Performance

Report

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| Name of service: | Berrigan Aged Care Hostel |
| Service address: | 51-53 Davis Street BERRIGAN NSW 2712 |
| Commission ID: | 0377 |
| Approved provider: | Berrigan and District Aged Care Association Ltd |
| Activity type: | Site Audit |
| Activity date: | 21 March 2023 to 23 March 2023 |
| Performance report date: | 9 June 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Berrigan Aged Care Hostel (**the service**) has been prepared by K.Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 22 May 2023

# Assessment summary

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

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

# Areas for improvement

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 1(3)(d) - The Approved Provider ensures each consumer is supported to take risks to enable them to live the best life they can.
* Requirement 2(3)(a) - The Approved Provider ensures assessment and planning, considers risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services.
* Requirement 2(3)(b) - The Approved Provider ensures assessment and planning identifies and addresses the consumer’s current needs, goals and preferences.
* Requirement 2(3)(c) - The Approved Provider ensures the organisation demonstrates that assessment and planning 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.
* Requirement 2(3)(d) - The Approved Provider ensures 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) - The Approved Provider ensures care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Requirement 3(3)(a) - The Approved Provider ensures each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; tailored to their needs; and optimises their health and well-being.
* Requirement 3(3)(b) - The Approved Provider ensures effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 3(3)(e) - The Approved Provider ensures information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.
* Requirement 3(3)(f) - The Approved Provider ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 5(3)(b) - The Approved Provider ensures the service environment is safe and enables consumers free movement indoors and outdoors.
* Requirement 6(3)(d) - The Approved Provider ensures appropriate system are in place to record, review and use feedback and complaints to improve care and services.
* Requirement 7(3)(a) -The Approved Provider ensures the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Requirement 7(3)(c) -The Approved Provider ensures the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Requirement 7(3)(d) -The Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 7(3)(e) - The Approved Provider ensures the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Requirement 8(3)(a) - The Approved Provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Requirement 8(3)(b) - The Approved Provider ensures 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) - The Approved Provider ensures there are effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance and feedback and complaints.
* Requirement 8(3)(d) - The Approved Provider ensures effective risk management systems and practices, including managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.
* Requirement 8(3)(e) The Approved Provider ensures a clinical governance framework, including but not limited to the following: antimicrobial stewardship; minimising the use of restraint and open disclosure.

# 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. | Non-compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 1(3)(d) is non-compliant:

The Assessment Team spoke with consumers who said that the potential harms were not explained when they made decisions about taking risks. Consumers said they are allowed to take risks as their choice, however their decision relating to taking risks were not assessed. Risk assessment forms or dignity of risk forms were not attended to for consumers who were taking risks. Management and clinical staff were not consistently aware of the risks that consumers were taking, nor had they been assessed or supported to take risks. Management acknowledged deficiencies in relation to the organisation’s risk management systems and practices and said the service has recently hired a quality and education manager who is reviewing and updating policies and procedures. Documentation review showed that risk assessments were not completed for consumers who were taking risks. The Assessment Team identified one named consumer with severe back pain who regularly left the service independently on a mobility scooter. There was no record of discussion or consultation regarding the potential risks to this consumer and management advised that there were no risk assessments in place for any consumers.

A further named consumers with choking risks was found by the Assessment Team to have been prescribed a minced moist diet, however, was observed being served a soft diet instead. Dietary records in the kitchen had incorrectly recorded dietary information for this consumer and management advised that the consumer eats other non-moist foods with the assistance of their representative, for which there was a dignity of risk form in place. The Assessment Team were unable to locate a risk form for this consumer.

Two consumers were found by the Assessment Team to regularly attend Men’s shed sessions outside of the service on a weekly basis, both consumers were identified as having a risk of absconding However, there were no risk assessments completed for either consumer in relation to the risks associated with them leaving the service to attend these sessions.

The Approved Provider’s response of 21 May 2023 addressed these issues and acknowledged that dignity of risk forms have been underutilized. The service has reissued the Dignity of Risk policy and is reviewing the risk management systems and practices within the service. The service has further undertaken to review the current risk assessments for those consumers identified as wanting to undertake activities involving risk by June 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider’s response. While some of the actions planned by the Approved Provider may be sufficient to resolve the deficiencies, they are yet to be realised and implemented and I have placed weight on the potential ongoing risk to consumers until these changes are implemented, I therefore find Requirement 1(3)(d) non-compliant.

I am satisfied the remaining five requirements of Standard 1 are compliant.

Consumers and representatives stated they were treated with respect and dignity and their culture and identity was valued. Staff could describe how they treat consumers with respect by using their preferred name, acknowledging their choices, and knocking before they enter their room.

Staff could describe how they treat consumers with respect by using their preferred name, acknowledging their choices, and knocking before they enter their room. The activities program included events and celebrations that acknowledged cultural diversity and enabled participation by consumers with diverse abilities. The activities program included events and celebrations that acknowledged cultural diversity and enabled participation by consumers with diverse abilities.

Consumers stated they were supported to exercise choice about the way in which care and services were delivered, said that they have as much control over the planning and delivery of care and services as they want. Staff confirmed consumers could exercise choice described strategies for supporting consumers to exercise choice and independence on a day-to-day basis. Documentation demonstrated consumer consumer’s preferences and choices.

