Performance

Report

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| Name of service: | Benjamin Short Grove |
| Service address: | 130 Huntley Road ORANGE NSW 2800 |
| Commission ID: | 1056 |
| Approved provider: | Mission Australia |
| Activity type: | Site Audit |
| Activity date: | 26 September 2022 to 29 September 2022 |
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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 Benjamin Short Grove (**the service**) has been prepared by M. Nassif, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 28 October 2022.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 3(3)(b) – Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 4(3)(f) – Ensure meals provided are varied and of suitable quality and quantity.
* Requirement 7(3)(a) – Ensure 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.

# Standard 1

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

Findings

Consumers said staff made them feel accepted, valued, and their culture, identity, and background were respected. Staff were familiar with consumers’ backgrounds and individual needs. Lifestyle and dietary assessment of consumers included information about what is important to them.

Consumers said they felt culturally safe with their physical, spiritual, cultural, and social needs catered for. Staff described how they adapted the individual care of each consumer, so they were culturally safe and respectful to them. Care planning documents captured information about consumers’ cultural and spiritual needs.

Consumers and representatives confirmed they were supported to exercise choice, independence and to maintain important relationships within and outside the service. Staff described strategies for supporting consumers to exercise choice and independence in care planning and on a day-to-day basis.

Consumers felt the service supported their choices to engage in activities involving risks. Care planning documents included risk assessments completed in consultation with consumers and their representatives. Staff could identify the risk management strategies in place for consumers participating in risky activities and this was consistent with the information in their care planning documents.

Consumers and representatives said they were provided with current and accurate information about their daily choices. Staff explained how they asked consumers what they would like to do and eat, and they involved them in meetings and encouraged them to ask questions. Staff described diverse ways they communicated information clearly to consumers, including those with sensory cognitive or language barriers.

Consumers said personal care was undertaken in a way that respected their privacy and dignity and staff protected their personal information. Staff advised they were supported by policies and had training in how to maintain consumers’ privacy and dignity. Staff were observed implementing strategies consistent with the organisation’s privacy and confidentiality policy.

# Standard 2

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

Findings

The Assessment Team recommended Requirements 2(3)(a) and 2(3)(d), were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 2(3)(a), the Site Audit report found care planning documents for some consumers did not identify risks to their health and well-being. The following deficiencies were brought forward:

* The assessments and care planning documents for a consumer that had been in the service for 28 days had not been completed in accordance with the service’s policies.
* Care planning documents for one consumer did not reflect a catheter management plan and guidelines in relation to their catheter care were not available for staff. A hospital discharge letter for the consumer’s catheter care was uploaded to their care plan prior to the conclusion of the site audit.
* A consumer with escalating behaviours, did not have a behaviour management plan in place, despite their behaviour being one of the risks identified. Staff demonstrated an understanding of how to manage their behaviour however, the information was not documented and available for staff at the time of the audit.

The provider’s response detailed corrective actions undertaken in support of compliance, including:

* The service conceded the assessments and care plan had not been completed for a consumer within 28 days of entering the service. The new electronic care management system failed to trigger the relevant assessments. All assessments have now been completed, there were no adverse impacts on the consumer and the fault has been reported to the software developer.
* The consumer with a catheter had care documentation from an external specialist instructing how to manage their catheter and their skin assessment clearly specified that a visual site assessment needs to take place for any signs of infection. This information is now in the consumer’s care plan and all registered nurses have been re-educated about the importance of skin care and temperature monitoring because of the risk of infection.
* The consumer with escalating behaviours had a behaviour management plan in place and a copy was provided in the response. The plan had also been communicated to staff.

While the assessment and planning process for one consumer was found to be behind schedule, I accept there was no impact to the consumer and assessment and planning has now been completed. I am satisfied assessment and planning considered risks to consumers’ health and well-being and informed the delivery of safe and effective care and services. Therefore, based on the evidence before me, I find Requirement 2(3)(a) compliant.

Regarding Requirement 2(3)(d), the Site Audit report brought forward the following deficiencies:

* Consumers and representatives had not been offered or given a copy of care planning documents.
* Staff were not aware of the requirement to ensure each consumer is supported to access care planning documents if they wished.
* Management acknowledged they had not given or offered consumers/representatives a copy of consumer care planning documents.
* One consumer’s representative said they were not aware that their loved one was losing weight or the outcome of a dietitian review.
* Outcomes of dietitian and speech pathologist assessment for 2 consumers was properly documented into care planning documents.

