Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Blue Care Redcliffe Aged Care Facility |
| Service address: | 91 Anzac Avenue Redcliffe QLD 4020 |
| Commission ID: | 5750 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 3 May 2023 to 5 May 2023 |
| Performance report date: | 8 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 Redcliffe Aged Care Facility (**the service**) has been prepared by P. Sherin, 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 30 May 2023 submitting additional information;
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

|  |  |
| --- | --- |
| 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 | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 1(3)(a) - Ensure each consumer is treated with dignity and respect.
* Requirement 2(3)(e) - Ensure regular review of care and services for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer.
* Requirement 3(3)(a) - Ensure safe and effective personal and clinical care in relation to provision of continence care and monitoring and management of restrictive practices.
* Requirement 3(3)(f) - Provide timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 7(3)(a) - Ensure staffing levels are sufficient to enable the provision of care and services in a timely manner.
* Requirement 8(3)(c) - Ensure effective organisation-wide governance systems for workforce governance and regulatory compliance.
* Requirement 8(3)(e) - Implement an effective clinical governance framework in relation to clinical care, timely and appropriate referrals, and management of restrictive practices.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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

Having considered the Site audit report and the Approved provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating the dignity of each consumer is maintained.

I have made this decision based on the following analysis.

*Requirement 1(3)(a)*

**Site audit report**. The assessment team's audit report identified the following deficiencies:

* Three consumers, including one consumer who chose to remain anonymous, and one representative expressed concerns regarding consumers’ dignity not being maintained by having to wait long periods of time for toileting assistance from staff, including experiencing frequent episodes of incontinence as a result.
* Consumers who were immobile or required staff assistance for toileting advised they felt ‘embarrassed’, ‘felt forgotten’ and ‘very, very uncomfortable’.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* Documentary evidence was submitted to demonstrate meetings have been arranged with the identified consumers and representative in the Site audit report to provide an apology and discuss their feedback.
* The provider referred to consumer surveys which identified satisfaction with privacy and dignity. I note the surveys were conducted prior to the Site audit and did not capture all consumers and/or representatives at the service.
* Actions planned and implemented to address deficits in this Requirement include additional call bell monitoring and analysis of response times, dignity and respect training of staff with a focus on impact of delays in attending to continence care needs, utilisation of workplace practice monitoring tools to monitor staff practice, and completion of consumer surveys to solicit feedback capturing 100% consumers and representatives.

**Assessment**. Having considered the Site audit report and the provider's response, I am not satisfied the service has demonstrated each consumer is treated with dignity and respect. I have based this decision on the following:

* I note the negative impact on consumers with their dignity not being maintained; whilst complaints have been logged by the service, nil evidence has been provided to demonstrate these complaints are now resolved and the issue is no longer occurring.
* Improvement actions have not been fully implemented, will require time to be embedded within the service’s processes, and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 5 requirements of Quality Standard 1 are compliant as:

Consumers and representatives confirmed the service recognises and respects consumers’ cultural background and supports them in expressing their cultural identity and interests. Staff demonstrated knowledge of consumers from culturally diverse backgrounds and their preferences which aligned with information under care planning documentation. The service celebrates various cultural events related to the backgrounds of the consumer cohort as part of its lifestyle calendar.

Consumers and representatives said consumers are supported to maintain relationships and exercise choice and independence. Staff described how consumers are supported to make informed choices about their care and services such as through menu selection, participation in activities, choosing their care preferences and who they wish to be involved in decisions about their care.

Consumers said they are supported to take risks to enable them to live the best life they can. Staff demonstrated awareness of risks taken by consumers and described how the service supports consumers’ wishes to take those risks. Review of care planning documentation identified signed dignity of risk forms for consumers who choose to engage in activities of risk. A consumer choice and decision-making framework is available to guide staff practice.

Consumers and representatives said information is provided to assist consumers in making choices such as lifestyle activities and meal selections. Consumers attend consumer meetings and food focus groups where information is provided. A range of information such as a monthly activities planner, daily menu, feedback forms and advocacy material was observed available to consumers around the service.

