Beecroft House Residential Aged Care

Performance Report

134 Beecroft Road   
BEECROFT NSW 2119  
Phone number: 02 9876 3471

**Commission ID:** 2442

**Provider name:** Thompson Health Care No.2 Holdings Pty Ltd

**Site Audit date:** 12 April 2022 to 14 April 2022

**Date of Performance Report:** 30 June 2022

# Performance report prepared by

Stewart Brumm, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 31 May 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

Consumers and representatives considered that staff are kind, treat them with dignity and respect and they feel valued as an individual. The organisation has staff training around consumers being treated with dignity and respect which also acknowledges diversity. Staff demonstrated an understanding of consumers’ backgrounds and reported that activities, celebrations and events planned always consider consumers’ identity and culture. Care documents reviewed by the Assessment Team included lifestyle choices and preferences on a day-to-day basis for all consumers.

Consumers interviewed from culturally diverse backgrounds said that their culture was respected. Staff were able to describe cultural, religious, and personal preferences for consumers and what matters most to them. Care planning documents identified consumers’ religious, spiritual, and cultural needs and personal preferences.

Consumers revealed that they can make informed choices about their care and services and maintain relationships important to them. Staff identified that consumer choices and decisions are supported through the care planning process. Review of minutes from resident meetings indicated consumers have the opportunity to participate in decision making and were able to exercise choice and independence.

Consumers and representatives considered, they are supported to take risks to enable them to live the best life they can. The organisation uses clinical and non-clinical risk assessments processes to identify and assess risks to consumers for the different activities they wish to undertake.

Staff demonstrated their awareness to notify the consumer’s representative when adverse events occur and discuss routine matters with consumers and representatives that are recorded in care documentation. Consumers and representative expressed satisfaction with the information they receive relating to their care and changing needs. Menus, activity calendars and other notices were observed throughout the service to communicate current information to consumers and representatives.

Consumers expressed satisfaction in the way their privacy is respected, and staff demonstrated how they respect consumer’s privacy. The Assessment Team observed staff respecting consumer’s privacy, for example by knocking on doors before entering into their room and keeping personal information confidential.

The Quality Standard is assessed as Compliant as six of the six specific Requirements have been assessed as Compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

Consumers and representatives expressed satisfaction with the assessment and care planning at the service. There are policies and procedures to guide staff practice regarding assessment and planning for consumers.

Care document highlighted consumer needs and preferences are captured during assessment and care planning supports the strategies in place to address those needs and goals. Staff informed that end of life and advanced care planning information is approached during care planning consultations. Consumers reported that staff had discussed end of life planning with them.

Care planning documentation sampled by the Assessment Team reflected the involvement of consumers and representatives and other health professionals including Medical Officers and Allied Health Professionals. This was consistent with feedback from staff who described how consumers, representatives and other allied health professionals are involved in consumer’s assessment and planning. The Assessment Team reviewed policies and procedures relevant to assessment and planning which identified consumers and representatives as partners in care planning that support delivery of care.

Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team provided information that although staff could identify when incidents or changes in circumstances might alter consumer needs and preferences, care plans were not regularly reviewed and as a result, found the service did not comply with this Requirement. Relevant summarised evidence included:

* Consumer care needs were not consistently reviewed following incidents or changes in circumstances.  For example, in case of a named consumer where the behaviour management plan does not seem to be effective and strategies included do not demonstrate any change or improvement in the consumer’s behaviour. For another consumer, staff failed to conduct follow-up wound care on a consumer within 24 hours post fall as per service policy. One consumer, whose wound management review directed change of dressing on a specified date, however dressing wasn’t changed for a period of three days post the specified date.