The provider’s response detailed corrective actions undertaken in support of compliance, including:

* The response outlined how the transition to the new electronic care management system, along with COVID-19, the process of communicating care planning documents to consumers was not followed as smoothly as it was expected to. All consumers/representatives have now been offered, or provided, a copy of care planning documents and staff have been reminded of the requirement to do this.
* The representative who was not informed of the outcome of a dietitian assessment for their loved one was provided a copy of care planning documents which included all updated assessments.
* Outcomes of the dietitian and speech pathologist assessment for 2 consumers were documented in care planning documents.

I am persuaded by the provider’s response which demonstrated 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. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(d) compliant.

I am satisfied the remaining 3 Requirements in Quality Standard 2 are compliant.

Consumers and representatives said the assessment and planning process identified and addressed the consumer’s current needs, goals, and preferences, including advance care and end of life planning, if they wished. This was consistent with what care planning documents demonstrated.

Consumers and representatives confirmed they were involved in the assessment and planning of their care, and they could involve other individuals and organisations, if they wished to. Care planning documents demonstrated allied health practitioners were regularly involved in assessment and planning of care. Management described how assessment and planning is based on a partnership with the consumers/representatives and other individuals or organisations were involved when required.

Care planning documents evidenced they were regularly reviewed for effectiveness every 4 months, and when circumstances changed, or incidents impacted on the needs, goals, and preferences of consumers. Staff described processes for the regular review of care and services and when circumstances changed. Consumers and representatives confirmed their care and services were reviewed regularly or when circumstances changed.

# Standard 3

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

Findings

The Assessment Team recommended Requirement 3(3)(b), was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 3(3)(b), the Site Audit report brought forward the following deficiencies:

* Two consumers experiencing weight loss were referred to the dietician, however their weight loss was continuing, and it was unclear to the Assessment Team whether all the recommended interventions were being implemented.
* Although one consumer self manages their catheter and another consumer’s catheter care is provided by external providers, care planning documents for both consumers did not include any information or directives on how to manage their catheter care.
* Three consumers having unwitnessed falls were not monitored and managed in accordance with the services policies, despite staff demonstrating sound understanding of post fall assessments and procedures. This included observations not being made and recorded at intervals set out in the service’s policies and review by a physiotherapist post fall.
* Management said staff need to be engaged in more education about post-fall assessments. However, the internal policy and procedure for unwitnessed falls had changed and all unwitnessed falls were now to be transferred to the hospital.

The provider’s response acknowledged deficits and detailed corrective actions undertaken, commenced, or planned, including:

* The consumers experiencing weight loss were under the care and supervision of the dietician and their medical officer. The service was monitoring their weight and care was being provided, where possible, in accordance with the directions of the dietician, medical officer and specialists.
* Care planning documents of the 2 consumers requiring catheter care have been updated to include information about their catheter care. Although the consumers either self-care or receive care from an external organisation, the response acknowledged that it is staff responsibility to monitor and report any skin changes. The response stated that staff have been informed of their duty and responsibility.
* In relation to falls management:
  + Increased number of staff have been trained to be able to carry out post falls observations.
  + An external physiotherapist did assess consumers following falls.
  + The service acknowledged there were some instances where the procedures for observations were not fully followed in relation to unwitnessed falls. Policies have been revised and a copy sent to staff. Revised policies have also been laminated and displayed in clinical areas of the service. All staff have been informed of the procedures to be followed post fall.

I am persuaded by the provider’s response outlining appropriate actions have been undertaken to demonstrate appropriate management of weight loss and consumer’s requiring catheter care. However, while I acknowledge the service has taken appropriate actions to address deficiencies in relation falls management, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate effective management of high impact or high prevalence risks, particularly in relation to falls management. Therefore, based on the evidence before me, I find Requirement 3(3)(b) non-compliant.

I am satisfied the remaining 6 Requirements in Quality Standard 3 are compliant.

Care planning documents showed how each consumer gets safe and effective personal and clinical care that is tailored to their needs and optimises their health and well-being. Care planning documents reflected best practice care including for management of skin integrity, pain and use of psychotropic medication and restrictive practices. Consumers and representatives said consumers received tailored personal and clinical care that optimised their health and wellbeing. Staff described individual consumer’s care needs and goals which reflected care planning documents.

Consumers and representatives expressed confidence in the service providing quality end of life care and supporting them to be as free as possible from pain and to have those important to them with them. Care planning documents for consumers nearing the end of life showed their needs, goals and preferences are recognised, and their comfort maximised. Staff described how they adjust the delivery of care for consumers nearing the end of life.

