Blue Care Carbrook Wirunya Aged Care Facility

Performance Report

559 Beenleigh Redland Bay Rd   
CARBROOK QLD 4130  
Phone number: 07 3290 9777

**Commission ID:** 5273

**Provider name:** The Uniting Church in Australia Property Trust (Q.)

**Site Audit date:** 28 March 2022 to 30 March 2022

**Date of Performance Report:** 6 June 2022

# Performance report prepared by

James Howard, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information was considered in developing this performance report:

* the Assessment Team’s report for the Site Audit conducted from 28 March 2022 to 30 March 2022; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report, received 11 May 2022.
* Other information and intelligence held by the Commission in relation to this service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific requirements were assessed as Compliant.

Consumers and representatives confirmed staff always treated them with respect and dignity. Consumers advised they could maintain their identities, make informed choices about their care and services and live the life chose. Consumers confirmed their culture and diversity was respected and staff maintained their privacy. Examples provided by consumers included being able to do things they liked, such as going shopping, bowling, and participating in meetings at the service. Consumers advised their cultures and backgrounds were respected and supported and they could attend family events and express their cultural identities through religious observances and celebrations. Consumers spoke about choice and independence through having trips outside the service with family and friends and choices through meal options available. Consumers advised they were provided with information to assist in making choices about their care and lifestyle, such as lifestyle calendars and menus.

Consumers confirmed they were supported to take risks in their everyday lives, such as going for walks, playing bowls and eating food they liked. Consumers confirmed staff respected their privacy, including when family members visited, and staff knocked on doors before entering.

Staff sampled demonstrated familiarity with consumers’ backgrounds and diversity and described how they showed respect and supported consumers to maintain their identities, including supporting attendance at church services and multicultural experiences.

Staff advised they always treated consumers with respect and dignity and the Assessment Team observed staff treating consumers with dignity, taking time to listen and asking consumers what they would like. Staff spoke of how they supported consumers to make choices for themselves and encouraged independence, such as providing a consumer with advocacy services, a social worker and specialist medical professionals to assist her in her desire to return to living independently in the community. The Lifestyle Coordinator advised they arranged a variety of activities that included family participation and during Christmas and Easter the service allowed time for extended family visits. Staff showed an awareness of risk in consumers’ activities, how risk was discussed in staff handovers and the ways they supported activities. Staff described how they provided information to consumers, such as information packs on admission and if requested at other times. Staff confirmed they discussed changes in health conditions or needs with consumers and representatives and that when communicating with consumers, they used multilingual services as well as methods such as noticeboards, meetings, newsletters and other published materials for sharing information. Staff advised they always knocked before entering consumers’ rooms, spoke respectfully about consumers and did not discuss private details in public areas.

The Assessment Team observed the service identified and recorded consumers’ backgrounds, identities and diversity upon admission to the service. Care planning documentation guided staff on how to provide care and services in a respectful and dignified manner. The organisation trained staff using a person-centred care service model, to support staff in providing for consumers’ diverse needs. The Assessment Team observed lifestyle calendars showed activities for culturally important dates such as ANZAC Day, Easter and Christmas. The service had processes in place to ensure consumers and representatives had information that enabled them to make informed choices, decide who was involved in care and services delivered, and maintain relationships inside and outside the service as they desired. The resident handbook referred to a commitment to promoting and maintaining dignity, self-esteem and freedom of choice, and for consumers to ‘have control over and make choices about my care, and personal and social life, including where the choices involve personal risk’.

Care planning documentation showed the organisation ensured information was shared in a timely manner with consumers and representatives concerning any changes to consumers’ needs and communication was appropriate to the audience and included cultural and other considerations in delivery. The service had policies that set out how it collected, used, kept secure and disclosed personal information and had a code of conduct and values that supported staff to understand privacy obligations. Staff received privacy and confidentiality training in the service’s orientation process

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

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

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

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Quality Standard is assessed as Non-Compliant as one of the five specific requirements was assessed as Non-Compliant.

The Assessment Team recommended Requirement (3)(a) as Not Met, as it considered some elements of consumers’ care needs were not adequately assessed or documented, and some material in certain consumers’ care plans was not consistent with their care needs.

Consumers and representatives sampled advised they were involved in care planning, including when changes were made to their care plans. Consumers and their representatives advised they were informed of the outcomes of care planning and assessments and consumers confirmed they had access to their care plans as they wished. Consumers and representatives advised other health professionals or organisations were involved in their care and service delivery if they requested. Consumers and their representatives advised their end-of-life wishes were known to staff and were respected and care planning documentation included their wishes. Consumers provided positive feedback on the staff and the way they provided care.

