Performance

Report

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| Name of service: | Blue Care Mackay Homefield Aged Care Facility |
| Service address: | 87-95 George Street MACKAY QLD 4740 |
| Commission ID: | 5122 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 9 May 2023 to 11 May 2023 |
| Performance report date: | 14 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 Blue Care Mackay Homefield Aged Care Facility (**the service**) has been prepared by K. Reed, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others
* the provider’s response to the assessment team’s report received 09 June 2023
* other information and intelligence held by the Commission in relation to the service.

# 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 | **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.

* Consumers are to be provided with care and services that promote their dignity and respect.
* Assessment and planning processes need to consider the capacity of consumers to partake in decision making, including where risks are involved.
* The high impact and high prevalence risks associated with consumer who have fallen needs to be effectively managed.
* Appropriate actions need to be taken following complaints. Consumers and representatives need to be consulted to ensure they are satisfied with the resolution of complaints.
* Improvement opportunities need to be considered through the review of feedback and complaints raised.
* Staff need to be sufficient in number and skills to provide quality care and services.
* Effective monitoring of staff competency needs to occur to ensure staff have sufficient skills.
* Staff need to be equipped and trained appropriately to perform their roles.
* Each member of the workforce needs to complete regular assessment and review of their performance.
* Organisational systems need to be re-established at the service to ensure organisational governance.

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

Findings

While consumers provided some positive feedback regarding staff conduct other consumers provided feedback their dignity was compromised due to interactions with staff or lengthy delays in staff assistance. Three named consumers experienced humiliation and embarrassment relating to their continence care by being told to use their continence aid instead of going to the toilet, lengthy delays in a soiled continence aid and delays in toileting assistance causing incontinence. For a fourth named consumer, while they provided feedback staff were kind and caring, they did not feel they were treated with dignity as staff drew their curtains and turned off their television which was against their wishes. Staff confirmed there were delays in providing care due to a lack of staff.

The Approved provider in its written response to the Site audit report stated they were saddened by the examples provided by consumers and representatives where the organisation had not consistently lived up to the commitment of providing heart-felt and compassionate care and services, due to delays for assistance and inappropriate staff interactions. Consumers and representatives named in the Site audit report have had meetings arranged, to apologise, discuss their feedback and determine next steps to address individual concerns and rebuild trust with the provider. According to the service’s Plan for continuous improvement, three of the five named consumers have met with management, one consumer has a planned case conference to be scheduled in July 2023 and one consumer named in the report sadly passed away. Survey forms were provided to consumers and representatives following the Consumer and representative meeting held 30 May 2023 to gauge consumers’ experiences. This initiative will be completed by 30 July 2023, according to the Plan for continuous improvement. Education was in development in relation to dignity and respect training according to the Plan for continuous improvement and will be provided throughout June during handovers and across all shifts. An observation tool relating to workplace practices to be completed three times a week has commenced to identify any additional concerns and to monitor improvement to the consumer experience. The Plan for continuous indicates this is an ongoing action and was completed on 22 May 2023, whereby management addressed observations at the time of the walkaround. No further information was recorded regarding other observations or actions taken following the observations. A focussed review of the call bell system to ensure its effectiveness is included in actions taken to address the Non-compliance in Requirement 1 (3) (a), daily reports have been generated and reviewed by management with an investigation to be undertaken for any call bell response times over ten minutes. Call bell response times have been added as a standing agenda item to Consumer and representative meetings, and a staff memorandum was sent to all staff 24 May 2023 regarding call bell monitoring and wait times. The Plan for continuous improvement indicates call bell reporting trends completed 31 May 2023 demonstrated improvements in staff responsiveness to consumer needs. An all staff meeting with 48 participants was held 19 May 2023 and education was provided including Code of Conduct, organisational values, open disclosure and call bell responsiveness. I am unable to determine the effectiveness of the training provided or if all staff attended the education session based on the Approved provider’s response and the Plan for continuous improvement submitted as part of the response.

While I conclude the Approved provider has committed to the above actions to address the Non-compliance in Requirement 1(3)(a), it is my decision these actions have not been completed or reviewed for their effectiveness and will need time to be implemented. Therefore, it is my decision Requirement 1(3)(a) is Non-compliant.