Consumers and representatives confirmed a deterioration or change in a consumer’s condition was promptly identified and responded to. Staff described how they recognise and respond to a deterioration or changes in consumers’ condition, including communicating the situation to other staff and representatives. Care planning documents showed staff monitor consumers’ condition and changes in consumers’ care needs are recognised and responded to in a timely manner.

Care planning documents contained adequate information to support effective and safe sharing of the consumer’s information in providing care. Staff explained how current information is documented and shared with representatives, staff and other health professionals involved.

Consumers and representatives said there were timely and appropriate referrals to other relevant medical specialists and allied health practitioners. Care planning documents evidenced prompt referrals to other medical services such as dietitians, physiotherapists, speech pathologists, dementia specialists, mental health specialists and medical officers.

Consumers and representatives were satisfied with the measures in place to minimise infection risks. The service had implemented policies and procedures related to antimicrobial stewardship, and infection prevention and control, including for the management of a COVID-19 outbreak. Staff confirmed they had received training in infection minimisation and understood the purpose of antimicrobial stewardship.

# Standard 4

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

Findings

The Assessment Team recommended Requirement 4(3)(f), was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 4(3)(f), the Site Audit report brought forward the following deficiencies:

* Consumers and representatives expressed dissatisfaction with the quality and variety of meals provided by the service. Feedback included:
  + Multiple consumers said the range of snacks available was insufficient. Some consumers said they purchased their own snacks.
  + One representative said the service served the same pureed food all the time and the food appeared unappetising and unrecognisable.
  + One consumer said the chicken schnitzel was like cardboard and boiled and scrambled eggs looked and taste the same.
  + Multiple consumers said if they don’t want the single choice of hot meal on offer the only alternative was a sandwich.
  + Multiple consumers said they are always served the same food.
* Two consumers were observed not touching their salad at lunchtime. Both explained it did not meet their preferences.
* Staff said consumers can only be provided with salad for lunch and sandwiches for dinner if they do not like the hot meal offered to them. Staff said they were not permitted to go to the kitchen to get more food for consumers and the only food they could offer consumers at night was cereal and yoghurt.
* The current weekly menu was observed to have similar choices of hot meals and cold meals to the previous week.
* A recent menu survey and consumer meeting minutes showed consumers consistently raised concerns about the limited meal options and alternatives.
* Management said they were aware of concerns about the food and had already identified improvement actions on the continuous improvement register such as providing 2 choices of hot meals for dinner, adding vegetarian stir fry to the lunch and dinner menu, and snacks such as fruits, cheese, and biscuits are available at all times.

The provider’s response detailed corrective actions undertaken, commenced, or planned, including:

* Consulting with each consumer identified in the Site Audit report to understand and address their concerns and complaints. All feedback about meals was taken on board to the extent possible and gave an example of the chef regularly preparing a goat curry especially for a single consumer.
* The response clarified that snacks was an established arrangement at the service and these items are regularly ordered by the catering area. The service has reminded staff of the availability of these snacks at any time. All staff had access to the servery and can access snacks for consumers at any time.
* The provider explained at any time consumers can raise any concerns about meals directly with the chef or other staff/management. All catering staff are expected to attend the fortnightly consumer meetings where food is regularly discussed.
* A new menu has been developed and further improvements are planned to the dinning experience.

While I acknowledge the service has taken appropriate actions to address feedback and concerns raised by consumers and representatives in relation to the quality and variety of meals, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate meals are varied and of suitable quality and quantity. Therefore, based on the evidence before me, I find Requirement 4(3)(f) non-compliant.

I am satisfied the remaining 6 Requirements in Quality Standard 4 are compliant.

Consumers described how the service met their needs, goals and preferences and helped maintain their independence and well-being. Staff explained how services and supports were safe and effective for each consumer and met their needs and preferences. The activity programs and minutes from residents' meetings showed consumers had input into the leisure and lifestyle program to ensure it met their needs.

Consumers described how the service promoted their emotional, spiritual, and psychological well-being. Care planning documents recorded consumers’ individual emotional support strategies and how these were implemented. Staff provided examples of supporting consumer’s emotional, spiritual, and psychological well-being.

Consumers said they can partake in activities within and outside the service and described how the service supported them to maintain social and personal connections. Management described how the service supported consumers to participate in the outside community and maintain social and emotional connections. The service collaborated with an external organisation to provide an extra person to accompany consumers to their shopping activities, medical appointments, and provide one-on-one emotional support.