In their response to the Site Audit report, the Approved Provider acknowledged some deficiencies identified by the Assessment Team, however provided evidence to support that reviews were in fact completed post incidents. The clinical information provided by the Approved Provider:

* Identifies that the wound care and review post falls for the consumer was completed on the following Monday as the consumer returned from the hospital on Saturday. The information although supports the observation by the Assessment Team however presents further information that the consumer was provide post-acute care and was attended to by staff including checking for vital signs and ensuring they were comfortable. Furthermore, the timeline provides an indication on availability of the specialised allied health practitioner to meet the 24-hour requirement per the service policy. As this requirement focuses on regular review of care for effectiveness, I have found that the weight of this evidence is more relevant to effective management of high- impact or high prevalence risks associated with consumer care and will therefore examine this in detail under Requirement 3(3)(b).
* Revealed that wound review was completed on the specified date however no information on if the dressing was changed as the consumer was in palliative phase and passed away three days after the specified date.

The Approved Provider plan for addressing the deficiencies includes the following relevant improvements:

* The consumer’s behaviour management plan was scheduled, and appropriate specialist referrals have been made.
* Policy and procedure review commenced for Falls Prevention and Post Falls Management with expected completion date in June 2022.

While I acknowledge the findings of the assessment team, I have found that the weight of this feedback is more relevant to safe clinical care for each consumer. I have considered this evidence in Standard 3 Requirement (3)(a).

On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Approved Provider did not demonstrate that consumers always get safe and effective clinical or personal care. The Approved Provider did not demonstrate that care provided was always best practice, nor was it tailored to the consumers needs and did not optimize the consumers health and wellbeing.

The Approved Provider did not demonstrate that high impact or high prevalence risks to consumers were effectively managed in relation to falls management, wound care and behaviour management.

The Approved Provider did not demonstrate Information about the consumer’s condition, needs and preferences is consistently documented.

Staff and management indicated that they regularly communicate with consumer and representative regarding consumers advance care plan and make referrals for the palliative care team if they have identified any consumers with deterioration. Staff were able to describe how they ensure comfort and dignity of consumers receiving palliative care is maximised. The service has a palliative care policy and process which focuses on end-of-life care.

Consumers and representatives indicated that the service kept them regularly informed of changes when an outbreak occurs. Staff said that they have received infection prevention and control training. Infection control assessments were completed in the clinical information system for consumers with infections. The service has policies and procedures in relation to infection control and practices to reduce the risk of resistance to antibiotics.

The Quality Standard is assessed as Non-compliant as four of the seven specific Requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team provided information that consumers do not get safe and effective personal care as consumers, representatives and staff expressed concerns about not meeting personal hygiene preferences due to short staffing. Best practice guidelines were not followed in areas including wound management and restrictive practices. Evidence relevant to the finding included:

* For one consumer with a history of behavioural incidents, behaviour management plan was not reviewed effectively as the non-pharmacological strategies used were mostly ineffective.
* Care planning document show that the tests requested by medical officer were not completed.
* Feedback from three consumers representatives reflected that consumers do not receive personal care in a timely manner resulting in skin and nail issues.
* Care planning documents indicated deficits in consumer’s conditions not being documented consistently or missing entries.
* One consumers’ mobility and pain assessments and plans were not updated post falls.
* Ineffective clinical oversight and monitoring mechanism at the service to ensure each consumer gets safe and effective personal and clinical care for example, in respect to bowel obstruction, falls management, fluid and food intake.
* Feedback from consumer representatives indicate staff cannot support maintenance of assistive devices.
* One consumer with cognitive decline often has to vocalise to get staff to assist in absence of an effective call bell system suitable for their need.
* Falls preventions strategies or equipment not operating or not assessed for two consumers.
* For two consumers’ following weight changes or significant weight loss, no review was organised with the dietitian.
* Follow-up wound care on a consumer not completed within 24 hours post fall as per service policy.

I find the evidence provided by Assessment Team can be examined under multiple requirements through the entire Standard in this case, therefore I have considered the evidence related to this requirement below and others in relevant requirements within this standard as appropriate. For example, the evidence regarding fall prevention and management has been considered under Requirement 3(3)(b), issues in relation to inconsistent entries and documentation of consumer condition have been reviewed within the scope of Requirement 3(3)(d) and evidence in relation to significant weight change or weight loss without timely referral to dietician is examined under Requirement 3(3)(f).