Consumers and representatives described how staff valued the consumers’ culture, values, and diversity, including how the consumer’s culture influenced the way staff delivered their care daily. Care documentation reflected consumers’ cultural needs and preferences, and consumers from culturally and linguistically diverse backgrounds stated their cultural needs were met. Consumers confirmed they could decorate their rooms with items that were significant to them and remind them of who they are and what is important to them. Staff provided examples of consumers who received religious support, consumers who had relationships within and external to the service, and consumers who chose to participate in cultural events.

Consumers were supported to exercise choice and maintain their independence by making decisions about their care and services. Care documentation demonstrated consumers were supported to nominate who they would like involved in their care, communicate their decisions, make connections with others, and maintain relationships of choice. Staff described how consumers were supported to maintain relationships of choice through receiving visitors to the service, undertaking outings to visit friends and family, and choosing whether to attend the service’s group activities.

Consumers described how the service supported them to take risks, and this was evidenced in care documentation. Staff were aware of the risks taken by consumers, and said they supported the consumer’s wishes to take risks to live the way they choose. Risk assessments were completed and signed by consumers who wished to consume alcohol, and for consumers who chose to undertake risks such as food preferences which did not align with recommendations by the Speech pathologist

Current, accurate and timely information was provided to consumers and representatives and communication was clear, easy to understand, and supported consumers to exercise choice. Posters and flyers of upcoming activities or other information, such as the Site Audit were observed on noticeboards and in rooms. Staff asked consumers each day for their meal choice from the options provided on the menu displayed pictorially on an electronic device.

Consumers’ privacy was respected, and staff provided various examples of how consumers’ personal information was kept confidential. Staff respected consumers’ privacy by knocking on doors, closing doors when providing cares and keeping computers locked when not in use. Consumers were provided with the Charter of Aged Care Rights and the organisation’s privacy information in the consumer handbook which explained how personal information is protected by the service.

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

Findings

Assessment and planning processes did not consider the capacity of consumers to ensure appropriate consent and authorisations for restrictive practices. Three consumers provided feedback they had not been consulted during the decision-making process for the use of bedrails. Care documentation review demonstrated, and the service was unable to provide evidence, that discussions had been held with consumers to authorise the use of mechanical restraint, or alternatively, that an assessment of capacity had been completed to enable deferment to the substitute decision maker hierarchy.

Following feedback, management reviewed all consumers subject to mechanical restraint and identified from thirteen consumers, two consumers had current assessments to determine their decision-making capacity.

The Approved provider in its written response accepts that appropriate assessment, consent, and authorisation processes were not consistently demonstrated in relation to restrictive practices. A review of all consumers subject to mechanical and chemical restrictive practices has been undertaken to ensure appropriate assessment, consent and authorisation processes have been completed. Capacity assessments of consumers were reviewed, and each consumer or substitute decision maker has been consulted and informed of the restrictive practice being considered. The Plan for continuous improvement indicates this process was completed 7 June 2023. Case conferences have been held with consumers identified as using bedrails to reaffirm their care plans accurately reflect their needs, goals, and preferences. The Plan for continuous improvement indicates this process will be ongoing to minimise the use of bed rails at the service. A team of physiotherapists conducted an audit to ensure the safety and suitability of consumers with bedrails, in conjunction with a full site equipment audit to ensure all alternative safety equipment can be purchased prior to the reduction of mechanical restraints to reduce the risk to consumers. A restrictive practice audit will be completed by 31 July 2023 to monitor if the above actions have been effective. Incident investigation was commenced 6 June 2023 to ensure inappropriate usage of restrictive practices have been identified and reported to the Serious incident response scheme.

Behaviour support plans were noted to be ineffective in guiding staff when managing consumers with challenging behaviours. For one named consumer, staff reported they were unsure how to manage the consumer’s aggressive behaviours and would generally ask registered staff to administer antipsychotic medication in the form of chemical restraint to the consumer. The named consumer has had four incidents of unreasonable force in the previous six weeks and suggested interventions in their behaviour support plan were generic in nature and progress notes indicated the interventions were ineffective.