Staff confirmed consumers’ care plans were reviewed every 3 months and changes to consumers’ conditions were raised at handover and through the shift workbook. Staff confirmed they had access to the service’s electronic care management system and used it to check care plans during shifts. Sampled staff provided examples of end-of-life considerations and understood consumers’ end-of-life preferences. Staff spoke of how they approached end-of-life planning with consumers and how they were guided by the service’s policies on assessment, care planning, palliative care and advance care planning. Staff described how and when they undertook assessment and care planning for consumers, which included the involvement of other health professionals and/or organisations as required. Consumer records included referrals to, and consultation with, external health professionals such a podiatrist, dietitian, speech pathologist, physiotherapist, occupational therapist, behaviour management specialists and social workers. Staff described how they documented outcomes of care planning and communicated outcomes to consumers and representatives. Staff gave examples of consulting with consumers during the process of assessment and checking with the consumer if they wished for a representative to be involved. Staff described how and when care plans were reviewed, which included speaking with clinical staff if they noticed changes to a consumer’s condition or had concerns. Staff knew of the service’s incident reporting process and how incidents could trigger referrals to other health professionals.

The service demonstrated that its care planning and management systems were effective, at times, in protecting the safety and wellbeing of consumers. The facility used an electronic care management system that provided staff with access to care planning documentation. The organisation had a suite of assessment tools available for staff to produce care plan documents which included tools for wound care, hygiene, dietary needs and clinical pathways. Consumers’ progress notes were stored in the electronic system and these were fed into handover notes. End-of-life documentation was contained on consumers’ files within the electronic system. The service maintained policies and processes which guided staff in assessment, care planning, palliative care and advance care planning. Policies, procedures, pathways and guidelines were available on the intranet to guide staff in the delivery of care and services. The Care Coordinator explained all clinical incidents are entered into an electronic risk monitoring system and the service gathered and analysed clinical incident data each month and identified trends to ensure appropriate strategies were in place to minimise reoccurrence of incidents.

Having considered the Assessment Team’s report and the Approved Provider’s response, I decided the service was Non-compliant with Requirement 2(3)(a). I have explained my reasons below.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team reviewed 7 consumer files. The files demonstrated that some elements of care needs were not adequately assessed or documented, and some were not consistent with consumer’s care needs, such as weight management, personal care and dental care needs. The Assessment Team’s observations identified that changes in care needs were not being communicated effectively.

Examples included:

* A consumer with a history of chronic airway disease, who received oxygen via nasal prongs, had no information in their care plan regarding nasal care, or care of oxygen tubing (cleaning and changing).
* The personal care plan of a consumer with a history of lower leg oedema did not contain any reference to the frequency, assistance, or washing of their compression stockings.
* A consumer on a pureed diet had a weight loss over the past month. Their care plan stated staff were to assist with meals; however, it did not define what assistance meant, such as whether they could feed themselves at times and whether to assist in accordance with their fluctuating alertness state and independence levels. Their file did not contain a food or fluid chart.
* A consumer had a significant weight loss between December 2021 and the site audit in March 2022. The consumer was referred for speech therapy in March 2022 due to ‘choking’. A subsequent progress note described consumption of meals as slow with only ¼ of a meal eaten. There was no food or fluid chart and the consumer was weighed monthly. The consumer’s care plan from January 2022 stated the consumer ‘requires encouragement and supervision’ to eat, but a care review conducted in March 2022 did not make any reference to weight loss.
* A consumer was on a soft diet, as well as high protein drinks 3 times per day. The consumer experienced a weight loss over the month prior to the site audit. The eating and drinking assessment stated the consumer ‘forgets to eat’ but did not contain any instructions as to assistance required.
* A consumer had an indwelling catheter and care was complicated by other conditions. Care staff advised the consumer recently requested weekly showers and documented this in a communication book. However, the consumer’s current personal care plan and the laminated shower schedule was not updated and did not reflect the consumer’s wishes.
* A consumer had disturbed sleep and staff changed his room to reduce the disturbance from a consumer in the neighbouring room making noise at night. The consumer’s file did not contain any reference to the consumer’s disturbed sleep patterns.
* All dietary requirements were provided to the kitchen, with new diet plans printed when changes were made. However, if a consumer’s diet plan did not change, the old plan remained in the kitchen file, with diet plans dated 2020 located in the kitchen folder. Whilst the Assessment Team identified that the diet details held in the kitchen for each consumer were accurate, the kitchen did not hold correctly dated diet plans and therefore kitchen staff could not be certain they had the most updated details for consumers’ dietary needs.
* Dental care needs were generally not documented in care plans and there were no progress notes in relation to a representative’s concerns about their parent’s dental care.

The Approved Provider’s response of 11 May 2022 acknowledged the issues raised and confirmed that since the site audit, it had taken comprehensive action and issues had been addressed or were well advanced in implementation.

The Requirement states the service’s assessment and planning must support the delivery of safe and effective care. The above examples show that, at the time of the site audit, the service failed to properly document consumers’ needs in care plans and these issues were compounded by a lack of communication between staff.

Although the service provided evidence of remedial action, at the time of the site audit, it was Non-Compliant with the Requirement.

Therefore, I decided the service was Non-Compliant with Requirement 2(3)(a).

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

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

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

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

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

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as Non-Compliant as three of the seven specific requirements were assessed as Non-Compliant.

The Assessment Team recommended Requirements 3(3)(a), 3(3)(b) and 3(3)(e) were Not Met, as it considered there were shortcomings in the service’s provision of safe and effective care, with effective management of high impact or high prevalence risks, and with documenting and communicating information about consumers’ conditions, needs and preferences.