The Approved Provider’s response did not refute all of the Assessment Team’s findings and provided supporting information on actions such as a Corrective Action Plan that have been undertaken since the Site Audit which includes:

* The case conference with the representatives to understand the personal care preferences of the consumer and their concerns effectively and address them;
* Tests as requested by medical officer were completed;
* Staff education in relation to maintenance of assistive devices; and
* Staff education for procedures in actions and escalation process in bowel obstruction

The Assessment Team also considered that incidents were not reported appropriately, however I find there is insufficient evidence to determine the nature and severity of the incident to confirm this finding. The Approved Provider’s response however indicates that the Incident form is planned to be reviewed by a Clinical Governance Consultant.

I note, from other parts of the Site Audit Report where the Assessment Team observed at various mealtimes staff were not assisting the consumers with food even when the care plan indicated supervision or assistance with meals for some consumers indicating that the consumer did not receive effective care at mealtimes according to their care plan. The Assessment Team also observed fewer staff to assist at mealtime including nurses being present at the nurses’ station however not assisting the consumers with their meals. This observation is considered under Standard 7, Requirement (3)(a).

While I acknowledge the service has taken actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes.

I consider at the time of the site audit the Approved Provider did not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care. On the balance of the evidence provided.

I find this requirement is non-compliant.

### Requirement 3(3)(b) Non-compliant

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

The assessment team provided information that the service did not demonstrate effective processes to manage the high impact and high prevalence risk associated with the care of the consumers. I have noted the following from other parts of the Side Audit report where the assessment identified:

* Falls preventions equipment not operating or effective when managing a consumer with high risk of falls such as sensor mat and adequate height for the bed;
* Post fall observations including wound care, falls risk assessment and mobility care plan not updated or completed in line with service’s policy; and
* behaviour management plan was not reviewed effectively as the non-pharmacological strategies used were mostly ineffective.

The Approved Provider did not refute all of the assessment team’s findings in its written response and provided information including supporting evidence of actions that have been taken since the Site Audit:

* Urgent review of Falls Policy and Procedure;
* Further actions taken to manage consumer high impact or high prevalence risks, including planned staff training on post falls management and safe height of bed for consumer;
* The referral has been made to external specialist provider to review the behaviour management plan.

The Approved provider has not responded to all deficiencies identified such as for a consumer where the care plan specifies that the sensor mat must be on at all times, the call bell records indicated that day the consumer had unwitnessed fall, no calls were raised suggesting that sensor mat was not on.

I acknowledge the approved provider has implemented some planned actions to address the deficiencies identified by the assessment team, however, at the time of the Site Audit the service did not consistently demonstrate that consumer high impact or high prevalence risks were managed effectively.

I find this Requirement Non-compliant.

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Non-compliant

*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.*

The Assessment Team provided information that the service did not demonstrate that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to appropriately. The Assessment Team identified:

* a lack of documented evidence in the identification and monitoring of a consumer’s changed condition until two consumers received treatment in a hospital post fall and were diagnosed with infections.
* ineffective identification and monitoring of a consumer’s weight changes including inefficient response by not referring to a dietician.

I note, evidence from other parts of the Site Audit Report includes:

* Ineffective clinical oversight, monitoring mechanism and therefore inadequate timely response at the service to recognise and respond to deterioration in consumer condition for example, in respect to bowel obstruction, falls management, fluid and food intake.

The Approved Provider did not agree with the Assessment Team’s findings in its written response and provided clarifying information as well as clinical records extracts for named consumers including:

* The response stated that monitoring vital signs were appropriate measures and the findings in the hospital were coincidental;
* For one consumer experiencing significant weight changes the referral to dietician was in the electronic system on 31 March 22 prior to the Site Audit and appropriate nursing interventions were in place;
* Case conference with identified consumers and representatives on the deficiencies raised; and
* Further actions taken to improve recognition and responded to consumers’ changed conditions were included in Requirement 2(3)(e) and other Requirements in Standard 3, for example, staff training in post falls management.

I note there is insufficient information to conclude that monitoring was not effective for consumers pre-admission to hospital where post admission they were diagnosed with infection.

The Approved Provider’s response indicated that the referral to the dietician was already completed prior to Site Audit, however, this was not evident in the clinical record and the progress notes confirm the findings from the Assessment Team.

