sometimes carers from agencies are used to replace permanent employees who cannot come to work, but the replacement carers are not briefed on what they are supposed to do.

The regional operations manager advised that it has been a challenging time for the service due to the high number of outbreaks and exposures at the service and high staff turnover. He advised that the organisation has been supporting the service during this time and has put in place strategies to ensure the ongoing recruitment and retention of new staff. The educator has been supported by head office in assisting the service in the training of new staff.

The Assessment Team found the service does not have effective systems and processes to monitor and review the performance of each member of the workforce.

The residential manager said that staff appraisals have fallen behind since the previous residential manager left the service last year. Currently approximately 40% of staff appraisals have been completed and the organisation’s head office team are assisting the service to catch up on appraisals.

The residential manager said there were no staff that have had to be performance managed since her employment and but was able to provide internal file notes indicating that some staff have been performance managed in the past. However, file note documentation provided did not indicate that there had been discussion with staff regarding performance improvement plans or that a procedural fairness process had been followed in accordance with the organisations policies and procedure for managing staff performance.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement and advised that comments made by the representatives referred to staff shortages prior to January 2023 and since that time that recruitment has occurred and reliance on agency staff had decreased. The provider acknowledges that in the few months prior to January 2023, large numbers of agency staff were needed. The service continues to support additional hours for 132 consumers despite the lower occupancy rates of 114. The provider also advised that 100% of staff have had their first step of appraisal completed prior to the Site Audit and staff are currently completing their part to finalise their appraisals, in which 40% have been completed. The previous management had fallen behind and are now working toward completing the staff appraisals.

I have considered the providers response and acknowledge that since January 2023, the provider has recruited 7 registered nurses, 4 enrolled nurses and 19 care staff and reduced the use of agency staff by 90%. The current manager is working towards all staff having staff appraisals completed.

I find that based on the approved provider’s response, the service is compliant with these Requirements 7(3)(a) and 7(3)(e).

**Standard 8**

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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. | Compliant |

**Findings**

The Quality Standard has been assessed as non-compliant as two of the five specific Requirements have been found to be non-compliant.

The following Requirements 8(3)(a), 8(3)(b) and 8(3)(e) have been found to be compliant.

The Assessment Team found that the organisation is generally able to demonstrate that it actively engages and supports consumers in the development, delivery and evaluation of care and services. Consumers and representatives advised that they generally feel supported by the service to have a say in their care and services and feel the service is well run.

The Assessment Team asked the chairman of the board, of ways that consumers are engaged in the development and delivery of care and services, the chairman responded that this is done through feedback from resident and family meetings, consumer surveys, consumer engagement such as language and signage in wings and through feedback from different consumers on various topics which will flow through to education and training of staff.

Whilst the organisation has organisation wide policies and information with regard to the partners in care program this program has not yet been implemented at the service. Management advise they have identified essential visitors at the service however this has not been documented.

While the service has not yet fully implemented consumer engagement at the service, consumers and representatives advise that they generally feel supported by the service to have a say in their care and services.

The Assessment Team found that the service demonstrates the governing body provides regular communication to management and staff in promoting quality outcomes for consumers.

Discussion with the organisation’s management and records reviewed by the Assessment Team include that the board has a diverse membership including members with experience in clinical governance and are represented on the boards sub committees such as the care and clinical governance committee. The board receive detailed service reports including results of audits, serious incidents, clinical indicator data, feedback and complaints and continuous improvement. The organisation’s strategic plan for the next 4 years is in development with board members and management. The chairman of the board stated the main topics include leadership, chemical restraint, funding, people acquisition and staff progress. The board receives information regarding legislative changes from management and this information is disseminated through the service through team meetings, newsletters and online forums.

The Board members attend stakeholder conferences and seek advice from clinical developments. Members have access to the institute of company directors and receive corporate governance skills training online. Board meeting agenda reviewed includes topics such as the chairman’s report, work health and safety report, risk and compliance, feedback and incidents and care and clinical governance meeting report at a regional level.