The Approved provider accepted in its written response improvements could be made to further personalise behaviour support plans to equip staff with behavioural strategies reflective of the consumers’ experiences. The named consumer with aggressive behaviours was reviewed by a Nurse practitioner and a referral made to a Geriatrician and Medical officer, with a review date for a dementia advisory service yet to be confirmed. The Approved provider stated the consumer is under close supervision while a process of reviewing the consumer’s needs is undertaken. Two Nurse practitioners support the service on a weekly basis and will be increasing behavioural and clinical management relating to Dementia, as this was identified as an area of need for staff at the service.

I recognise the commitment of the Approved provider to addressing deficits in Requirement 2(3)(a), however these actions are yet to be commenced or completed, to understand if these actions have been effective or sustainable. Therefore, it is my decision Requirement 2(3)(a) is Non-compliant.

Consumers and representatives confirmed, and review of consumer care documentation evidenced individual consumer’s current needs, goals and preferences were addressed, and included advance care planning and documentation of consumers’ wishes. Registered staff advised there was discussion about a consumer’s advanced care planning, including end of life wishes when a consumer entered the service and if a consumer's condition deteriorates.

Most consumers and representatives confirmed they were involved in the assessment, planning and review of consumers’ care and services. This was not inclusive of assessment and planning of the need for restrictive practices. Care planning documents reflected the consumer and others involved in assessment and planning, including Medical officer, physiotherapist, dietitian, and Speech pathologist. Consumer files demonstrated input from other health care professionals and services.

Consumers and representatives confirmed staff discussed consumers’ care needs and preferences with them and were responsive when there was a change. The service demonstrated care plans were reviewed every three months, as well as when circumstances changed, or an incident occurred. Staff described how, when an incident occurs, this triggered a review of the care plan which included relevant allied health professionals when necessary.

# Standard 3

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

Findings

Consumers and representatives provided positive feedback about the clinical care provided at the service. Review of care planning documentation and medication records demonstrated effective care delivery including in relation to management of wounds, pain, diabetes, and medication administration. Staff demonstrated a shared understanding of consumers’ care needs and the processes in place to support care delivery. The service had a suite of policies, procedures and tools to guide staff practice. The planning and use of restrictive practices by the service was not always best practice or tailored to a consumer’s needs, and this has been considered in Requirement 2(3)(a).

The service did not have effective processes to manage high impact or high prevalence risks associated with falls management. Although care documentation identified consumers at risk of falling, and appropriate after fall care including observation charting and physiotherapy assessment occurred, approaches to reduce falls and develop individualised strategies were not implemented in a timely manner, and consumers continued to sustain falls with injuries.

For one named consumer who sustained a significant number of falls, 13 falls between February and April 2023, falls prevention strategies including sensor mats, regular observations and toileting program were ineffective and the consumer continued to fall. Unsafe footwear was identified as a causative factor to the consumer, and while safer shoes were purchased, staff have not ensured the consumer consistently wears them.

For the second named consumer who sustained four falls between January and May 2023, preventative strategies were not documented for falls which occurred 16 January 2023 and 19 February 2023. While a sensor mat was in use prior to the consumer’s fall in March 2023, the sensor mat did not alarm, and the consumer fell and hit their head on the bathroom sink. An analysis of the reasons for the consumer falling has not occurred. It is noted that all falls have occurred while the consumer was mobilising unaided to the toilet. The consumer stated if staff don’t arrive they will mobilise to the toilet unaided. Care planning for the consumer confirms they require assistance when mobilising.

The risk management system used by the service was not effective in monitoring or informing risk patterns and did not consistently contain documentation around risk mitigation for future falls risks. Staff said they did not consistently receive information around falls risk mitigation strategies, and where there are strategies in place, they are not aware if these were reviewed for effectiveness.