Consumers reported the care and services provided met their needs; however, consumers and representatives advised staffing levels impacted negatively on the care provided at times. Consumers and representatives provided examples of the impact of low staffing levels on their care and on service delivery. Consumers and representatives advised they were comfortable with discussing end-of-life preferences with staff. Consumers reported they were confident their end-of-life wishes would be respected at the appropriate time, including comfort and pain management methods. Representatives confirmed they were contacted by the service and informed of any changes or deterioration in their family member’s physical, cognitive or mental health. Consumers advised they were satisfied with their care plans, and communication between staff about their needs and preferences was excellent, with consumers receiving the care they needed. Consumers confirmed they had regular access to external health providers as they needed, such as podiatrist services, and optometrist supplies. Consumers and representatives advised they were happy and satisfied with the way infection control was maintained at the service; however, representatives did report break downs in communication, such as where a family member tested positive for COVID-19 but they were delays in being notified.

Care staff advised they were comfortable in seeking guidance from clinical staff and confirmed they reported any changes in care needs or concerns about consumers. In interviews with the Assessment Team, multiple staff stated staffing levels did not support safe and effective delivery of care. Staff gave examples of absent staff not being replaced on shift, which negatively affected care delivery and delayed the provision of essential services to consumers. Management discussed how it monitored clinical indicators, high impact or high prevalence risks, medication errors, pressure injuries and falls; however, staffing levels affected the reporting of these incidents.

Clinical staff discussed the process of advanced care planning and palliative care. Staff confirmed case conferences were held with family members to discuss end-of-life considerations and planning, as well as referrals to external palliative care providers if required. Staff were familiar with managing pain, repositioning, skin care and massage. Clinical staff provided examples of change in the condition of sampled consumers, how it was recognised and responded to in a timely manner. Staff advised they received training on recognising and responding to signs of deterioration in consumers’ health. Staff described the ways in which information was shared amongst staff, which included the electronic care management system, communication book and handover meetings. Staff confirmed when consumers were referred to required health professionals, referrals were made in consultation with consumers, representatives, health professionals and their Medical Officer. Care staff demonstrated an understanding of infection control practices and said they received annual training which included handwashing competencies, donning and doffing and how to carry out administer Rapid Antigen Tests (RATs). The Care Coordinator confirmed all staff had completed these competencies.

The organisation had policies and procedures in place which guided staff practices in clinical governance, end-of-life, infection control, and restraint management. The organisation maintained best practice assessment tools in monitoring and assessing pain in consumers. The organisation had a risk management policy and procedures in place which guided how risk was identified, managed and documented. However, the Assessment Team found the service did not demonstrate effective management of high impact and high prevalence risks for consumers living with dementia.

The service demonstrated it had policies and procedures in place to manage end-of-life preferences for consumers. These were designed to maximise comfort and preserve dignity for consumers during the end-of-life stage and the service had registered staff on site 24 hours per day to support this. The organisation provided clinical pathways for staff which guided them in identifying and responding to a change or deterioration in consumers’ conditions. The Assessment Team reviewed clinical observation records and charts, such as vital signs and neurological charts, which indicated consumers were regularly monitored by registered staff and if a deterioration or change occurred in a consumer’s mental, cognitive or physical function, capacity or condition, staff recognised and responded in a timely manner. In relation to consumers who were receiving specialist care in relation to skin integrity, pain management and restraint, the Assessment Team found care documentation and information sharing to be satisfactory for the consumers’ identified risks. The organisation was unable to consistently show documentation and communication within the service concerning consumers’ conditions, needs and preferences, including where other organisations were involved in care delivery.

Having considered the Assessment Team’s report and the Approved Provider’s response, I decided the service was Non-compliant with Requirements 3(3)(a), 3(3)(b) and 3(3)(e). I have explained my reasons below.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team observed the organisation could not consistently demonstrate it satisfied the requirement. Staff and consumers advised personal care was not always delivered in alignment with care plans and consumers’ needs, with examples provided concerning nutrition, falls and oxygen management.

Examples included:

* The care plan for a consumer with serious emphysema did not mention the frequency with which oxygen tubing should be changed, in line with best practice principles. The consumer stated they “just lets the staff know when it needs to be changed”. The service stated there was a routine in place for oxygen tubing replacement; however, this could not be produced upon request.
* A consumer experienced significant weight loss. The consumer had a speech therapy assessment and was assessed as being able to tolerate very thick fluids. A subsequent progress note by care staff mentioned the “slow process of eating” and that the consumer only finished a small portion of their meal. However, the consumer did not have a food or fluid chart in place, the care plan did not contain any requirement for meal supervision, seating, or assistance, and there was no reference to weight being outside acceptable parameters in the most recent care review.
* Following a fall, a consumer passed away in hospital. A file examination showed that, over the previous four months, the consumer had over 20 documented falls. The communication book in the Memory Support Unit contained some notes from staff related to those falls. Data from the communication book was checked against progress notes and incident reports which identified inconsistency in incident reporting; for example, falls in the communication book were found to not to have incident reports, and other falls documented in progress notes were found not to have incident reports.