I acknowledge the Approved Provider has implemented some planned actions to address the deficiencies identified by the assessment team, however, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes.

I consider at the time of the site audit the service did not have effective systems to consistently demonstrate that deterioration or changes in consumer’s physical function, capacity or condition is recognised and appropriately responded to in a timely manner.

I find this Requirement Non-compliant.

### Requirement 3(3)(e) Non-compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

While the Assessment Team have recommended that the service meets this Requirement, there is information in the report in relation to care planning documents indicating deficits in consumer’s conditions not being documented.

This information will be considered here as it is relevant to this Requirement. Specifically, I consider the following information in the report that is relevant to this Requirement:

* Information as noted within in Standard 3 Requirement (3)(a) indicates that consumer’s conditions are not being recorded. For example:
* Food and fluid chart recording for one consumer showed missed entries by staff on her food and fluid intake.
* Another consumer’s fluid balance chart documented inconsistent entries.

The Approved Provider did not refute the assessment team’s findings in its written response and provided information and supporting evidence of actions that have been taken since the Site Audit including case conference with identified consumers and representatives as well as staff training on recording the information on consumer condition.

While I acknowledge the service has taken actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes.

I consider at the time of the site audit the service did not have effective systems to ensure information about the consumers’ needs, condition and preferences were accurately documented.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

Most consumers expressed satisfaction with the lifestyle program and reported the program supports their lifestyle needs and staff assist them to engage in activities of interest. Staff awareness of consumers’ interests is aligned with consumer feedback and care planning documents. The Assessment Team observed consumers engaging in a variety of group and independent activities such as card games, pancake day and social café during the site audit and with each other.

The Assessment Team observed various staff members attending to consumers who were experiencing emotional distress and helping them resolve the issue with the consumer. Consumer care plan documentation outlines the strategy to support them when they are feeling low including staff spending one-on-one time with them and offering a personalised activity such as hand massage or singing. All care plans reviewed by the Assessment Team found that all consumers had their religious and spiritual preferences listed. Consumers reported that staff are wonderful and provide a lot of different activities that they can attend.

Most consumers and representatives indicated that consumers are supported to keep in touch with people who are important to them. Care planning documents captured information about how and with who consumers wish to maintain their relationships. Staff provided examples of how consumers are supported to participate in the community.

Staff demonstrated an understanding of what organisations, services and supports were available in the community should a need be identified for a consumer. Staff reported that the service has a regular visitor from the local church for pastoral care. This was supported by the consumer feedback. The Assessment Team observed a variety of brochures and resources available to support referral to external organisations as required.

The Approved Provider was not able to demonstrate Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. The Approved Provided has commenced improvement actions to address the deficits.

The Assessment Team observed equipment which supports consumers to engage in activities of daily living to be suitable, clean and well maintained.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Non-compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

The Assessment Team provided information that the consumer’s condition, needs and preferences in relation to their supports for daily living are not communicated effectively within the organisation or with others where responsibility for care is shared. Evidence relevant to the finding included:

* One consumer representative noted that the staff do not know consumer’s dietary preferences due to which the consumer finds food unpalatable and therefore eats less.
* One consumer reported that they are bored due to no contact from the activities team in addition to no other contact to talk to or any visitors.
* The Assessment team noted only 20% of the consumers dietary preferences were recorded.

### The Approved Provider’s response acknowledged the deficits identified above by the Assessment Team, included the consumer specific action plan to rectify all the deficits identified including comprehensive case conference with consumer representative to identify and record dietary needs, initiate a lifestyle choices and support assessment to reduce social isolation and update dietary preferences for all consumers.

I acknowledge the service has taken improvement actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the information about the consumer’s condition, needs and preferences in relation to their supports for daily living were not communicated effectively within the organisation.

Based on the summarised evidence above, I find this requirement non-compliant.