Consumers said they received timely and accurate information in a way they can understand. which enabled them to make choices about their care and services. Staff confirmed they discussed pertinent information with consumers and representatives. Various communications, including documents and posters in relation to the service and other consumer services were observed at the reception and the entryway of the service. These included the weekly activity calendar, internal and external complaints mechanisms and information about advocacy services.

Consumers said their privacy and dignity is respected. Staff described practical ways they respected consumers’ privacy, including knocking on doors and requesting permission to enter before entering rooms and closing doors and curtains when providing cares.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that all 5 requirements in this Quality Standard are non-complaint.

The Assessment Team found the service’s assessment and planning processes did not consistently consider risks to each consumer’s health and wellbeing. During interview, some consumers did not know whether service staff had identified risks connected with their care and said staff had not discussed any risks with them. These included risks connected to environmental and chemical restraint, and mobility equipment, among others. The service’s management also stated that the service had not completed risk assessments, including the associated documentation, or held dignity of risk discussions for consumers at the service. Specific findings included:

* For a consumer who self-administered oxygen, the service had not completed a self-medication assessment, an oxygen management plan, or equipment maintenance directives.
* There was a discrepancy between the dietary care plan and written kitchen staff directions for a consumer on a prescribed soft-food diet.
* The service was found to have one consumer under chemical restraint and the service did not have a behaviour support plan in place for that consumer, or other supporting documentation.
* Two residents who attended a regular activity in a location outside of the service were known to have a risk of absconding and there was no risk assessment for this in their care files.
* The service had numerous policy documents covering aspects of its care but many of these had not been updated for between one and four years.
* During interview, the service’s Quality and Education Coordinator could not describe what restrictive practices were, or the risk management processes in place at the service.
* One care staff member did not have access to the service’s electronic care management system and so could not document important information about changes to consumers’ conditions or the care the staff member delivered.
* During interview, almost all staff did not demonstrate sufficient knowledge about restrictive practices or the assessment, planning and risk mitigation aspects of the use of restrictive practices.

The Assessment Team found that the care plans for consumers at the service did not reflect their current needs, goals, and preferences. Service staff had not discussed or followed up regularly on the initial assessments completed for consumers when they entered the service. Specific findings included:

* For a consumer who self-administered oxygen, the consumers’ care files did not contain a self-medication assessment, an oxygen management plan, or any directions to staff about maintaining the consumers’ oxygen equipment.
* One consumer’s care documents had not been updated to show a recent diagnosis.
* A consumer’s care plan did not contain a speech pathologist’s recommendations from December 2022.
* One consumer who entered the service in February 2022 had not had their care plan been updated since September 2022.
* The service had recorded advance care directives for some consumers on admission but had not discussed or followed up those directives regularly.
* The service’s electronic care management system contained out-of-date consumer information.

The Assessment Team found the service was unable to demonstrate it engaged consumers as part of its assessment and care planning process. Consumers said they were satisfied with their care but that they were not involved in the process of care planning. Care planning documents contained limited evidence of consumer or representative involvement in the care planning process. Specific findings included:

* During interview, a representative said they were not aware the consumer they represented was being administered medication for ‘behaviour management’. The representative also did not have a copy of the relevant care plan and was unable to give details about the consumer’s care.
* A representative said they were not informed about the existence of a care plan for their consumer.
* Management said the service did not have a scheduled case conference review process but that it did initiate case conferences in response to incidents, as appropriate. The service had a ‘Resident of the Day’ review process, but no records of this process were on file for any sampled consumer.
* Feedback and reports from the service’s speech pathologist, podiatrist and dietician were not evident in consumers’ care plans on the service’s electronic care management system.
* The service recorded consumers’ advance health directives when it developed their care plans. Management said a consumer’s family might change the advance health directives when a consumer deteriorated, but there was no evidence of changes recorded in consumers’ documentation.

The Assessment Team found the service did not always share the outcomes of its assessment and planning processes with consumers and their representatives. Consumers and their representatives reported they were not aware that the service kept records of the care it delivered to consumers, and they stated they had not been given a copy of relevant care plans. Management and staff were not aware of the requirement to ensure consumers had access to an up-to-date copy of their care plan. Specific findings included:

* During interview, three consumers said they had not been offered a copy of their care plan and were unaware of what a care plan is or how to access it.
* None of the consumers or representatives interviewed knew how to access the service’s information about their care needs, or who they should ask if they needed this information.
* The service had not documented the outcomes of a speech pathologist’s assessment for one consumer in their care plan.
* The Assessment Team did not find evidence of any communication with consumers or their representatives about how consumers might access their care plans. When the Assessment Team raised this with the service, the service advised that it is procedure for staff to discuss care plans with consumers and their representatives following ‘resident of the day’ reviews but that staff had not done this because the service was short-staffed.
* The service kept inadequate records concerning one consumer’s engagement with a psychiatrist, and medications the psychiatrist prescribed.

The Assessment Team found the service did not review its care regularly for effectiveness, or in response to changes in circumstances or incidents. The service’s incident data was not accurate and when staff completed incident forms, they did not conduct sufficient analysis to determine strategies to mitigate the relevant risk and ensure consumers’ safety. Additionally, the service had not reviewed its incident management policies since 2018. Specific findings included:

* For one consumer, the service did not complete a falls risk assessment following a serious fall.
* Management advised the assessment team that most consumer care plans are out of date and that the service did not have sufficient staff to update care plans as part of its resident of the day process.
* Information within the service’s clinical indicator report was not consistent across different versions, and it showed that staff lacked an understanding of restrictive practices.