Other consumers reported instances of missed personal care, such as not being able to have a shower for up to 5 days, worrying if they would be incontinent while waiting to go to the toilet, not being provided with oral care and delays in staff responding to call bells.

In the approved provider’s response of 11 May 2022, it acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to improve the provision of care at the service, this Requirement mandates that consumers must receive safe and effective personal care, clinical care, or both personal care and clinical care. The evidence showed that, at the time of the site audit, this was not the case.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

The Assessment Team observed the service was not consistently or accurately assessing consumers’ high impact risks, including weight loss and falls following changes or ongoing incidents. When strategies in the care plan were not effective, new strategies to manage risks were not always implemented, or documented adequality for care staff, to reduce or prevent further incidents or impacts to the consumer.

Examples included:

* Incident reports for a consumer were not completed following every fall. Multiple falls occurred, and a falls sensor mat was not provided prior to a fall that resulted in a hospital admission. See Requirement 3(3)(a) for further information on this example.
* A care plan for a consumer with a choking risk and significant weight loss did not adequately describe strategies to prevent choking during meals, such as monitoring and assistance, and the consumer did not have a food and fluid chart despite significant weight loss. See Requirement 3(3)(a) for further information on this example.

In the approved provider’s response of 11 May 2022, it acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure high impact or high prevalence risks are effectively managed, this Requirement mandates that the service must provide effective management of high impact and high prevalence risks associated with the care of each consumer. The evidence showed that, at the time of the site audit, this was not the case.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

The Assessment Team observed the service could not consistently demonstrate care planning documentation properly recorded and communicated consumer risk, needs, and areas of clinical health.

Examples included:

* Clinical documentation, including incident reports, progress notes, assessments and care plans showed the service was not consistently or accurately assessing consumers’ high impact risks, including weight loss and falls following changes or ongoing incidents.
* When strategies in care plans were not effective, new strategies to manage the risks were not always implemented, or adequately documented, to reduce or prevent further incidents or impacts to the consumer.
* Incident reports were not completed for consumer who suffered multiple falls.
* Care planning documentation did not contain adequate strategies for a consumer with choking risk and weight loss.
* A consumer’s preference for weekly showers, rather than daily showers, was not recorded in the consumer’s care plan.
* A consumer’s care plan did not have information for care staff concerning the need for the consumer to wear compression stockings and assisting the consumer to wear them.
* There was a lack of care planning documentation concerning the provision of continuous oxygen and checking nose and ears, for a consumer with emphysema.
* Several hygiene sheets on display throughout the service were out of date.

In the approved provider’s response of 11 May 2022, it acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure that consumers’ conditions, needs and preferences are documented and communicated within the organisation, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific requirements were assessed as Compliant.

Sampled consumers confirmed they were supported and encouraged to engage in activities and things they wanted to do and this had a positive effect on consumers’ health and wellbeing. Consumers gave examples such as playing bowls at the local bowling club, participating in bingo, watching films and participating in exercise programs. Consumers advised the service helped them stay in touch with family and friends for comfort and emotional support. Families could meet freely at the service or use technology to stay in touch with consumers during lockdowns. Consumers confirmed they were supported to keep in touch with the local community and people who were important to them. Consumers talked about family visiting regularly, outside visits to the hairdresser and attending events with family away from the service. Consumers advised their needs and preferences were well communicated amongst staff and anything they needed from external people or providers were accommodated, with the service making timely referrals. Consumers provided examples such as new glasses provided through the visiting optometrist and services from a physiotherapist and dentist. Consumers reported the food provided was of good quality and met their dietary needs, menu options were flexible, and they could request alternatives if they wished. Consumer representatives advised equipment within the service, including mobility aids, was safe, suitable, and clean.

Staff gave examples of different activities consumers participated in and demonstrated services and supports for daily living promoted consumers’ emotional, spiritual, and psychological well-being. Lifestyle staff gave an overview of the service’s lifestyle planning and delivery services and showed how activities were organised, which included the use of external organisations as required. Examples included exercise, bingo, church services, trivia, volunteer-run programs, games, movies, mind games, concerts, visiting entertainment, resident meetings, happy hour, and special occasions such as ANZAC Day and Easter. Staff gave examples of how they met consumers’ spiritual needs through non-denominational services and pastoral care.

Staff described how they encouraged consumers to maintain relationships with people important to them and to participate in the community. Consumers were supported by technology to maintain contact during lockdown periods, other consumers were supported to go out into the community and participate in religious and sporting events, and visitors were always welcomed into the service. Staff described how they shared information and were kept informed of consumers’ conditions, needs and preferences through methods such as verbal and documented information, which included handover meetings and progress notes. Staff confirmed care planning for each consumer was reviewed every 3 months. The clinical team guided staff in assessment and planning for consumers, which included referral to external providers. Lifestyle staff described how they worked with and used volunteers to help supplement the lifestyle activities offered by the service.