Staff advised they receive privacy training and were observed accessing consumer information under the electronic care management system securely, knocking on doors before entering consumers’ rooms and seeking consent prior to attending to consumers. Consumers and representatives confirmed consumers’ personal privacy is respected and information is kept confidential.

# Standard 2

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

Findings

Having considered the Site audit report and the provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not ensuring regular review of care and services for effectiveness in consumers with multiple falls and escalating behaviours.

I have made this decision based on the following analysis.

*Requirement 2(3)(d)*

The assessment team brought forward information to evidence the outcomes of assessment and planning were not always communicated to consumers and representatives, and/or ensuring these were up to date. One named representative advised they utilised the services of an advocacy agency to gain access to a copy of the consumer’s care plan, however the copy provided was not current. One representative who chose to remain anonymous said they requested for the consumer’s care plan copy over a period of 6 months and still did not have one. Staff were unfamiliar with how consumers and representatives could access a copy of consumers’ current care plan. Review of the service’s plan for continuous improvement identified the service had identified this issue in February 2023 with planned actions to circulate information on accessing care plans via consumer meetings and case conferences with no completion date.

The provider in its response advised a copy of the consumer’s care plan was provided to the named representative in the Site audit report. The provider submitted evidence of consumer and representative meeting minutes and registered staff meeting minutes where information on accessing care plans had been disseminated, and where all representatives were offered a case conference in March and April 2023. Evidence was provided to demonstrate a memo was circulated to consumers and representatives in May 2023 on how to access a printed copy of the care plan. Access to care plans has been included as a standard agenda item on consumer and representative meetings.

I have considered the information provided by the assessment team and the provider and am satisfied the provider has demonstrated actions to effectively communicate and make available a copy of the care and services plan to consumers and representatives.

I, therefore, find this Requirement is compliant.

*Requirement 2(3)(e)*

**Site audit report**. The assessment team's audit report identified the following deficiencies regarding the service not regularly reviewing the effectiveness of care and services for consumers with multiple falling incidents or ongoing behaviour escalations.

* Some representatives who wished to remain anonymous said they do not always receive communication from the service until several days after an incident has occurred.
* The representative of one consumer who has had 4 falls in recent months including requiring hospitalisation said they raised concerns with the service that ‘not enough is happening to investigate the falls’, however no changes have been made.
* Review of documentation for one named consumer who experienced 15 falls over a period of 4 months including hospitalisation with injuries identified there had been no investigation and/or change in strategies following physiotherapist, nurse practitioner and medical officer review after each fall.
* For one named consumer with escalating behaviours, there had been no consideration of individualised behaviour management strategies or referral to a dementia support service.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider acknowledged that some care plans had not been reviewed for effectiveness as this was the responsibility of the service’s Care Coordinator; the position was vacant at the time of the Site audit and a new Care Coordinator has been appointed 9 May 2023 to strengthen clinical monitoring and oversight processes at the service.
* An external nurse advisor has commenced late May 2023 to coach and mentor the service’s clinical team and ensure clinical follow-up occurs.
* Planned improvement actions include a thorough analysis to be conducted for the 2 consumers who experience frequent falls as per the Site audit report; falls prevention education to staff; behaviour charting commenced for consumers with escalating behaviours and referrals to be organised where required; introduction of weekly clinical leadership meetings; enhancement of daily huddles; and review of care plan review and case conference processes.

**Assessment**. Having considered the Site audit report and the provider's response, whilst I acknowledge the efforts by the provider to strengthen its performance in this Requirement, I am not satisfied the service has demonstrated regular review of care and services for effectiveness. I have based this decision on the following:

* Improvement actions have not been fully implemented and will require time to be embedded within the service’s processes and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 3 Requirements of Quality Standard 2 are compliant as:

Consumers and representatives said staff understand the consumers’ needs and they had input into how they would like care and services delivered. Review of care planning documentation identified assessments include the consideration of risks to consumers’ health and wellbeing. In response to feedback regarding some assessments not being activated in the system and therefore not appearing under consumers’ care plans, management implemented improvement actions to review care plans and provide staff education to ensure activation of care and services is completed.