The Approved provider in its written response acknowledged the service was unable to consistently demonstrate effective management in respect to consumers’ falls and have taken action to address the required areas of improvement. For the two named consumers in the Site audit report identified as sustaining numerous falls and falls with injury, one consumer sadly passed away and a comprehensive analysis is being undertaken into the circumstances leading to their death. The other consumer has been moved to a room which is fitted with technology to alert staff if the consumer attempts to mobilise. A referral has been made to a medical officer for the consumer and a review of clinical and lifestyle assessments and care plans is underway. Two physiotherapists have been engaged commencing 5 June 2023 to review all consumers’ falls risks, this process is to be completed by 30 June 2023. Five consumers identified as having complex care needs have been referred to either a Geriatrician or specialist for review. Further information in relation to the results of the referrals was not included in the Approved provider response. Full body physical assessments for all consumers have occurred to ensure that all emergent consumer needs have been identified and planned for accordingly with risk mitigation strategies implemented. No further information was provided in relation to this initiative, and it was not included on the Plan for continuous improvement. Falls education was provided to staff on 7 June 2023, no further details have been provided in relation to the number of staff who attended or the effectiveness of the education. Clinical leadership team meetings were re-established to clinical indicators are reviewed. A meeting occurred 18 May 2023, however, results or actions from the meeting have not been documented in the Plan for continuous improvement. All other improvement actions included in the Plan for continuous improvement and Approved provider response are yet to occur or to be established.

I am unable to determine the effectiveness of the improvement initiatives implemented as they are either yet to occur or in their infancy. These actions will require considerable time to be implemented, monitored, and reviewed for effectiveness. It is my decision high impact risks to consumers were not identified or effectively managed and Requirement 3(3)(b) is Non-compliant.

Consumers and representatives felt confident staff would provide end of life care in line with consumers’ preferences to maximise dignity and comfort. Consumers’ end of life care preferences were documented in a care plan, and staff discussed end of life preferences with consumers and representatives during case conferences and when consumers move through palliative care phases. Staff monitored consumers for comfort during end of life care and follow care plans for individualised consumer preferences. The service had an end of life and palliative care pathway to guide staff practice.

Consumers and representatives confirmed staff were able to identify when there had been a deterioration in consumers’ health status, and they were confident staff would notice when there was something wrong. Consumer care planning documentation reflected the identification of, and response to, deterioration or changes in a consumer’s condition. Registered staff explained the assessment process following changes to a consumer’s condition. Staff said they report changes to clinical management. If a consumer deteriorated after business hours, staff could call management or a Medical officer or transfer the consumer to hospital. Clinical records indicate consumers were regularly monitored by registered staff and if deterioration or change of a consumer’s mental, cognitive, or physical function, capacity or condition occurred, this was recognised and responded to in a timely manner and representatives were notified.

Consumers’ care needs and preferences were effectively communicated between staff. Care planning documentation contained adequate information to support effective and safe sharing of consumers’ information in providing care. Consumers’ care plans demonstrated staff notified consumers’ Medical officers and their representatives when the consumer experienced a change in condition or clinical incident, was transferred to, or returned from hospital, or was ordered a change in medication. Staff confirmed they received up to date information about consumers at handover.

Review of care documentation identified, and consumers and representatives confirmed, other health professionals assessed consumers and provided directives for their care. Management and staff described how changes in consumers’ health or well-being prompted referral to a relevant health professional. Staff were aware of the processes to initiate a referral and the service had documented procedures for inexperienced staff.

The service demonstrated effective processes for prevention and control of infection including management of an infectious outbreak and there were practices to promote evidence-based use of antibiotics. The service had a current outbreak management plan, policies, and procedures to guide staff in prevention and control of infection. Registered staff provided examples of practices to prevent and control infections such as hand hygiene, encouraging fluids, and the use of personal protective equipment.

# 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 confirmed the service’s lifestyle program supported consumers’ needs and said staff supported the consumer to participate in activities or pursue individual interests. Consumers care planning included a Life History Assessment and Lifestyle and Wellbeing Assessment which captured consumers’ background, individual needs, capabilities and interests and information about what was important to them. While consumers provided positive feedback regarding the lifestyle program, it was noted some lifestyle documentation was not complete including assessments, management stated they were in the process of employing a part-time lifestyle officer to support the lifestyle team.

Consumers and representatives described the services and activities provided by the service to support consumers’ emotional, spiritual, and psychological wellbeing. Staff also provided examples of how the service spiritually and psychologically supported consumers. A multi-denominational church service was held every Tuesday in the on-site chapel and a Catholic priest attends the service one day each month to support consumers. Consumer care documentation reviews reflected the spiritual and psychological needs of consumers, and their preferred level of engagement and subsequent need for encouragement by staff.