On 22 May 2023 the Approved Provider submitted a written response that clarified some of the information included in the Assessment Team’s report and accepted the findings made during the Site Audit, the service’s plan to address these findings includes:

* Recruiting a Registered Nurse to bolster the service’s capacity to conduct care assessments, care planning and risk assessments. The service also updated its ‘Resident of the Day’ process to incorporate a greater focus on risk assessments, and to integrate capturing valid consent concerning changes to consumers’ care.
* Completing relevant assessments and documentation for the consumer who self-administered oxygen. The service advised that from March 2023, it had completed the assessments and documentation, and developed a schedule for maintaining the consumer’s oxygen equipment.
* Coordinating a speech pathologist to review consumers’ diet plans and the service’s food consistency guidelines.
* Coordinating a Medical Officer to review the care arrangement for the consumer identified to be under chemical restraint. Additionally, conducting initial analysis of what further actions are required to ensure the service is compliant concerning its use of restrictive practices. As at May 2023, the consumer’s medication had ceased and the service had updated the consumer’s care plan and scheduled discussions with the consumer’s representatives.
* Conducting risk assessments for the consumers who were at risk absconding during off-site activities. As at May 2023, the service had conducted these assessments and ceased activities that involved a high-risk of absconding for the relevant consumers.
* Reviewing the service’s current electronic care management system to determine whether it is fit for purpose and delivering education to staff about how to use the service’s electronic care management system. The service had scheduled this education to occur in June 2023.
* Undertaking care assessments for all consumers within the service, to ensure their needs are identified and recorded onto their care plans. This included a commitment to undertake a formal ‘resident of the day’ care plan review process, to ensure consumers’ care plans are reviewed regularly.
* Instating a process to update consumers’ progress notes in response to reviews by external care providers, such as allied health professionals.
* Reviewing consumers’ advance care plans in collaboration with their representative.
* Committing to reviewing the service’s palliative care policy and procedure, in collaboration with the Murrumbidgee Local Health Network Palliative Care Team.
* Undertaking care assessments for all consumers within the service, to ensure their needs are identified and recorded onto their care plans. This included a commitment to formalise the service’s ‘resident of the day’ care plan review process, to ensure consumers’ care plans are reviewed regularly.
* Expanding the Resident of the Day Process so that the service discusses care plan updates with the consumer and their representative and provide them with a copy of the resulting care plan. This process is also intended to ensure staff record updates in the service’s electronic care management system.
* Investigating whether the service can conduct case conferencing with a multi-disciplinary team in response to consumer deterioration. The multi-disciplinary team is canvassed to comprise a Medical Officer, Pharmacist, Registered Nurse, Physiotherapist, other allied health staff and the Life Style manager, along with the consumer and their representative.
* Undertaking care assessments for all consumers within the service, to ensure their needs are identified and recorded onto their care plans. This included a commitment to undertake a formal ‘resident of the day’ care plan review process, to ensure consumers’ care plans are reviewed regularly.
* Developing guidelines for transporting consumers to external medical appointments.
* Introducing a new process to govern consumers’ appointments with external providers. The new process will request that consumers sign a consent form and will require that the external provider complete a guided progress note pro-forma to enable the service to capture information about the care provided.
* Reviewing its Incident Reporting Policy and Procedure. This included updating the policy to bring focus to analysing the root cause of incidents and canvassing what further work needed to occur in relation to the findings for Requirement 2(3)(e).

Having considered the evidence brought forward in the Assessment Team’s report and the Approved Provider’s response, I have accepted the explanation and additional evidence submitted by the Approved Provider in relation to some of the issues identified by the Assessment Team. However, I am of the view that there were deficiencies in the overarching systems within the service relating to the service’s care plan review processes. While the Approved Provider has begun processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change. I am satisfied Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) are non-compliant.

# Standard 3

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirements 3(3)(a), 3(3)(b), 3(3)(e) and 3(3)(f) are non-compliant:

The Assessment Team found that the service did not provide best-practice care that was tailored to consumers’ needs and optimised their health and well-being. This included care relating to skin integrity, pain management, and restrictive practices. The service also did not have behaviour support plans or consent forms in place concerning its use of restrictive practices, and it did not regularly review specific instances of its use of restrictive practices. Specific findings included:

* During interview, staff reported that the service did not have any consumers under chemical restraint, but the Assessment Team identified one consumer who received medication for behaviour management. The consumer’s representative was not aware the consumer was on medication and had not consented to the service using medication to manage the consumer’s behaviour. The service had not used a valid assessment to determine the appropriateness of placing the consumer under chemical restraint and during the site audit, the Assessment Team observed staff resorting to chemical restraint as a default method to calm the above consumer when they presented with behaviours of concern.
* The service had a secure memory support unit where 7 consumers resided. The service did not have signed forms showing it had consent to place these consumers under environmental restraint, nor did it review its use of environmental restraint for them.
* The service could not demonstrate that it consistently followed the legislative requirements for using restrictive practices.
* The service had no documented strategies or risk assessments for consumers who use low beds and motorised scooters.
* The service management acknowledged staff need further education on restrictive practices, but it could not provide an education calendar showing that this training had been planned.
* The service did not have a wound chart in place for one consumer who had a wound on their finger.
* One consumer said there was no physiotherapist available to provide pain relief using massage techniques.
* The service’s care files for one consumer living with insulin-dependent Type 2 Diabetes Mellitus did not contain any documentation or directives for minimum and maximum blood glucose levels, or under what circumstances their condition should be escalated to their general practitioner. The consumer’s handover chart stated that blood pressure should be monitored each day but the records pertaining to this did not show that daily monitoring had occurred.
* Care documentation for a consumer who regularly self-administered oxygen did not have an oxygen management plan, nor did it include a self-medication assessment. The oxygen equipment had also not been cleaned recently prior to the Site Audit.