Management and hospitality staff advised how they identified whether consumers liked the food through monitoring consumption and informal feedback from consumers following meals. The service also sought formal feedback via consumer food focus meetings, consumer experience surveys, consumer meetings, and care planning reviews. Staff confirmed equipment was available, clean and suitable for use; however, staff reported another hoist was needed. Staff described the process for requesting and reporting any maintenance needed on equipment, which included speaking directly to maintenance staff when urgent matters arose.

The organisation maintained care planning documentation which allowed for staff to readily see consumers’ needs, goals, and preferences to know how to deliver care and services to each Consumer. The Assessment Team reviewed documents that showed consumers could involve other people in their care planning and have input into how care and services were delivered to them. The organisation maintained an electronic care management system which scheduled three-monthly reviews for consumer care planning. The organisation demonstrated incidents were appropriately managed and it captured and acted upon continuous improvement feedback, such as information about meals.

The service had processes and policies in place to provide activities and deliver services in line with consumers’ emotional, spiritual, and psychological needs. Care planning documentation showed examples of how the organisation ensured it supported and maintained social and other engagement with the community. Care planning documentation for consumers guided staff in delivering care and advised or risks associated with consumer activities, such as leaving the facility and participating in various activities. The organisation maintained processes and procedures that enabled consumer involvement in menu planning and provided opportunity for consumer feedback regarding meals. The kitchen was well maintained and the service had hygiene practices in place. All equipment was clean, well maintained and be easily accessible to staff as needed.

## Assessment of Standard 4 Requirements

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

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

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

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

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

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Consumers reported the service was safe and comfortable, advised they could move about easily within the service and enjoyed the areas available to them. Consumers advised they enjoyed sitting outside in the sunshine. Consumers and their representatives said the staff were friendly and the service was welcoming, clean and well-maintained. Consumers advised they could decorate their rooms with personal items, which included their own furniture and access to their own washing machine. Consumers advised fittings and equipment were clean and well maintained.

The Care Co-ordinator explained the service’s features and described how the environment assisted consumers to move about freely and assisted with their daily socialisation and relaxation. Staff advised they sought feedback from consumers about ways to make them comfortable and feel at home in the service. The service’s maintenance officer described current projects underway within the service and processes for maintenance checks and unscheduled repairs. Staff confirmed furniture and fittings were in good order and were regularly checked for suitability and safety.

The organisation felt welcoming and was well organised, with a dedicated COVID testing area and space for visitors to wait if needed. The organisation had policies and processes in place for gathering feedback and improvement suggestions from consumers. The layout of the service allowed for consumers to easily navigate their own way around the service and gave them access to areas, such as the recently upgraded garden and communal spaces. Key pads and locks were used for staff areas, which prevented consumers from wandering into these areas. The organisation supported consumers with personalising their rooms. The service demonstrated processes were in place that ensured the service environment was safe, clean, and well maintained. Cleaning equipment was well organised and chemicals were safely secured. The service had policies and procedures in place that ensured timely responses to incidents and maintenance issues and safety inspection documentation was complete and current.

During the audit, the Assessment Team raised the following issues with management:

* A plastic tabletop was hanging across a table.
* Some garden furniture was upside down in garden.
* A shower chair was in the garden, plants were ripped from beds, and pots were upended.

The service advised a newly-admitted consumer had moved the items. The Care Manager was notified and the resident was supervised by the Care Manager; however, the following day some items were again moved in a similar manner.

Other issues raised were confined to the service’s Memory Support Unit;

* A large blind was mouldy and torn.
* The bedroom protected by the blind had a sheet used as a curtain.
* The bases of two downpipes were recently broken.
* Garden hoses were not fully wound-up or retracted.
* An air-conditioner was sitting at an angle.
* Some outdoor paths were mouldy.

When the Assessment Team raised the above issues with management, it provided a prompt response to the issues and advised that a project to upgrade the area was underway. The Assessment Team observed several of the issues were repaired the following day, during the course of the site audit.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The Quality Standard is assessed as Non-Compliant as two of the four specific requirements were assessed as Non-Compliant.

The Assessment Team recommended Requirements 6(3)(c) and 6(3)(d) were Not Met, as it considered there were shortcomings with the service’s handling of complaints and with the use of complaints and feedback to improve the quality of care and services.

Consumers and representatives confirmed they knew how to provide feedback and lodge complaints. Consumers and representatives said they were encouraged and supported to provide feedback or lodge complaints through various means, such as consumer meetings, through available forms, or by speaking directly to staff.

Consumers and representatives reported they were happy and comfortable with speaking with staff directly about any concerns they had. While some consumers advised they were not aware of advocacy services, consumer representatives advised information had been provided to them at admission. Most consumers and representatives advised they had opportunities to provide feedback; however, most consumers and representatives also stated they felt the service did not take appropriate action in response to complaints and feedback. Consumers provided examples of instances where their concerns had either been minimised or not acted upon.