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team provided information of consumers providing mixed feedback in relation to the quality of meals. Evidence relevant to the finding included:

* One named consumer indicated that food quality was good however he needs staff assistance with his meals which is not provided.
* A consumer representative indicated that the consumer has lost appetite as the food provided is unpalatable and lacking the variety raising concerns on consumer’s weight loss as a consequence.
* The Assessment team observed the dietary information on the kitchen whiteboard and in the Dietary Book did not align, was not complete and current and did not reflect the preferences and needs of consumers.
* The Assessment Team observed various mealtimes and observed staff not assisting the consumers with food even when the care plan indicated supervision or assistance with meals for some consumers.

The Approved Provider’s response acknowledged some of the deficits identified above by the Assessment Team, includes investigation into the issues raised and improvements implemented have been implemented in a Corrective Action Plan. The Corrective Action Plan includes actions taken such as review staffing levels and change to the structure of the roster to ensure that more staff were available including additional shift. The Approved Provider response note that the issues raised by the Assessment Team relate more to the staff assistance during meal times and dietary plan information than the actual meal quality and quantity. The Corrective Action Plan provided by the service indicates the consumers and representatives were satisfied with the action taken by the service to remedy the deficits identified.

I acknowledge the feedback from the Assessment Team that a consumer had experienced weight loss, however, I have considered this evidence this under Standard 3 as it is more relevant there. I accept that the service has sought to accommodate the consumer’s preferences. Therefore, I do not consider this evidence supports Non-compliance with this Requirement.

The evidence provided indicates the staff assistance at meal times as main concern for consumers and representatives affecting their dining experience. I consider the feedback is better dealt with under Requirement 7(3)(a).

I consider that the examples presented by the Assessment Team demonstrates that consumers were provided with meals that are varied and of suitable quality and quantity.

Therefore, I find this Requirement is Compliant.

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team observed the service environment to be welcoming, safe, with freedom of movement both indoors and outdoors reflecting dementia enabling principles of design. Staff described how the layout compliments the service, with the courtyard and common areas for the consumers to socialise and relax throughout the day. Consumers and representatives indicated they were content with the environment and feel safe.

Consumers indicated they are supported to move around the service, including access to the courtyard, gardens and outside the service if they wish and are supervised if required for their safety. The Assessment Team observed the service to be safe, clean, well serviced, and maintained at a comfortable temperature. The Assessment Team observed that all maintenance updates and preventative schedules within the service are recorded, actioned and managed.

Consumers advised they feel that furniture, fittings and equipment are safe, clean, well maintained and suitable for them. The Assessment Team observed furniture, fittings and equipment were safe, clean and well-maintained. Staff reported that furniture, fittings and equipment are assessed for suitability prior to purchase to meet consumers’ personal and clinical needs.

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. The Approved Provider has a range of formal and informal process to receive feedback and complaints.

The Approved Provider was not able to demonstrate consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. The Approved Provider has commenced improvement actions to address this deficit.

The Approved Provider was not able to demonstrate Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Consumer and representatives were not consistently satisfied with the action taken in response to complaints or concerns. The Approved Provider has commenced improvement actions to address this deficit.

Feedback and complaints are not consistently reviewed and used to improve the quality of care and services.

The Quality Standard is assessed as Non-compliant as three of the four specific requirements have been assessed as Non-compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### The Assessment Team provided information that the service was not able to demonstrate that consumers, their family, friends, and others are encouraged and supported to provide feedback and make complaints. Evidence relevant to the finding included:

* Consumers stating that they were unsure about complaints process however if the need arises they will contact management;
* Staff interviewed were unable to describe the service’s various process for consumers who wish to raise feedback or complaints; and
* The Assessment Team observed no information regarding feedback and complaints are displayed in the communal areas. However, observed the feedback forms were located throughout the service level.

### The Approved Provider’s response disagrees with the recommendation of the Assessment Team and contested that evidence documented by the Assessment Team describes management being easily alerted to issues and complaints by residents and representatives. The Approved Provider also contended that information and brochures regarding feedback and complaint process are displayed throughout the service starting at the entry door and it would just have been requiring replenishment.

I acknowledge that the service has a complaints and feedback system that is supported by the organisation’s broader complaints and feedback framework. The above evidence from consumers support that informal verbal feedback is provided as management is easily approachable to raise any issues consumers have. It also indicates that staff deal with the adhoc consumer issues as they are reported verbally and in case of a formal feedback or complaint a clinical staff member such as a nurse if involved to provide support to consumers.