Consumers and representatives said the service communicated information effectively to support continuity of care inside the service and to the outside providers involved in their care. Staff said current information about consumers’ care needs was shared regularly at shift handovers and through progress notes in the service’s electronic clinical database.

Consumers confirmed the service promptly organised appointments when they require services from external providers. Care planning documents demonstrated collaboration with external providers in a timely manner to support the diverse needs of consumers.

Consumers and representatives said the equipment provided by the service was safe, clean, and suitable to support their independence. Staff described how they clean equipment routinely and set aside and report equipment requiring repair or servicing. Equipment such as mobility aids and lifestyle activity products were observed to be safe, clean, and suitable for use.

# Standard 5

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

Findings

Consumers and representatives said the service was welcoming and they could furnish their room and surroundings with their personal items, to feel at home. Staff said they enjoyed assisting consumers in personalising and maintaining the service to promote their sense of belonging. The service was observed to be warm, adequately lit and had clear signage throughout that leads to rooms, common areas and other areas of the service.

Consumers and representatives said the service was safe, clean, well maintained, and comfortable and could move freely in and outside the service. Staff explained how they assisted consumers to access all areas of the service and cleaning staff demonstrated a sound understanding of the cleaning process and consumers’ personal needs and preferences.

Consumers said the furniture and equipment was suitable, clean, well-maintained, and safe. Consumers said maintenance requests were attended to quickly and fixtures and fittings were functional and safe. The maintenance register evidenced consumer equipment, such as walkers, are cleaned monthly.

# Standard 6

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

Findings

Consumer and representatives felt encouraged, safe, and supported to provide feedback and make complaints. Staff described the various avenues available for consumers and representatives to provide feedback or make a complaint, and the process they followed. The service had documented policies, processes and systems in place to provide feedback or make a complaint.

Consumer and representatives said they were aware of other avenues for raising a complaint. Staff had a shared understanding of the advocacy and translation services available for consumers/representatives and described how they assisted consumers with a cognitive impairment or difficulty communicating. Brochures and posters were displayed throughout the service, providing information regarding internal feedback and complaints processes and contact information for external assistance.

Consumer and representatives said concerns were promptly addressed and resolved and an apology was provided when they made a complaint or when things went wrong. Staff confirmed all complaints are escalated to senior personnel and management for investigation and follow-up. Management confirmed an open disclosure process is applied following an adverse event.

Consumer and representatives described changes implemented at the service as a result of feedback and complaints. Management described the process of recording and reviewing the service’s complaints and incident registers and using them to inform improvement actions. The Plan of Continuous Improvement (PCI) register demonstrated feedback, complaints and incidents were recorded, actioned, resolved and used to inform continuous improvement.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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 Assessment Team recommended Requirement 7(3)(a) and 7(3)(e), was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 7(3)(a), the Site Audit report found the service planned their workforce and developed and published a forward monthly roster however, the service was not able to demonstrate the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services. The following deficiencies were identified:

* Consumers, a representative and staff stated the service did not have sufficient staff to provide care and services to consumers.
* One consumer described feeling scared when there were no staff around to protect them from another consumer that tended to approach them and grab their food/drink or urinate on the floor (a Serious Incident Response Scheme report was lodged in relation to such an incident). The consumer stated there were not enough staff to help the ‘residents’, especially in the afternoon.
* One consumer said they felt sorry for staff always rushing and said they had to keep food in their room, as there was often no staff around to ask for a snack, if they needed one.
* All staff spoken to reported they felt exhausted and overwhelmed with the tasks and responsibilities they needed to fulfill.
* A nurse and a care staff with a sound understanding of behaviour management said they cannot effectively implement the documented behaviour management strategies as they had too many residents to attend to.
* The call bell report for August 2022 identified 52 occasions where the response time exceeded the organisation’s policy timeframe of 10 minutes.
* Management acknowledged the issue regarding their staffing levels and said the Board had already agreed to a proposal for additional staff to work in the afternoon. Management explained they were finding it difficult to recruit new staff and they have initiated an employee referral program which involves providing a monetary reward to staff who refers qualified candidates to the service.