Consumers and representatives said consumers felt supported to participate in activities within the service and in the outside community. The service enabled consumers to maintain social and personal connections which were important to them. Staff provided examples of services and supports being adapted to a consumer’s needs when their situation changed. Care planning documentation identified the people important to individual consumers and the activities of interest to them.

Consumers and representatives confirmed services and supports were consistent, the staff knew consumers’ individual preferences and were confident information was recorded and shared with others when necessary. Staff explained they received information via a printed consumer care plan or via the electronic care system.

The service demonstrated appropriate referrals to other individuals, organisations, or providers and how they collaborated to meet the diverse needs of consumers. Lifestyle staff stated consumers living in the Memory support unit were referred to Dementia Services Australia for support with activities advice and materials and consumers without family connections were referred to the social support volunteer service. The activities calendar evidenced several external organisations providing service and support for activities.

Consumers expressed satisfaction with the meals provided at the service, and said meals were varied and of suitable quantity and quality. Consumers were provided with a choice of menu meals for each main meal, and alternatives were available if neither of the offered options were suitable. Staff explained internal communication and processes used to monitor and support the varying and changing nutritional, dietary and hydration needs of consumers. Consumers within the dining areas of the service were observed to be enjoying their meals and appeared to be in a relaxed and comfortable atmosphere.

Consumers felt safe when using equipment and knew how to report any concerns they may have about safety. Equipment being used in common and dining areas, lifestyle areas, and personal rooms was observed to be clean and maintained. Maintenance was promptly attended via service and equipment repair requests. Jobs requiring outside specialist assistance or skills were expedited promptly and monitored until finalisation.

# Standard 5

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

Findings

The service was welcoming, had wide corridors and suitable natural light and there was clear internal signage to different areas of the service. Communal areas included furniture with books and games, and the service had several indoor and outdoor common areas, a hairdresser facility, and a chapel. Consumers had personalised rooms decorated with furnishings and personal items which reflected individual tastes and styles.

The service grounds were expansive and well maintained and included areas that were accessible via communal doors or direct access from consumers’ rooms. The internal walls of the service displayed large photos of different local landmarks, locations, and memorabilia to remind and connect consumers with the surrounding area. Consumers living in the Memory support unit were observed be moving freely inside and outside and the service was clean and well maintained.

Consumers and representatives confirmed furniture, fittings and equipment were well maintained, clean and safe. Staff had processes in place to promptly address maintenance issues when required and issues could be escalated by way of categorising the urgency if necessary. The organisation and local maintenance staff had preventative maintenance schedules and reactive maintenance procedures were in place. All personal, social, and outdoor areas were observed to be clean and well maintained with clean and suitable furniture and fittings. Hand sanitiser was provided in various indoor communal areas and distributed throughout the service.

# 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

Consumers and representatives felt encouraged, safe, and supported to provide feedback and make complaints and could describe the various methods available for them to do so including speaking to management or staff directly. Staff described how they escalated consumers’ or representatives’ feedback or complaints to team leaders or assisted the consumer or representative to fill out feedback forms. Consumer and representative complaints were sourced from various sources including consumer meetings and surveys, or consumers reaching out to management directly.

Consumers and representatives confirmed they were comfortable to make a complaint internally and if they needed to make a complaint to an external advocacy service, they knew how to do this. Staff were aware of external feedback and complaint mechanisms and information on these services was made available and accessible to consumers. The Commission’s complaints brochure, external advocacy, and language services brochures were available in various languages and displayed at the service’s reception area and several the communal areas.

Consumers and representatives were not satisfied the service implemented appropriate actions to address complaints. Complaints documentation demonstrated the service did not involve consumers or representatives in the resolution process to ensure complainants were satisfied with outcomes. Management stated, and complaints documentation confirms, open disclosure was not always practised at the service. Three representatives provided feedback their concerns had not been addressed or remediated.