Based on the summarised evidence above, I find this requirement is compliant.

### Requirement 6(3)(b) Non-compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### The Assessment Team provided information that consumers, representatives and staff members were unaware regarding access to advocates, language services and other methods for raising and resolving complaints. Evidence relevant to the finding included:

* The service did not have brochures regarding translation services complaints and feedback mechanisms displayed.
* The Assessment Team observed information regarding advocacy services that was not accessible in the communal areas for consumer/representatives.

The Approved Provider’s response indicated that information on external complaints processes are provided to consumers and representatives via the resident handbook, brochures throughout the service, and the open-door policy ensures quick responsiveness to complaints.

The Approved Provider agreed that there is room for improvement in providing information and resources on advocacy services and have added this to continuous improvement plan.

I acknowledge the service has taken steps to ensure consumers and their representatives are aware and have access to advocacy, language services and external complaints mechanisms moving forward.

However, at the time of the site audit the consumers were not made aware of or had access to advocates.

Based on the summarised evidence above, I find this requirement is non-compliant.

### Requirement 6(3)(c) Non-compliant

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

### The Assessment Team provided information that the Approved Provider was not able to demonstrate that an open disclosure is practised when unexpected happens. The Assessment Team provided mixed feedback regarding response to complaints raised by consumers and representatives. Evidence included:

* All staff members were not aware of open disclosure and its relevancy in complaints process.
* Consumer and representatives were not satisfied with the action taken in response to complaints or concerns, for example three consumer representatives complained about personal care, notification of an unwitnessed fall, concerns about sensor mat and call bell functioning were left waiting without an acknowledgement of complaint.
* A representative reported that they raised complaint regarding laundry and missing items which has been actioned.

### The Approved Provider’s response disagrees with the Assessment Team’s recommendation and provided a Corrective Action Plan which noted care conferences to address each issue raised by the Assessment Team.

I acknowledge the Approved Provider is committed to address the deficits identified by the Assessment Team. However, at the time of the site audit all staff did not understanding of the open disclosure process and its relevance and the complaints were not acknowledged per the representative feedback leaving them waiting for an assurance that the concerns have been heard and appropriate action will be undertaken in response.

Based on the summarised evidence above, I find this requirement is non-compliant.

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team provided information the service has not consistently identified areas of continuous improvement from feedback and complaints to improve care and services. The Assessment Team provided the following findings and evidence in relation to their recommendation of not met in this Requirement:

* The Assessment Team found that there was no evidence to support improvement actions being implemented in response to feedback and complaints from consumers/representatives.
* Staff interviews identified some individual examples of responses to complaint but did not advise of improvements made to the quality of care and services provided to consumers.

The Approved Provider agreed to the deficits identified by the Assessment Team and indicated that the service is in ‘developing’ phase of meeting this requirement and there is currently work being undertaken by external clinical governance specialist including complaint tracking and establishing trends.

I acknowledge, the Approved Provider has agreed that there are opportunities to improve in relation to continuous improvement activities and use of feedback in data analysis. However, at the time of the site audit the service did not demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services.

Based on the summarised evidence above, I find this requirement is non-compliant.

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Approved Provider demonstrate the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

Consumers and representatives reported that staff are respectful and helpful. The organisation has staff training around consumers being treated with dignity and respect which also acknowledged diversity. Staff were observed interacting with consumers, supporting their needs and preferences.

Consumers did not identify any areas for staff training. Most staff interviewed confirmed they had received training on the serious incident response scheme. The education records reviewed demonstrated staff members have received training on incident reporting, restrictive practices, privacy and dignity.

The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The service regularly assesses, monitors and reviews the performance of staff through formal performance appraisals three to six months after commencing employment and thereafter on annual basis. Management advised that staff performance appraisals occur annually.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team provided information the service did not demonstrate that the workforce is planned to enable the delivery and management of safe and quality care and services. Evidence relevant to the finding included:

* The consumers who needed assistance, encouragement and prompting to eat were not assisted by staff.
* Feedback from one consumer and four consumer representative that there is not enough staff to attend to consumer needs and sometimes they wait for a long time to be assisted.
* Feedback from one consumer and one representative reflected that due to functional impairment the consumers are unable to use the call bell, instead they call out to staff however they are left waiting for long time to be attended.