The Assessment Team observed care and clinical and governance committee meeting minutes include regular updates through service reports. The committee requests details with regard to information of service reports to meet executive actions for example requests on the current status of the identified clinical issues such as falls and pressure injuries. Management advised the organisation’s new risk management system will be going live across the organisation at end of March 2023 and will supply real time information to managers with regard to risks, hazards, incidents and feedback in order to improve outcomes for consumers.

The Assessment Team found that the organisation has a documented clinical governance framework and clinical oversight at the governance level. Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Staff said they had been educated about the policies and were able to provide examples of their relevance to their work.

Staff interviewed stated they have received training in policies and processes relating to antimicrobial stewardship. Staff were able to demonstrate a good understanding of antimicrobial stewardship and have access to relevant information.

The Assessment Team observed efforts by management to minimise the use of restraint including chemical restraint. The service has systems in place to manage an outbreak and minimise infection related risks.

Staff were generally aware of open disclosure processes.

While the organisation has policies in relation to antimicrobial stewardship, the use of restraint and open disclosure, practices do not always reflect the organisation’s policies and procedures.

The following Requirements 8(3)(c) and 8(3)(d) were found to be non-compliant.

The Assessment Team found that the organisation’s systems for information management do not provide sufficient, consistent or readily available information for staff and management to perform their roles effectively. The organisation’s electronic care management system is limited in scope with regard to its ability to accurately reflect consumers care needs, such as the inability to change or add fields causing misidentifying of any update and often needing to use separate spreadsheets that are not readily accessible to staff. Photos of wounds cannot always be uploaded, and some wound photos have to be put onto mobile phones. Quality of wound photos is poor and not always effective in identifying the wound accurately. Care plans cannot be changed. Behaviour support plans are not easily accessible or available to manage. Care plans and behaviour support plans including goals and interventions tend to be generic and not individualised to the consumer.

The Assessment Team also observed that consumer assessments override previous assessments not providing staff with history of assessments.

Management acknowledge that the current electronic care management system is challenging and advise that the organisation will implement a new clinical care system to be rolled out later this year. The system will interface so that care staff will only have one source to access information. The quality improvement unit manager said staff will be trained and documentation will be provided to assist them in management of the new system.

The Assessment Team found that the organisation does not have effective continuous improvement systems in place. The organisations system is to collect and review the feedback of consumers and their experience is not routinely included as part of the quality improvement system. I reviewed the providers response and found that the feedback of consumers has since been updated in the Plan for Continuous Improvement and quality improvement system.

The organisation has recently improved staffing levels through recruitment and supporting the service with the recruitment and training of additional staff and putting in strategies to attract and retain more staff. The service is also working toward having regular assessment and review of the performance of staff.

The organisation has a risk management system to identify potential risk to the organisation and to consumers, however deficiencies have been identified in the effectiveness of intervention strategies as they have not been analysed or evaluated for effectiveness.

The service has policies and procedures in place for its risk management systems and practices. The service has systems and practices for managing high impact high prevalence risk. However, the organisations policies and procedures are not always reflective of practices. Deficiencies have been identified in the effectiveness of the service’s information management system regarding behaviour management and in preventing incidents from reoccurring and in wound management. The Assessment Team found that behaviour charts were mainly generic and not individualised and there is no evidence that strategies implemented to manage behaviours were reviewed or evaluated. Documentation does not clearly reflect that informed consent has been obtained for the use of restrictive practices or ensuring behaviour management strategies are personalised to each individual. Wound management reflected inconsistent application of organisation policy and procedure in the delivery of wound care.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement and advised that there are systems that are currently in place in relation to information management and wound care plans, however staff were using an inefficient process to record and photograph the wounds, the provider also stated that Behaviour Support Plans are lengthy and are available in the summary care plans. Person centred goals were previously not well documented, however the service advised improvement in this practice is occurring. The provider advised the new electronic clinical documentation system will provide improved function. The provider stated that behaviours are being evaluated and behaviour interventions are reviewed each month. The provider acknowledged that charting was often fairly generic in relation to interventions, however actions to address this have been added in the Plan for Continuous Improvement.

I have considered the providers response, however, feel that it will take some time to reflect compliance with these Requirements.

I find that the approved provider is non-compliant with Requirements 8(3)(c) and 8(3)(d).

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