On 22 May 2023 the Approved Provider submitted a written response that clarified some of the information included in the Assessment Team’s reports and accepted the findings made during the Site Audit, the service’s plan to address these findings includes:

* Addressing its practices concerning behaviour support plans. This included consulting with Dementia Australia about how the service should administer its Behaviour Support Plans and organising to train staff on how to develop behaviour support plans. It also included scoping work to identify whether the service could incorporate Behaviour Support plans into its electronic care management system. As at May 2023, the service had engaged Dementia Australia and was awaiting communication to schedule training.
* Addressing the deficits in its use of restrictive practices. This included reviewing its Restrictive Practice Policy and Procedure, ensuring it had consent forms on file for all types of restrictive practices and ensuring any use of restrictive practices was documented and validated in consumers’ care files.
* Bolstering its processes concerning vital sign monitoring. This included reviewing its Clinical Review Policy and Procedure, ensuring the relevant GP records all vital sign parameters in the relevant consumer’s care plan and making a daily duty list available to staff. As at May 2023, the service had updated its processes to provide staff with a daily task list.

Having considered the evidence brought forward in the Assessment Team’s report and the Approved Provider’s response, I have accepted the explanation and additional evidence submitted by the Approved Provider in relation to some of the issues identified by the Assessment Team. However, I am of the view that there were deficiencies in the overarching systems within the service relating to its personal and clinical care. While the Approved Provider has begun to implement processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change and have placed weight on the ongoing risk to consumers while this occurs. I am of the view the service is non-compliant against Requirement 3(3)(a).

The Assessment Team found that the service did not effectively manage high-impact or high prevalence risks for each consumer, including risks such as falls, weight loss, behaviour management and medication management. The Assessment Team also found that the service lacked clinical governance concerning high-impact and high-prevalence risks. Specific findings included:

* One consumer experienced gradual weight loss from December 2022 and had been referred to the service’s dietitian and speech pathologist. The consumer’s care files did not show that the service had kept records related to monitoring the consumer’s weight or any interventions related to weight loss management.
* Another consumer had significant unplanned weight loss over approximately 6 Days, between December 2022 and January 2023. The service did not refer the consumer to a dietician and it had not kept records showing it monitored the consumers’ weight.
* The service did not document what actions staff took in relation to a minor medication incident involving one consumer.
* Care files showed the service had had 12 medication incidents between December 2022 and 23 March 2023. The Assessment Team could not find evidence to show the service had trained and educated staff to attempt to prevent further medication incidents.
* The service did not respond appropriately to one consumer’s behaviours of concern, which presented during the site audit. Care staff did not use the non-pharmacological strategies identified in the consumer’s care documentation to attempt to calm the consumer and instead used medication.
* The Service’s Falls policy had not been updated since 20 November 2020.
* The service had not conducted risk assessments and neurological observations for two consumers who had experienced falls, despite that its post-fall assessment procedure document directed staff to do so.

The service’s plan to address these findings included:

* Reviewing and updating its Nutrition and Hydration Policy and Procedure. Updates include adding a flow chart to improve readability, requiring that staff transfer dietitian notes to consumers’ assessment and care plans, and identifying circumstances in which staff should involve a Medical Officer in a consumers’ care.
* Reviewing and updating the Medication management policy and ensuring staff complete medication competencies for relevant medication findings.
* Review and update the Falls Management policy to require staff to complete assessments after all falls, and to require a physiotherapist to review the consumer after all falls. As at May 2023, the service had organised for a physiotherapist to commence on-site visits on Thursdays.

Having considered the evidence brought forward in the Assessment Team’s report and the Approved Provider’s response, I have accepted the explanation and additional evidence submitted by the Approved Provider in relation to some of the issues identified by the Assessment Team. However, I am of the view that there are deficiencies in the systems and application within the service relating to its management of high-impact, high-prevalence risks. While the Approved Provider has begun to implement processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change. I am of the view the service is non-compliant against Requirement 3(3)(b).

Concerning Requirement 3(3)(e), the service did not demonstrate that its staff documented and communicated information relating to a consumer’s condition, needs and preferences effectively. This included communication within the organisation, and with external providers. Care planning documents did not contain sufficient information to support effective and safe communication about consumers’ care. Some staff said they did not have logins for the service’s electronic care management system, that the service was generally short-staffed and that they did not have time to make records of the care they delivered. Consumers and representatives said service staff did not record information about consumers’ conditions and preferences adequately. Specific findings included:

* One representative said that service staff call if the consumer has a fall, but they do not call if the consumer’s condition or medication changes.
* Consumers care plans are not reviewed and updated regularly.
* The service did not share information among staff and with consumers’ families when appropriate, for example:
  + One consumer’s representative said the service administered anti-virals to the consumer without seeking consent or consulting the consumer’s representative or family. The family believed the consumer would not have wanted to be treated with antivirals.
  + One consumers’ representative said the service did not advise how often the service gave the relevant consumer medication to manage behaviours and that they would like to be kept informed about this.
* A staff member employed at the service for several months stated they were unable to access the service’s electronic care management system because they did not have login credentials.
* Some staff said other staff have not received proper training in the electronic care management system.