Staff detailed the ways in which they supported consumers and representatives to provide feedback and make complaints, which included developing a culture of open communication within the service. Staff confirmed the service provided feedback and suggestion boxes, feedback and complaint forms, encouraged direct conversations with staff and provided opportunities to attend consumer-led meetings. Staff said they assisted consumers to provide feedback and complaints and helped with access to external advocacy services if needed or requested. Staff confirmed advocacy and language support information was provided to consumers and representatives upon admission to the service. Some staff stated that staffing levels had negatively affected the care provided at the service, gave examples of staff on leave not being replaced which placed pressure on areas such as cleaning, and stated management was aware of staff concerns. Staff advised feedback and complaints were not always entered in the register as they tried to manage issues themselves.

The organisation maintained a feedback register and had a feedback user guide for consumers and staff which explained how to provide feedback and how they were supported to do this. The service’s Resident Information Book included information about accessing advocacy and language services. The service’s documentation included a Blue Care Language Services Policy and Process, which contained information on meeting the accessibility needs of clients from diverse cultural and linguistic backgrounds who might require the assistance of interpreters. Kitchen staff advised consumers were involved in food focus meetings.

The service demonstrated it had an open disclosure policy which stated appropriate action should be taken in response to feedback and complaints and an open disclosure process should be used when things went wrong. However, the Assessment Team identified several areas of concern, including a failure to effectively use and review complaints, feedback and continuous improvement data in its records management systems in a way that supported continuous improvement within the service. This is discussed further below under Requirements 6(3)(c) and 6(3)(d).

## Assessment of Standard 6 Requirements

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

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

### Requirement 6(3)(b) Compliant

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

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

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

The Assessment Team examined feedback and complaints from consumers and carried out observations during the site audit and concluded the service did not always take appropriate action in response to complaints, nor did it always use an effective open disclosure process.

Examples included:

* A Consumer made an allegation of aggressive behaviour toward them by a staff member on two separate occasions. The consumer’s representative alleged that the service took insufficient action to protect the consumer. As a result of the complaint, the service temporarily stood down the staff member and ordered them to attend additional training and attend review meetings. However, records from the service show three of the six meetings were not recorded. As part of the resolution of the complaint with the consumer’s representative, the service agreed staff member would not work with the consumer. However, in interviews with the Assessment Team, three care workers stated the staff member continued to work directly with the consumer, because the consumer required a two-person lift and care workers often needed to move between wings when they were short-staffed or needed extra assistance.
* Three consumers said that feedback about the quality of food either had not been actioned or would not be actioned if they complained about it. One consumer said they raised the issue of food being overcooked multiple times at resident meetings but that nothing changed. A second consumer said they know how to give feedback but feel as though it will not make any difference. A third consumer stated the food can be nice but meat is sometimes tough and another item was often tasteless, stated they had told the kitchen but the situation did not change. The Assessment Team examined the feedback register but could not find any record of feedback about food.

In its response of 11 May 2022, the approved provider acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure that consumers’ feedback and complaints are now properly recorded and responded to, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

The Assessment Team examined the way the service dealt with feedback and complaints from consumers and concluded the service did not always review and use the information from feedback and complaints to improve the quality of care and services.

Examples included:

* A consumer stated they complained about the toast, as it was not toasted at all. However, the consumer said that nothing happened in response so they asked their adult child to purchase a toaster for them so they can toast their own bread.
* Another consumer said they complained that toasted bread from the kitchen was undercooked and consumers had repeatedly asked for a toaster which finally turned up during the site audit.
* All consumers interviewed said that staffing levels were affecting the level of care provided and they had voiced concerns to the service. Impacts on consumers included missed and delayed hygiene. These issues were not reflected in the complaints and feedback data, and actions were not reflected in the service’s Quality Improvement Plan.

The Assessment Team analysed the service’s Quality Improvement Plan against complaints data and other findings and identified the following issues:

* The service commenced a Quality Improvement activity concerning an incident that related to a complaint and allegation against a staff member. There was no desired outcome recorded for the activity, nor was there a person allocated as responsible for the activity. The activity was marked as commenced on 30 July 2021, with no recorded summary and no outcome. The activity remained open at the time of the site audit.
* A Quality Improvement activity dated approximately October 2021 stated that a dietician attended to review residents and asked a staff member whether a particular consumer was receiving a supplement that the dietician had previously ordered for the consumer. The staff member responded they did not know and were not even aware the resident should take the supplement. A similar case was recorded for another consumer, where the consumer stated that care staff had not familiarised themselves with consumers’ eating and drinking requirements. The activity had no desired outcome, nor was there a person allocated as responsible for the activity. The activity was not commenced in the system, no outcome was recorded and it remained open.
* A Quality Improvement activity dated 8 February 2021 stated the service should investigate why there was an increase in disruptive behaviours around 2pm daily and that the service should review what activities were occurring at that time; review staff availability and supervision; identify potential triggers for behaviours around that time and how to prevent them; review the handover process which took place at that time; and whether there may be a link between behaviours and staff handover. The record did not show any desired outcome, no actual outcome was recorded and the activity remained open.

In its response of 11 May 2022, the approved provider acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure that consumers’ feedback and complaints are reviewed and used to improve the quality of care and services, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as Non-Compliant as two of the five specific requirements were assessed as Non-Compliant.