The Approved provider was disappointed several consumers and representatives were not satisfied in relation to the resolution of their complaints, and stated action has been taken to address the areas of improvement. Actions to address the deficiencies included ongoing discussions with consumers and representatives named in the report and any previous or further concerns to be documented in the incident management system. I am unable to determine the frequency of the discussions or the satisfaction of the consumers and representatives as this was not documented in the response. Key management at the service have commenced daily walk-arounds of the service. The Plan for continuous improvement noted the walk-arounds are proving to be a successful tool to engage with all stakeholders, there is no evidence included in the Approved provider response to support the success of this initiative. Feedback has been included as a standing agenda item at all meetings. Meeting minutes were not included in the response to gauge the effectiveness of this initiative. Education will be provided to staff in relation to managing feedback and open disclosure. The Plan for continuous improvement notes this action to be completed by 31 August 2023. A memorandum has been sent to residents and representatives relating to how they could escalate concerns and details of new key personnel appointed to the service.

While I acknowledge actions taken or to be commenced by the service demonstrates the service is committed to addressing deficits in relation to Requirement 6(3)(c), these actions have not been completed or assessed for their effectiveness, and therefore, this Requirement is Non-compliant.

Feedback and concerns raised directly with staff were not captured, recorded, or analysed to identify trends in complaints. Management confirmed that only issues raised in writing or directly with management appeared to be captured. The service was unable to provide evidence of improvements which have occurred because of consumer feedback. Management was unable to demonstrate a process for capturing and reviewing unsolicited feedback or concerns raised, contrary to the service’s complaints policy which outlined the documentation and escalation process.

Staff stated where issues or concerns were raised, they attempted to resolve these themselves. Staff do not complete any complaint or feedback documentation for issues raised while they are working. Staff said sometimes, depending on the concern raised, it may be added to the consumer’s progress notes.

The service’s Plan for continuous improvement and complaints register did not contain complaints or feedback as described by consumers and representatives, feedback obtained through consumer surveys, or other verbal feedback direct to staff.

The Approved provider’s response to the Site audit report included their disappointment the service was unable to demonstrate effective functioning of their complaints system, including improvements relating from feedback. Mandatory electronic training has been allocated to clinical staff to demonstrate the link between feedback and quality activities, this initiative is to be completed by 16 June 2023, therefore it has not been evaluated for effectiveness.

Actions have commenced to address deficiencies in Requirement 6(3)(d); however, these actions have not been completed or assessed for their effectiveness, and therefore, this Requirement is Non-compliant.

# 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

The service did not demonstrate the workforce was planned, and the mix of staff did not deliver safe and quality care and services. Five consumers and seven representatives provided feedback the service was understaffed, and consumers provided examples of impacts due to staff availability. Call bell data demonstrated extensive delays in call bell responses. Consumers stated their dignity had been compromised due to lack of staff availability.

Management confirmed the call bell times which demonstrated lengthy delays were accurate, and not affected by the system malfunction, however, was unable to provide evidence of any investigation into the significant delays in call bell response times. The call bell response times were monitored every three months; however, the service was unable to provide evidence of call bell trends and strategies to resolve and minimise call bell delays.

The Approved provider response to the Site audit report included meetings are to be held with each consumer or representative named in the Site audit report to apologise, discuss their feedback, and determine next steps to address individual concerns and rebuild trust in the provider. I am unable to determine what progress the service has made with this initiative through review of the Plan for continuous improvement or Approved provider response. Call bell response times are now analysed daily and call bell response times over ten minutes are investigated. A review of call bell response times completed 31 May 2023 indicate improvements in staff responsiveness, however there was no corresponding evidence submitted in the response to support this information.

A roster and staff review were undertaken, additional resources were sourced to ensure response to consumers is appropriate and existing staff are provided with additional resources during review and improvement activities. Additional registered nurse coverage commenced 6 June 2023 and 8 June 2023, following the sourcing of agency registered nurses. Four personal care staff commenced at the service 6 June 2023; these staff members were sourced through an agency. The renewal of a current agency registered nurse from 14 June 2023 was included in the Plan for continuous improvement, however I am unable to determine how long the extension of the agency registered nurse’s contract will be. Staffing arrangements will remain unchanged until the roster and allocation review are completed and necessary improvement has been implemented to return to business as usual. The completion date has been recorded for the roster and allocation review as 27 June 2023.