The service’s plan to address these findings included:

* Following the site audit, the service provided access to its electronic care management system for staff that did not have access.
* Introducing a Policy and Procedure to govern consumer vaccinations. The policy will include medications arising from public health directives, such as antiviral medication relating to COVID-19.

Having considered the evidence brought forward in the Assessment Team’s report and the Approved Provider’s response, I am of the view that there are ongoing deficiencies in the systems within the service relating to its communication about consumer’s care information. While I note the Approved Provider has acted in response to some of the information raised in the Assessment Team report, I was not provided sufficient evidence in the approved provider’s response to satisfy me that the service has addressed all of the deficiencies identified in the site audit; these include having the systems and processes to identify and address communication between the service, staff and consumers and representatives. I am of the view the service is non-compliant against Requirement 3(3)(e).

Concerning Requirement 3(3)(f), the Assessment Team found there was insufficient evidence to show the service made timely and appropriate referrals to individuals, other organisations and providers of other care and services. Care planning documents did not show the service had made referrals where needed, or that other providers, such as allied health practitioners, dementia specialists or medical officers, had input into consumers’ care. Specific findings included:

* For one consumer, the service had not made any referrals in relation to behaviour management despite that the consumer presented with behaviours of concern.
* The service had not had a physiotherapist on-site for 6 weeks due to staffing issues. As at the Site Audit, it was negotiating its contract to address this item.
* The service had not referred a consumer with significant weight loss to a dietician.
* For another consumer who experienced weight loss, the service had referred the consumer to a dietitian and speech pathologist, but it did not follow up on the effectiveness of the specialist’s recommendations.
* Other consumers with regular changing behaviours were not referred to any other allied health practitioners for further behaviour management strategies or planning.

The service’s plan to address these findings included:

* Providing education to staff about the service’s electronic care management system and reviewing the system to identify if it was meeting the service’s needs. The service had scheduled this education to occur in June 2023.
* Conducting a full assessment process to ensure the service had identified consumers’ needs on their current care plans.
* Transferring care directives from other providers to consumers’ care plans at the time of the other provider’s review.
* Instating a process to review consumers’ Advance Care Plans as their care needs change.
* Introduce a more formalized process for the ‘Resident of the Day process’.
* Consulting with Dementia Australia about how the service should administer its Behaviour Support Plans and organising to train staff on how to develop behaviour support plans. It also included scoping work to identify whether the service could incorporate Behaviour Support plans into its electronic care management system.
* Update its referral process documents to incorporate a flow chart to guide staff in making referrals to allied health professionals.
* The service reinstated physiotherapy support from May 2023.

Having considered the evidence brought forward in the Assessment Team’s report and the Approved Provider’s response, I have accepted the explanation and additional evidence submitted by the Approved Provider in relation to some of the issues identified by the Assessment Team. While the Approved Provider has begun to implement processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change. I am of the view the service is non- compliant against Requirement 3(3)(f).

I am satisfied the service is compliant with the remaining requirements of Quality Standard 3.

Consumers and their representatives said staff had spoken to them about advance-care planning and their end-of-life preferences. The service’s care records showed it had advance-care directives in place for consumers. The service encouraged families to be present throughout the end-of-life phase and during palliative care, staff attended to mouth care, skin care, repositioning and personal hygiene, and they prioritised consumers’ comfort and dignity.

Consumers said they were satisfied with the service’s delivery of care, and that staff recognised deterioration or changes in their condition. Staff could cite recent examples of when they had recognised and responded to deterioration in a consumer’s condition and they said the service’s clinical staff respond quickly when a change or deterioration is escalated to them. Care planning documents, progress notes and clinical charting showed that staff responded to deterioration and changes in consumers’, health, capacity and function.

The service had policies to guide infection control practices and staff received training on infection control practices, including in outbreak management, donning and doffing personal protective equipment and hand hygiene, among other training. Consumers and their representatives said they were satisfied with the service’s infection control practices, including for COVID-19. The service had appointed an infection prevention and control lead who was responsible for overseeing infection control.

# Standard 4

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

Findings

Consumers and representatives sampled said they feel supported to pursue activities of interest to them that optimise their independence. Lifestyle staff explained how they partner with the consumer or their representative to conduct a lifestyle assessment which collects the consumer’s individual preferences, including leisure likes, dislikes and interests, social, emotional, cultural and spiritual needs.

Consumers considered their emotional, spiritual, and psychological needs were supported, and said they can stay in touch with family or friends for comfort and emotional support. Lifestyle staff described facilitating connections with people important to consumers through face time and phone calls during lockdown, the chaplain and lifestyle staff support, church, and religious services. Care plans included information on consumer’s religious and social preferences.

Consumers and representatives felt that they are supported to participate within and outside the service, stay connected with people who are important to them and do the things of interest to them. Staff described how they support consumers to participate in the community or engage in activities of interest to them such as bus trips, bingo and music. Staff could describe specific consumers who undertake individual activities outside the service.

Consumers and representatives said the consumer's condition, needs and preferences in relation to lifestyle and activities of daily living, are communicated within the service and with others responsible for care. Lifestyle staff described ways in which they share information and are kept informed of the changing condition and needs of consumers. Lifestyle care planning documentation for consumers sampled provided information to support safe and effective care as it relates to services and supports for daily living and lifestyle. Staff said they are made aware of any changes to a consumer's needs through verbal and documented handover processes, information available in the care managements system and dietary folders.