The provider’s response provided detailed corrective actions undertaken, commenced, or planned, including:

* The provider detailed a number of planned initiatives they had pursued to secure additional funding to increase staffing.
* With increased funding now anticipated, the service has been working closely with its recruitment team to advertise the new expected roles.
* The provider advised the whole aged care sector had workforce challenges however, they had taken a number of measures to enhance recruitment such as; taking up more sophisticated advertising, putting agency contracts in place, offering recruitment and retention bonuses, offering referral bonuses to existing staff.
* Staff survey results from April-May 2022 showed staff satisfaction was 81% and staff wellbeing was at 73%.

I acknowledge the service has taken appropriate actions to address feedback and concerns raised by consumers, representatives, and staff in relation to staff sufficiency, including significant efforts to plan and fund a workforce that is adequate to deliver the care and services needed. However, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did demonstrate that workforce was planned however, I consider the evidence demonstrated that the number/mix of staff was insufficient to deliver safe and quality care and services. Therefore, based on the evidence before me, I find Requirement 7(3)(a) is non-compliant.

Regarding Requirement 7(3)(e), the Site Audit report found that the performance of each member of the workforce was not regularly assessed, monitored or reviewed. The Director of Nursing said it was their responsibility to conduct annual performance reviews but has not done so since they commenced employment at the service in early 2021. However, the Director of Nursing stated informal conversations with some staff regarding their performance have occurred. Management acknowledged the deficiency and stated they planned to commence performance reviews of all staff in October 2022.

The provider’s response acknowledged the deficit and detailed corrective actions undertaken, commenced, or planned, including:

* As advised in a staff meeting prior to the site audit, performance reviews would resume in October 2022, after the COVID-19 pandemic had died down, the service was more stable, and staff were more able to resume business-as-usual.
* The service worked with the organisation’s human resources team to review the performance reviews completed and found some gaps with some staff not completing a performance review of a 5-year period.
* The service has begun working on completing performance review of all staff and as at the date of the response 36 out of 50 staff (72%) have completed their review, with the remaining staff already booked in.

I acknowledge the service was found to be behind schedule in completing their annual staff performance reviews at the time of the site audit. However, there was no evidence of consumer detriment resulting from the delay in completing annual staff performance reviews and the Site Audit report demonstrated some level of monitoring staff performance still occurred. I further note the service had already identified the issue and had put steps in place to address the backlog of annual staff performance reviews.

I am persuaded by the provider’s response which demonstrated the service has completed performance reviews for most staff, with the remaining staff booked in to have their reviews completed. Therefore, based on the evidence before me, I find Requirement 7(3)(e) compliant.

I am satisfied the remaining 3 Requirements in Quality Standard 7 are compliant.

Consumers said they were treated with care and respect. Staff were observed interacting with consumers in a kind, caring, and respectful manner throughout the audit. Staff demonstrated how they provided care that was respectful to identity, culture, and diversity.

Consumers felt staff were competent in performing their roles and meeting their care needs. Management explained the recruitment process which ensures staff are competent and have the qualifications and knowledge to perform their roles effectively. The service maintained an up-to-date register of staff qualifications and registrations and reviewed this register regularly. Staff said they have the necessary skills to perform their role and were supported by senior staff.

Consumers considered staff were trained and equipped to deliver their care and services. Management described the organisation’s training program and the processes for identifying staff training needs. Staff confirmed they received comprehensive training during their orientation and induction, and regularly throughout the year.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Management provided examples of how they engaged consumers/representatives in the development, delivery and evaluation of care and services and how this input informed the service’s continuous improvement register. Consumers and representatives confirmed the service had sought their input in various ways such as through residents’ meetings, feedback forms, regular surveys, and face-to-face discussions.

The Board, Committee meetings and embedded policies and governance arrangements enable the Board to have oversight of the operation of the service and satisfy itself that the Quality Standards are being met. The Board communicates regularly with the service and monitors the performance of the service and the implementation of any changes required.

The service had effective organisation wide governance systems related to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Management described the processes in place for each governance system and provided examples of how their day-to-day practice aligned with the governance systems. Staff confirmed their understanding of the governance arrangements and how they applied them in their work.

The service had effective risk management systems in place for high impact or high prevalence risks to consumers, identifying and responding to elder abuse and neglect, supporting consumers to live the best life they can, and managing and preventing incidents. Management and staff demonstrated an applied understanding of the risks to consumers and how the service mitigates risks in line with best practice.

The organisation had a documented clinical governance framework which included policies related to antimicrobial stewardship, minimising restraint, and open disclosure. Staff advised these policies had been part of their mandatory training and there were recurring toolbox talks to remind them of these requirements. Staff gave examples of how these policies impacted clinical care and how they implemented them in a practical way on a day-to-day basis.

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