The Assessment Team recommended Requirements 7(3)(a) and 7(3)(d) were Not Met, as it considered there were shortcomings with the service’s workforce planning and with the service’s recruitment and training of the workforce.

Consumers and their representatives confirmed staff cared for them and delivered services to them in a caring and respectful way. Some consumers and representatives advised they felt some staff were not suitable and there were insufficient staff to always provide safe and quality care. Consumers stated staff were friendly and nice, while some consumers stated they preferred the service’s permanent staff over agency staff. Consumers and representatives confirmed staff were well trained and had sufficient knowledge to meet consumers’ needs.

Staff reported they sometimes faced issues with having sufficient time to do their jobs properly and consistently. Staff spoke of how shift reductions had a negative impact on care and services and provided specific examples of the reductions and the subsequent effects on consumers. Staff provided care to consumers in a caring and respectful manner. Staff spoke of the mandatory training provided to them upon commencement and the ongoing training available and of how they felt suitably qualified and competent to provide care and services to consumers. Some staff raised concerns with not feeling fully trained to do their jobs, including how they needed to teach themselves to use the electronic care system. Staff advised they were not always monitored to ensure they completed mandatory training modules. Staff confirmed they participated in annual performance reviews and how they were supported by Human Resources. Staff described the performance management process, including annual reviews and less formal discussions throughout the year.

Documentation provided by the service demonstrated it maintained a roster for all staff, including care staff and registered staff. The roster for the past two weeks showed:

* Three shifts had not been filled.
* Two staff were on unplanned leave.
* Agency staff were used for 20 shifts.

Records for one wing of the service contained numerous entries regarding instances where the wing was short-staffed.

Management monitored and reviewed the performance of staff as part of staff probation and on an ongoing basis. The service had clear procedures and systems in place for managing performance and underperformance of staff. Management also informally reviewed performance through performance conversations with staff.

## Assessment of Standard 7 Requirements

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

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

The Assessment Team examined the way the service dealt with workforce planning and concluded the service’s mix and number of staff did not always enable it to deliver and manage safe and quality care and services.

Examples included:

* Care staff advised that service’s reduction of a shift from a five hour period to a two hour period had a negative impact on care delivery, as they had insufficient time to attend to tasks such as showering consumers in the morning.
* A staff member advised they are not able to feed consumers properly as some consumers needed to be fed manually and they had insufficient time to do that.
* A staff member advised the “floater” shift is insufficient to provide care when needed, particularly around mealtimes, and that has a flow-on effect on attending to other care needs.
* A member of the care staff said they come in early to help feed breakfast to consumers as, if did not do so, consumers would be fed breakfast too late and would not be dressed on time.
* While management said that communication and discussions with staff occur in staff meetings, there was no record of monthly staff meetings occurring in January and March 2022. The minutes for the December 2021 and February 2022 meetings showed that all standing agenda items were missed, including the agenda item for discussing workload requirements.

In its response of 11 May 2022, the approved provider acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure that sufficient staff are available in the required numbers and mix of skills to provide safe and effective care, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

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

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

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

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

The Assessment Team observed the service had suitable systems and processes in place to ensure staff were properly recruited and trained when commencing employment with the service; however, ongoing and mandatory staff training was not delivered, monitored and reviewed to ensure staff were supported to deliver care and services in line with the Quality Standards.

Examples included:

* The training register showed that many staff had not completed mandatory training by the due date. Fifteen care staff who worked at the service had not completed multiple mandatory training modules by the due date. One member of the care staff was recorded as not having completed 10 out of 14 mandatory courses, with 2 of those courses having been overdue since 2019, and 4 of those courses having been overdue since 2020.
* Six members of care staff who worked at the service were not listed on the training register.
* While management advised staff, meetings were used to deliver staff updates for competency information such as incident management and current infection control practices, there was no record of monthly staff meetings occurring in January and March 2022. The minutes for the December 2021 and February 2022 meetings showed that all standing agenda items had been missed, including the agenda item for learning and development.

In its response of 11 May 2022, the approved provider acknowledged deficiencies in this area and provided a comprehensive statement of remedial actions it was taking to promptly rectify the situation.

Although the approved provider and service are now acting to ensure that staff are recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as Non-Compliant as two of the five specific requirements were assessed as Non-Compliant.

The Assessment Team recommended Requirement 8(3)(c) and 8(3)(d) were Not Met, as it considered there were shortcomings with the service’s workforce planning and with the service’s recruitment and training of the workforce.

Sampled consumers and representatives advised they felt the service was well run, and they were happy with the management team. Consumers reported being able to speak with management if they had any concerns. Consumers and representatives were aware of how they could engage in processes within the service.

Staff described the ways in which consumers were involved in decision making, which included feedback forms, discussions with staff and consumer and representative meetings.