A review of consumer care plans demonstrated that consumers are supported by other organisations, support services and providers of other care and services. The service is regularly able to refer consumers to appropriately skilled service providers to add to the care provided by the service in relation to lifestyle and activities of daily living. Consumer care planning identified referrals to other organisations and services such as the hairdresser, podiatrist, volunteers and external volunteer bus drivers. Staff could describe other individuals, organisations and providers of other care and services and specific consumers who utilise these services.

Most consumers and representatives expressed satisfaction with the variety and quality of food being provided at the service and said there were plenty of choices for each meal. Consumers said they could request different meals if they did not like what was on the menu that day. Changes in a consumer’s diet or preferences are documented in their care plan and communicated to kitchen staff. Staff could identify consumer’s dietary preferences and requirements including allergies and the need for alternative cutlery.

Consumers and representatives said they have access to equipment including shower chairs and manual handling equipment, to assist them in their daily living activities. They are also provided with resources and equipment for the leisure and lifestyle activities. Staff stated they have access to equipment when they need it and could describe how equipment is kept safe, clean and well maintained. Current cleaning and maintenance schedules were reviewed by the Assessment Team.

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 5(3)(b) is non-compliant:

Indoor areas of the service were observed to be clean and well-maintained. Staff described the maintenance process and explained how maintenance issues are logged in the Electronic Care Management System for actioning. Consumers and representatives provided feedback on the cleanliness of the service and the Assessment Team observed that the grounds were appropriately accessible for consumers.

However, the Assessment team did bring forward the following issues observed while onsite;

The external fence to the memory support unit was observed to be too low and climbable for consumers with absconding risks. The gardens were also observed to be uneven in places and unsuitable for consumers with mobility concerns. The kitchenette area in the memory support unit was not appropriately secured with pest products observed to be stored with consumable items in the fridge.

In the written response of 22 May 2023, the Approved Provider advised that following the site audit the service has implemented daily environmental reviews to ensure areas such as the kitchen were inspected for any safety concerns and a door installed on the kitchenette to ensure consumer safety. The external fence has been replaced with a high, unclimbable fence to address any absconding risks and a risk assessment planned for the outdoor areas and gardens to assess and consider options to address the uneven areas.

I have considered the evidence brought forward by the Assessment Team and the additional evidence provided by the Approved Provider in its response. I acknowledge the actions taken to date to address the issues identified during the Site Audit and accept that these actions have addressed the issues identified in most instances. However, I have also considered the outstanding matter relating to the external environment that may pose risk to consumers with mobility issues and note the Approved Provider is still undertaking steps to assess and action this issue and have placed weight on the potential risk to consumers while this work is undertaken. Based on this, I find Requirement 5(3)(b) non-compliant.

I am satisfied the remaining two requirements of Standard 5 are compliant.

Consumers and representatives said the service is welcoming and easy to move around. The service was clean, bright and airy with wide corridors. The service was one level, each consumer’s door was wide for easy access of equipment. All rooms included views to the manicured gardens. Staff said they thought the environment was welcoming, homely and safe for consumers.

Consumers said the equipment was clean and well-maintained. Consumers were using a range of equipment including walking frames, wheelchairs and comfort chairs. Furniture in the communal areas was clean and in good condition. Staff said they had access to sufficient, well-maintained equipment needed for consumer care. Furniture and equipment were under a scheduled maintenance plan with specialist contractors in place where required.

# 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 6(3)(d) is non-compliant:

The Assessment Team brought forward deficiencies in the way the service handled and used feedback within the service and found there were no systems in place to record and trend complaints, feedback, compliments, and suggestions in order to the improve quality of care and services. The Assessment Team found that while feedback and complaints were previously recorded in the Continuous Improvement Plan this system has not been maintained since October 2022.

The Assessment Team brought forward evidence of various situations relating to employees and consumers in which they stated they had raised concerns or feedback with management and included issues relating to medical consent, human resource issues and lost property.

In its response of 22 May 2023, the Approved Provider addressed the issues brought forward by the Assessment Team. In response to the consumer complaint relating to medical consent the Approved Provider advised this issue had been raised and addressed by the service and in response to the employee human resource issues the Approved Provider stated that these issues were not appropriate to have been recorded in the complaints register. I accept the explanation and evidence provided by the service in relation to these issues.

The Approved Provider has undertaken to address the gaps in how complaints management procedure to ensure verbal complaints are captured appropriately in complaints register that is maintained and reported to staff, resident, and Board meetings. The Approved Provider has also undertaken to introduce a revised Continuous Improvement Register that will also be tabled at meetings and publicly displayed.

Having considered the evidence brought forward in the Assessment Teams report and the Approved Provider’s response, I have accepted the explanation and additional evidence submitted by the Approved Provider in relation to some of the issues identified by the Assessment Team. However, I am of the view that there are deficiencies in the overarching systems within the service relating to the recording and trending of complaints and continuous improvement processes. While the Approved Provider has begun to implemented processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change. I am of the view the Requirement 6(3)(d) in non- compliant.

I am satisfied the remaining three requirements of Standard 6 are compliant.

Consumers felt comfortable making complaints and providing feedback and said they would have no concerns speaking with staff or management if they want to make a complaint. There was information on the noticeboards and in service publications on how to access both internal and external complaints systems. The service has several different methods for consumers to make complaints and provide feedback, including using a formal feedback form, raising issues at meetings, or speaking directly with any member of the management team.