While impacts to consumer dignity have been discussed in Requirement 1(3)(a) and this Requirement has been found to be Non-compliant, I have considered this information relates to sufficiency of staffing rather than staff interactions, and therefore I consider Requirement 7(3)(b) is Compliant. Consumers and representatives provided positive feedback in relation to workforce interactions and confirmed staff were kind and caring and treated consumers well. Staff demonstrated an understanding of sampled consumers, including their identity, culture, needs, and preferences. Management used consumer and representative feedback to monitor staff behaviour and ensure interactions between staff and consumers met the organisation’s expectations. The service had policies to guide staff, and staff received training in relation to consumer diversity and inclusion.

The service was unable to demonstrate effective monitoring of staff competency to ensure staff had the correct qualifications and knowledge to perform their roles. Representatives raised concerns around staff competency, relating to medication administration. A register of registered staff registrations did not contain all registered staff employed at the service. Staff did not demonstrate a shared understanding of restrictive practices and incident reporting.

The Approved provider in its response to the Site audit report in relation to Requirement 7(3)(c) stated their disappointment that they were unable to demonstrate staff had the necessary qualifications and knowledge and were competent to perform their roles. Actions taken by the Approved provider in addressing the deficiencies in this Requirement have included an apology provided to the named consumer representative, who questioned the skills of staff administering medication. A process to monitor staff registrations has been re-established and is maintained by human resource staff. To address the gaps in skills and knowledge of staff in relation to restrictive practices, incident management and ant-microbial stewardship, education has been delivered in these aspects. I am unable to determine the effectiveness of training provided. A Nurse practitioner will be providing coaching to senior clinical staff commencing 12 June 2023, the application of knowledge will be monitored by the Nurse practitioner through clinical monitoring processes.

Requirement 7(3)(c) is Non-compliant as the Approved provider has not had sufficient time to evaluate the effectiveness of education provided to address the gaps in staff knowledge.

The service did not demonstrate the workforce was supported to deliver effective outcomes. The service did not demonstrate review processes in relation to the learning, needs and development of the workforce. Staff felt the service did not provide enough support to perform their roles effectively. Training records confirmed 30% of the workforce were not current with mandatory training. For one staff member in a supervisory position, feedback was provided they felt they were not properly trained for their role. Two other staff provided feedback they had either not been provided with supervised shifts on commencement or required additional training to perform their role.

The Approved provider in its response acknowledged there were gaps in mandatory training completion and training and support for staff to feel comfortable in their roles. Actions taken by the Approved provider to address deficiencies in this Requirement have included a requirement for staff to complete mandatory training by 16 June 2023, this will be monitored by weekly reports reviewed by management. Staff duties and responsibilities are under review to include all shifts based on consumer acuity. Regional support staff were deployed to support the staff member in the supervisory role. Staff are required to document they have received two supervised shifts and confirm they feel confident and competent.

Actions to address the deficiencies in this Requirement have commenced but have not been completed to assess the effectiveness of these actions. Therefore, Requirement 7(3)(d) is Non-compliant.

The service did not demonstrate regular assessment, monitoring and review of performance of any member of the workforce. Management confirmed performance reviews were out of date and staff confirmed they had not received a review of performance. Management was unable to provide evidence of regular assessment, monitoring and review of the performance for any staff member. Management was unable to explain how staff performance was monitored. All staff confirmed they had not received a performance review.

The Approved provided stated it was disappointed that the organisational performance management system was not effectively implemented during the Site audit. Actions taken to address the deficiencies in this Requirement include all staff will have a performance development conversation with the relevant Head of Department by 7 July 2023. A tracker relating to the completion of performance development conversations will be monitored for completion rates.

As these initiatives are in their infancy, it is my decision Requirement 7(3)(e) is Non-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

The service did not demonstrate its approach to involve consumers in developing, delivering, and evaluating their care and services. Representatives did not feel listened to, and consumers and representatives confirmed the service was not engaging them in the development, delivery and evaluation of care and services. While management stated information was gathered from consumer advisory groups, consumer meetings and consumer feedback, they were unable to provide evidence or documentation relating to consumer feedback. Management could not demonstrate how the service had addressed or improved care and services driven by an issue raised by a consumer.

The Plan for continuous improvement submitted by the Approved provider indicates the reestablishment of the continuous improvement system has occurred and will include a review of the internal monitoring program. Consumer engagement will occur to ensure consumers and representatives feel valued, listened to, and engaged in the delivery, development and evaluation of care and services. The voice of consumers will be encouraged through the completion of surveys.