Staff advised feedback was used in continuous improvement processes via the quality improvement register and the analysis of leading indicators in care excellence reporting tool. Staff advised they were able to access the information they needed to perform their roles; however, one staff member advised they had to teach themselves how to use the information system. Staff described their roles and responsibilities to the assessment team. Some staff advised they had not received training in incident management; however, they described actions they needed to take if an incident occurred. Staff said they were educated about policies for high risk and high prevalence risk and provided examples of their relevance to their work. Staff demonstrated an understanding of strategies they implemented for individual consumers for falls prevention and pressure injuries, to manage psychotropic medications safely and effectively, and pain management.

Not all staff could describe their responsibilities relevant to their roles in relation to restraint and abuse and neglect of consumers. For example:

* One clinical staff member said they had not received any training on the legislative changes related to restrictive practices and could only express restraint as chemical, physical, environmental and mechanical.
* Two care staff said they were unaware about training on restrictive practices and were unaware of this terminology.

Staff demonstrated an understanding of dignity of risk and provided examples of how they safely supported consumers to take risks and what measures the service had in place to monitor those risks, which included speech therapy assessments for consumers on textured diets who wished to have ice-cream.

Management described how the governing body of the organisation promoted a culture of safe, inclusive and quality care and services with the following examples:

* Management and a Board member explained how the 2030 Vision and Strategy supported improvements in safe, inclusive and quality care and services.
* Blue Care values were promoted within the organisation, and these represented safe and quality service provision.
* Blue Care’s Code of Conduct and Values.

The organisation provided:

* a documented clinical governance framework.
* a policy relating to antimicrobial stewardship.
* a policy relating to minimising the use of restraint.
* an open disclosure policy.

The clinical governance framework was supported by an antimicrobial stewardship policy, fact sheet and checklist. The service also had a clinical care standard clinician fact sheet, Blue Care clinical governance framework and a GP letter for antimicrobial stewardship.

Regarding restraint, the new Service Manager demonstrated the online training module on restrictive practice in the Blue Care learning portal and also demonstrated the location of restrictive practice documentation in the clinical care section of the Blue Care online policy portal.

## Assessment of Standard 8 Requirements

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

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

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

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Non-Compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The assessment team found that the organisation had systems to support information management and financial management; however, it did not find adequate systems or processes to support continuous improvement, workforce management, regulatory compliance and management of feedback and complaints.

Examples included:

* an historical incident involving a consumer.
* feedback regarding meal quality.

In relation to the incident involving the consumer, the Assessment Team identified the matter was not reported correctly nor reported on time. The matter was originally reported as a priority 2 matter and was reported 12 days after the incident occurred. A priority 2 matter has a 28-day reporting window; however, the matter should have been classified as a priority 1 matter and should have been reported with 48 hours. Concerns were raised about the staff member involved still providing care to the consumer. In its response, the approved provider advised of the action taken, which included:

* a formal investigation into the matter.
* rostering changes to ensure the staff member did not provide care to the consumer.
* consultation with family representatives to ensure satisfaction with process.
* training and education provided to all staff regarding SIRS reporting, including police notification.

In relation to the meal feedback, the Assessment Team observed that consumer dissatisfaction with the way food was prepared was not captured by the service’s continuous improvement system. There were two instances of consumer feedback concerning undercooked toast, but there was no mention of the feedback in the feedback register nor in any continuous improvement documents. Similarly, several residents gave feedback regarding meal quality and these were not captured by feedback systems.

In its response of 11 May 2022, the approved provider acknowledged both issues and advised that, following the site audit, it had implemented further methods for feedback and quality assurance to ensure consumers were heard and appropriate actions were taken. In relation to the toast issue, it advised the original toaster was found to be faulty and had been replaced.

Although the approved provider and service are now acting to ensure that feedback and quality assurance methods are improved and used for continuous improvement, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The assessment team observed that incident information was not always used effectively to identify risks to consumers’ care.

Examples included:

* The communication book located in the Kingfisher Memory Support Unit contained details of incidents of falls for a consumer which were not recorded in consumer progress notes or in the Incident Register. An audit of the consumers’ care planning documentation subsequently found additional falls in progress notes were also not always reported in incident reports.

Whilst the service had a reporting framework in place and staff demonstrated an understanding of that framework, the service could not demonstrate the framework flowed into daily work practices.

Examples included:

* Not all staff could describe their responsibilities relevant to their roles in relation to restraint and abuse and neglect of consumers.
* One clinical staff member said they had not received any training on the legislative changes related to restrictive practices and could only express restraint as chemical, physical, environmental and mechanical.
* Two care staff said they were unaware about training on restrictive practices and were unaware of this terminology.

While management said staff, meetings were used to provide staff updates for competency information such as incident management and current infection control practices, there was no record of monthly staff meetings occurring in January and March 2022. The minutes for the December 2021 and February 2022 meetings showed that all standing agenda items were missed including:

* learning and development
* quality and governance
* mandatory reports
* WHS

Although the approved provider and service are now acting to ensure that effective risk management and reporting systems and practices are in place, the evidence showed that this was not the case at the time of the site audit.

Therefore, having considered all relevant evidence, I decided the service was Non-compliant with this requirement.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

# Areas for improvement

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

* Ongoing assessment and planning with consumers
* Personal care and clinical care
* Feedback and complaints
* Human resources
* Organisational governance