Consumers and consumer representatives said that although they are aware of other avenues for raising a complaint, such as through the Aged Care Quality and Safety Commission, through family or friends or an advocacy service, they are comfortable raising concerns with management and staff. They said they will escalate their complaint if it is not resolved to their satisfaction. Staff demonstrated that they understood the internal and external complaints and feedback systems and were aware of the advocacy and translation services available. Staff were able to describe how they would assist consumers who are living with a cognitive impairment or had difficulty communicating, to raise a complaint or provide feedback. The Assessment Team observed the service’s written materials, such as the Resident Handbook, feedback forms, brochures and posters displayed throughout the service. These documents provide information regarding internal feedback and complaints processes and contact information for external assistance.

Consumers and representatives stated that the service was prompt to resolve any concerns or issues. Staff were able to describe the process to lodge feedback or make a complaint and said that if consumers and representatives were to raise an issue with them directly, they would escalate all complaints to senior management for investigation and follow-up. Management was able to describe the process that is followed when feedback or a complaint is received and understood the principles of open disclosure and provided examples where they have used open disclosure.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e) in this Quality Standard are non-complaint.

The Assessment Team found deficiencies in the mix and sufficiency of staffing and skill levels within the service, which was supported by feedback from consumers who described impacts to the delivery of personal and clinical care. While the service has a mix of staff including care, personal, and registered staff the Assessment Team reviewed the roster that showed significant shift vacancies throughout the preceding roster period. The service engages allied health staff such as physiotherapists and podiatrists, and specialists such as dieticians and speech pathologists through external providers, however due to limited availability locally there are issues in planning regular allied and specialist health care for consumers. While staff demonstrated knowledge and understanding of the care needs of individuals, reduced staffing levels impacted areas such as documentation and care planning processes.

Consumers felt the care and clinical staff within the service were competent and sufficiently skilled to provide their care. However, staff said they feel that they need more education to have the necessary skills to perform their roles, and while they are supported by senior staff, there is not always a registered staff member available when needed. The Assessment Team also found issues with the functionality of the internal training system in place to support staff and staff advised that while they were aware of the new legislation changes, they had not undertaken training relating to it.

The service was not able to demonstrate that it has implemented appropriate systems and processes to ensure that appropriately trained and skilled staff are recruited. Staff are recruited using a formal process that includes interviews, referee checks and qualification checks. Management stated that the service has a policy for ongoing training and development, which is provided for all staff and their participation in the training programs is logged and recorded. However, the policy was found to be out of date and the training programs not consistently monitored. The service could not provide details of the mandatory training completion rates and the staff and management acknowledged there are skills gaps to the Assessment Team.

While some staff demonstrated awareness of the service’s performance development processes and described being involved in performance discussions they could not remember when this last occurred. The service was not able to demonstrate that they have a process to regularly assess, monitor, and review the performance of staff at the service. The service’s policy for performance of staff is that all staff are reviewed at least once a year using a formal performance appraisal process, however management stated they had not had time to complete all performance appraisals currently due to conflicting priorities.

In its written response of 22 May 2023, the Approved Provider responded to the concerns raised by the Assessment Team and advised of the following actions implemented or commenced since the Site Audit.

The service has continued to advertise for registered staff, engaged the use of agency staff and is exploring alternative workforce solutions to expand the workforce. The service has implemented additional training modules, such as the Aged Care Code of Conduct on to their internal training platform and staff have commenced the modules, including the Board. The service has also commenced a review of the Training Policy, including the education program and is collating data on the completion rates of staff. It has further scheduled mandatory training for all staff for May 2023. In response to staff performance appraisals, the service has commenced a staff appraisal program, with each department head responsible for the annual appraisal of their staff and developed an annual calendar to ensure performance is monitored regularly.

Having considered the evidence brought forward in the Assessment Team report and the Approved Provider’s response, I consider evidence submitted by the Approved Provider will address some of the issues identified by the Assessment Team. However, I have also considered some of the issues relating to staff recruitment and sufficiency of staff and skills will take time to address and implement solutions, while the Approved Provider has begun to implemented processes to address these deficiencies, I consider that some of these actions will take time to implement and effect change and have placed weight on the potential impacts to consumers while this occurs. I am of the view the Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e) are non- compliant.

Regarding Requirement 7(3)(b) consumers and representatives generally said staff were respectful and caring. Staff demonstrated how they provide care that is respectful manner, however noted that due to a lack of staff, time spent with consumers was very limited. Interactions were observed by the Assessment Team to be caring and respectful with staff taking time to listen when they could, and interact with consumers, asking their activity and meal preferences. Consumers and representatives stated that while staff were respectful and caring there were not enough staff to enable them to spend one on one time with consumers.

The Assessment Team recommended this requirement was not met based on evidence relating to one consumer and interactions observed during the Site Audit, the Assessment Team further brought forward statements made by staff and management during the Site Audit as evidence of non-compliance with this requirement. In its response the Approved Provider disputed the statements included by the Assessment team in the Site Audit report and provided additional explanation of the observations made by the Assessment Team.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response. I have accepted the Approved Provider’s explanation and evidence in relation to the observations by the Assessment Team and have also placed weight on the examples of positive and respectful consumer and staff interactions brought forward by the Assessment Team throughout the report and the positive feedback provided by consumers as detailed by the Assessment Team in relation to this requirement. I am satisfied that Requirement 7(3)(b) is compliant.

# Standard 8

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that all 5 requirements in this Quality Standard are non-complaint.