The Approved Provider’s response disagreed with the recommendation of the Assessment Team and provided evidence which included:

* The Direct Care Hours was above the requirement per the Department of Health for the number of Occupied Beds;
* All vacant shifts were backfilled per the Staff roster reviewed; and
* Call bell data indicated only 1.29% of the call bells were not answered within 10 minutes which is the acceptable time at the service.

### The Approved provider’s Corrective Action plan also indicates that they have planned review of the roster at mealtimes with an aim to add another shift at those times.

The Approved Provider’s response and the action plan demonstrates that they have plan workforce to enable the delivery and management of safe and quality care and services.

On balance, I find the service is Complaint with this Requirement.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team provided information that the Approved Provider did not demonstrate how the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Evidence relevant to the finding included:

* Staff did not know how to maintain assistive devices for functional impaired consumers;
* The Assessment Team observed the folders meant to have online position descriptions were empty;

### The Approved Provider contested part of this finding by the Assessment Team and provided the Corrective Action Plan which noted the action noted as review current process, consider referral to Hearing Aids Professional for services and education.

### The Approved Provider stated that:

* they provided position descriptions to all staff;
* staff training, mandatory checks and registrations are all done and maintained to achieve staff competency including staff being removed from the roster temporarily until they have completed the training;

I note the additional evidence provided by the Assessment team below:

* All staff interviewed were able to describe mandatory training expectations;
* Management advised that service has an educator who organises training in learning platform and toolbox education; and
* All registrations reviewed were current for staff members.

### I am satisfied the service has implemented appropriate actions including additional training requirement and regular monitoring to identify and address any further issues. I am satisfied the service has appropriately addressed the deficits and has systems in place to monitor and ensure that their workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles moving forward.

Based on the summarised evidence and reasons above, I find this requirement is compliant.

### Requirement 7(3)(d) Compliant

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

### Requirement 7(3)(e) Compliant

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The Board and governance structure monitor the delivery of services to ensure the service is well run and delivers safe, high quality care. Management advised the clinical and quality indicators are reviewed monthly and are discussed at the board meeting where the clinical and quality team of the organisation flags unusual trends and creates the continuous improvement plan for the service. Management noted that an external service provider supports the services ongoing focus around quality and clinical governance which supports that the governing body takes accountability to delivery of safe and quality care at the service. The Approved Provider has effective organisation wide governance systems.

The Approved Provider did not demonstrate effective management of managing high impact or high prevalence risks associated with the care of consumers.

The organisation has a clinical governance framework, which includes policies relating to antimicrobial stewardship, minimisation of the use of restraint and open disclosure. Staff interviewed were able to describe how these policies and framework were relevant to their work. Management were also able to provide examples of changes to the delivery of care as result of these policies.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### The Assessment team provided mixed examples where the feedback from consumers and staff did not corroborate that consumers are engaged and supported in the development, delivery and evaluation of care and services. The evidence included:

* Consumer representative felt that the service has lost touch with families over last few years;
* Consumer and representative meetings were only organised twice in 2021; and
* Staff members were not able to describe the use of feedback forms to improve care delivery and support consumer needs.

The Approved Provider did not agree with the Assessment Team’s findings and provided examples where consumer and representatives provided feedback and the service responded with appropriate resolution to the satisfaction of consumers. The Approved Provider acknowledged that the consumer and representative meetings were influenced by lockdowns due to the pandemic and the service has planned to organise these vital meetings again.

I have considered the Approved Provider’s response and acknowledge the disruption due to the lockdowns in the pandemic and the management change at the service level. The Approved Provider’s response highlights that most consumer feedback is verbally raised directly with the staff and the staff resolve the issues raised.

On balance, I find there is insufficient evidence to support the consumers are not supported and engaged in delivery and evaluation of care and services within the service.

Therefore, I find this requirement is compliant.