The Approved provider will require time to embed processes relating to a continuous improvement system and to gain feedback from consumers and representative and therefore it is my decision Requirement 8(3)(a) is Non-compliant.

The service did not demonstrate how the organisation’s governing body promoted a culture of safe, inclusive, and quality care and services. While the service was able to demonstrate ways communication was transferred from the governing body, the service did not demonstrate how the governing body was accountable for the delivery of care and services. Management could not provide documentation on ways the governing body ensured the Quality Standards were being met. Care documentation identified not all incidents were reported, investigated, and analysed to inform the delivery of safe and effective care and services or to identify areas of improvement. Management confirmed while internal reporting was sent to the governing body, no further communication regarding the reports or significant trends was received from the governing body to support the service to monitor or reduce significant trends in data.

The Approved provider in its response refutes the information recorded in the Site audit report relating to management being unable to identify the most significant incident relating to the safety of consumers in the past year, and management being unable to provide an example of continuous improvement action driven by the Board. I have considered the Approved provider’s response in my decision, however, I also note improvement actions required in this Requirement include re-establishing compliance with organisational systems, to ensure escalation and reporting of information occurs. This information supports my decision of Non-compliance in Requirement 8(3)(b) as the organisation’s governing body was unaware of circumstances at the service and that organisational systems were not being effectively utilised or monitored.

The service was not able to demonstrate there were effective organisation wide governance systems in place as deficiencies were identified in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and Negative feedback was received from a representative in relation to the information/ received from the service in relation to the deterioration of their loved one. Information requested by the Assessment Team was not provided by the service in a timely manner or not provided. Management was unable to identify an example of a continuous improvement action supported by the Board, or as a result of consumer feedback. The service was unable to demonstrate processes were in place to ensure enough adequately skilled and qualified staff were available to ensure delivery of safe, quality care and services. Four of five Requirements in Standard 7 Human resources are Non-compliant which does not support effective workforce governance. Regulatory compliance requirements were not completed in relation to restrictive practices and reporting of serious incidents. The service was unable to identify trends in complaints or how complaint resolution strategies were discussed with consumers and representatives.

The Approved provider in its response to this Requirement has noted Regional and organisational support teams have been to support the review of the services at the service and re-establish compliance with organisational systems. This includes re-establishing continuous improvement systems, workforce governance systems, incident management system, feedback and complaints system and the risk management system.

It is my decision that if the re-establishment of vital and core systems need to be re-established, this will take time to implement and evaluate, therefore it is my decision Requirement 8(3)(c) is Non-compliant.

The service did not demonstrate effective risk management systems and practices to help identify the health, safety, and wellbeing of each consumer. There was inconsistency between the governing body and management’s understanding of the service’s high prevalence risks, and management was unable to provide strategies to prevent and mitigate high impact and high prevalence risks. The service did not demonstrate how it appropriately responded to abuse and neglect of consumers, and management could not explain how incidents were monitored or prevented. While consumers were encouraged to take risks, a review of consumers’ dignity of risk information demonstrated the information was a risk assessment of the activity only and lacked substantial evidence of discussion with the consumer or representative of the hazards and risks.

The Approved provider has provided information in their response to a previous Requirement that the risk management system requires re-establishing at the service to ensure effective reporting, investigation, and analysis of risk. The Approved provider has also suspended any new consumers entering the service until they are confident that care and support needs for all current consumers are being met.

In the absence of an effective risk management system in place, it is my decision Requirement 8(3)(d) is Non-complaint.

The service was unable to demonstrate initiatives to reduce inappropriate antibiotic usage. The service provided examples of where it had minimised the use of restrictive practices however was unable to demonstrate open disclosure is always practised. Management was unable to provide evidence on ways the service was supporting staff to reduce inappropriate antibiotic usage and resistance. The service did not always use open disclosure and management confirmed they only conducts open disclosure for significant incidents.

The Approved provider has stated the organisation has a highly developed clinical governance framework that works to support the provision of safe and effective care of consumers, and the service is working towards re-establishing organisational processes relating to antimicrobial stewardship, restrictive practices and open disclosure.

In the absence of an effective clinical governance framework, it is my decision Requirement 8(3)(e) is Non-Compliant.

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