Consumers and representatives felt they had limited ongoing input into how care and services are delivered. The service does provide avenues of communication like Resident Meetings, surveys, and face to face discussions around food choices and activities. However, no consumers or representatives said they were regularly engaged with regarding how the service provides individual care for consumers and there are no consumers or representatives sitting on advisory boards at the service. Management said that all feedback or suggestions made by consumers and representatives are included in the service’s Continuous Improvement Plan for investigation and actioning however the Assessment Team observed no complaints or feedback within the Continuous Improvement Plan.

The service was unable to demonstrate that the organisation’s governing body promotes a culture of safe, inclusive care. The governing body uses information from consolidated reports to identify the service’s compliance with the Quality Standards however, the service’s policies are out of date and the governing body are not aware of the Aged Care Code of Conduct or any recent legislative changes.

The service does not have an effective governance system in place to guide information management, continuous improvement, financial governance, the workforce, regulatory and legislative compliance, or feedback and complaints. The organisation utilises a diversity of online systems such as an Electronic Care Management System (ECMS) and risk management system; however not all staff are trained to use these. The service does not have a finance department responsible for managing the annual budget and has recently changed accountants, with the new accountancy firm yet to commence.

Most staff interviewed said they can access information they need to deliver safe and quality care and services, such as care documentation, policies and procedures through the ECMS, and have their own personal logins and passwords; however, one staff member stated they have not had access to the clinical functions of the ECMS for 3 months since commencing, so has no access to consumer care plans, and has asked management ‘a few times.’ Management stated that they are currently unable to access more than seven days’ worth of previous medication history in the ECMS, making trends difficult to assess. The services administration and information management and information access, amendments and correction policies were due for review in March 2019. Management said the continuous improvement process is drawn from a variety of sources, including consumer and/or representative feedback mechanisms, consumer survey results, analysis of clinical and incident data. However, the Continuous Improvement Plan did not include complaints or feedback from consumers or reflect clinical or incident data. The Continuous Improvement Plan had not been updated or reviewed since October 2022.

The service acknowledged there were some concerns regarding the current financial position of the service. A new accountancy firm had been contracted however at the time of the Site Audit had not commenced. The Assessment Team found deficiencies in the workforce governance systems within the service relating to recruitment, training and sufficiency of staff. The service acknowledged the significant difficulties in recruitment and increasing staffing levels and the Assessment Team identified gaps in the internal training systems used to support staff in their roles.

The service was unable to demonstrate effective processes and systems were in place to monitor changes to legislation; or access information from external peak bodies to ensure timely updates of changes to legislation that impact on the organisation’s policies and overall operations. The Assessment Team found issues in relation to the understanding and application of restrictive practices within the service, specifically in relation to consent forms for chemical restraints. The service does not have a current complaints and feedback register and the Assessment Team found a breakdown in how verbal complaints are documented.

The service has a risk management system in place to identify and manage risks to the safety and well-being of consumers. Management was able to describe how incidents are reported, however they are not analysed, and reports are not used to inform improvement actions. The Assessment Team reviewed the organisation’s risk management framework which were in place and included policies describing how high impact or high prevalence risks associated with the care of consumers are managed, and how the abuse and neglect of consumers is identified and responded to; however incident data has not been used to guide training to minimise incidents from occurring again. Staff said they had not received education, nor were they able to provide examples of relevance to prevention of falls, infections, managing changing behaviours or minimisation of the use of restrictive practices. Staff were able to demonstrate a shared understanding of what constitutes elder abuse and neglect and its inclusion within the Serious Incident Response Scheme; however, did not understand how to support consumers to take risks and make informed decisions. A review of the reportable incidents registers and current incident management system demonstrates compliant reporting is taking place.

The organisation has a clinical governance framework to ensure open disclosure is used and the service promotes antimicrobial stewardship; however, it does not ensure the minimisation of restrictive practices, or the quality and safety of clinical care. Open disclosure was evident in progress notes for medication incidents and falls however representatives were unaware that chemical restraint medications were prescribed, or consumers were provided with as-needed medication for changing behaviours. The clinical governance framework is available to guide clinical practice and includes policies and procedures on clinical risk management, antimicrobial stewardship, falls minimisation and the identification and response to potential reportable incidents, however these policies were all overdue for review.

The Approved Provider responded to the issues raised by the Assessment Team on 22 May 2023 and advised of the changes planned and implemented in response to the Site Audit report.

The service has introduced consumer representatives in various groups and portfolios to ensure consumer representation at the point of decision making, these include areas such as services programs, meal services and the service environment. The Approved Provider has undertaken to review the risk register in relation to Human Resource management and planning, which will be tabled at Board meetings and subcommittees that are due to occur through May and June 2023.

The Approved Provider has also engaged a new accounting firm who is now responsible for quarterly reporting and undertaken an audit of the ECMS to ensure it is fit for purpose and all staff have access by May 2023. A review of the regulatory compliance policies to ensure they comply with legislative changes and review antibiotic stewardship through the clinical governance committee throughout June and July of 2023.

The evidence compiled during the site audit was acknowledged by the Approved Provider, and persuasively showed non-compliance for requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the response to satisfy me that the service has addressed all of the deficiencies identified in the site audit; these include having the systems and processes to engage consumers in the delivery of care and services, address the issues relating to the workforce sufficiency and skill mix and continuous improvement initiatives. The Approved Provider is still undertaking improvements and I encourage them to embed these improvements. I am satisfied that Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) are non-compliant.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)