### Requirement 8(3)(b) Compliant

*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) Compliant

*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.*

The service was able to demonstrate organisation wide governance systems are in place for information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. However, the Assessment Team found the service did not demonstrate that it has an effective organisation wide governance system in place, with respect to regulatory compliance. The Assessment team observed that there was no incident report for a potential incidents classified under Serious Incident Response Scheme (SIRS) and no follow up in progress notes for such incidents either.

The Approved Provider’s response disagreed with the recommendation of the Assessment Team however noted that evidence related to incident reporting have been dealt with under Standard 3. Within the response for Standard 3 in relation to incident reporting, the Approved Provider noted that they have planned a review of Incident Form in electronic care management system by a Clinical Governance Consultant to incorporate serious incident response scheme reporting requirements into the incident workflow.

There are organisational wide governance systems in place however the evidence provided shows there are some deficits in the management of risks. I have considered this evidence and find them more relevant to Standard 8 Requirement (3)(d) which I have found Non-compliant.

Based on the summarised evidence above, I find this requirement is compliant.

### Requirement 8(3)(d) Non-compliant

*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.*

The Assessment Team provided information the organisation has risk management systems to direct and guide staff. However, the risk management systems have not been consistently implemented or effective and staff are not always following organisational risk management procedures to ensure high impact and high prevalence risks are managed, abuse is identified and responded to, consumers are supported to live their best life or incidents are managed or prevented in line with the incident management system. The evidence includes no escalation pathway for potential SIRS incident.

I note, from other parts of the Site Audit report where the Assessment Team brought forward examples to indicate that risk management system and practices for managing high impact and high prevalence risks associated with the care of consumers were not effective.

The Approved Provider’s response indicates that the incident referred to by the Assessment Team is an isolated incident and does not confirm any systemic issues.

The Approved Provider provided information including supporting evidence of actions that have been taken since the Site Audit:

* Planned a review of Incident Form in electronic care management system by a Clinical Governance Consultant to incorporate SIRS reporting requirements into the incident workflow;
* Urgent review of Falls Policy and Procedure; and
* Further actions taken to manage consumer high impact or high prevalence risks, including planned staff training on post falls management.

I acknowledge the actions taken by the Approved Provider to ensure effective risk management systems for managing high impact and high prevalent risk and incident management system through reviewing the alerts systems and incident forms, however on balance, this evidence shows that incident reporting and risk management systems were not effective in governance systems prior to the Site Audit.

Therefore, I find this requirement is non-compliant.

### Requirement 8(3)(e) Compliant

*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.*

# Areas for improvement

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

Standard 3 Personal care and clinical care

* Requirement (3)(a) Ensure each consumer gets safe and effective personal care and clinical care which is in line with best practice and the consumer’s needs. Ensure staff practice in relation to restrictive practices, wound care, skin care and pain are in line with best practice and the service’s procedures to optimise the wellbeing of the consumer.
* Requirement (3)(b) Ensure each consumer receives services and supports that promote and support the consumer’s emotional, spiritual and psychological wellbeing. Ensure consumer’s specific emotional, spiritual and psychological needs are identified through consultation with consumers, incidents, feedback.
* Requirement (3)(d) Ensure information about the consumer’s condition, needs and preferences is accurately and effectively completed and communicated to those involved in supporting the consumer, specifically in relation to consumers activity and social engagement, attendance, assessments and records.
* Requirement (3)(e) Ensure information about consumer’s conditions, needs and preferences is documented and communicated within the organisation and with others where the responsibility of care is shared.

Standard 4 Services and supports for daily living

* Requirement (3)(d) Ensure information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

Standard 6 Feedback and complaints

* Requirement (3)(b) Ensure consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints
* Requirement (3)(c) Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement (3)(d) Ensure feedback and complaints are reviewed and used to improve the quality of care and services.

Standard 8 Organisational governance

* Requirement (3)(d) Ensure staff practice aligns with the organisation’s risk management framework and procedures including in relation to recognising, reporting and managing incidents, effectively managing consumer’s high impact and high prevalence risks and supporting consumers to live the best life they can.