Care planning documentation identified, and consumers and representatives confirmed, consumers’ needs, goals and preferences are addressed as part of assessment and care planning. Care documentation captured advance care planning and end of life wishes where the consumer and/or representative have chosen to do this. Staff described how end of life wishes are discussed as part of entry to the service, during case conferences and if a consumer’s condition deteriorates.

Consumers and representatives confirmed they are involved and consulted during the assessment, care planning and review process. Review of care planning documentation identified the service has access to and involves a range of health professionals, providers and organisations to support consumers’ needs.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Having considered the Site audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not ensuring safe and effective continence care and management of restrictive practices.
* The service is not ensuring timely referrals to health professionals for some consumers experiencing multiple falls and escalating behaviours.

I have made this decision based on the following analysis.

*Requirement 3(3)(a)*

**Site audit report**. The assessment team's audit report identified the following deficiencies:

* The service was unable to demonstrate it delivers continence care in line with individual consumers’ needs, goals and preferences. Three consumers and one representative expressed concerns regarding consumers not receiving toileting assistance within a timely manner and having to wait extended periods of time for assistance with hygiene cares when they were incontinent.
* Care documentation for 3 consumers who require staff assistance with toileting identified multiple recent episodes of incontinence. A review of the service’s plan for continuous improvement identified an open improvement action since 24 February 2023 in relation to complaints on continence care.
* Staff and management were unable to demonstrate a shared understanding of chemical restrictive practices with a total of 9 consumers identified by the assessment team as receiving a chemical restraint without appropriate authorisations and consent forms in place.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider in its response advised meetings have been arranged with the identified consumers and representative in the Site audit report to provide an apology and discuss their feedback in relation to continence care. Further improvement actions planned and implemented are outlined under Requirement 1(3)(a) above.
* Regarding restrictive practice, the provider accepted the service has not consistently demonstrated a shared understanding of chemical restrictive practice. Improvement actions planned in this regard include full review and update of the service’s psychotropic register, engagement with an external provider for education to registered staff on restrictive practice and knowledge test to be completed by end of June 2023, and weekly updates of the psychotropic register by the service’s Quality Officer.

**Assessment**. Having considered the Site audit report and the provider's response, I am not satisfied the service has demonstrated each consumer receives safe and effective care in relation to continence care, and monitoring and management of restrictive practice. I have based this decision on the following:

* I note the negative impact on consumers in relation to provision of continence care; whilst complaints have been logged by the service, nil evidence has been provided to demonstrate these complaints are now resolved and the issue is no longer occurring.
* Improvement actions regarding monitoring and management of restrictive practice have not been fully implemented and will require time to be embedded within the service’s processes and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

*Requirement 3(3)(f)*

**Site audit report**. The assessment team's audit report brought forward evidence the service was not ensuring timely referrals to health professionals for some consumers experiencing multiple falls and behavioural incidents.

* Three representatives expressed concerns regarding the service not referring consumers to specialist services despite multiple requests.
* For one consumer who experienced 15 falls within a 4-month period including hospital transfer and fracture, no strategies had been updated following physiotherapist review or additional referrals considered.
* The representative of one consumer who has had 4 falls in recent months including fractures said they raised concerns with the service that ‘not enough is happening to investigate the falls’, however no changes have been made.
* One representative advised the service does not respond promptly to personal or clinical needs change and that the family has had to arrange referrals.
* Following feedback by the assessment team, management acknowledged some consumers should have been referred for a review by a specialist service and that these consumers’ referrals would be initiated.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* Improvement actions implemented and planned include meetings with the service’s General practitioner to discuss the need for referrals; a clinical review commenced by the Nurse Practitioner for all consumers identified in the Site audit report to action appropriate referrals; toolbox talks to be organised for staff on recognition of escalation in behaviours and actions required; and review of the service’s referrals processes.

**Assessment**. Having considered the Site audit report and the provider's response, I am not satisfied timely and appropriate referrals occur to individuals, organisations and providers of other care and services. I have based this decision on the following:

* All required referrals have not been completed, improvement actions have yet to be fully implemented and need testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 5 requirements of Quality Standard 3 are compliant as:

The service demonstrated high impact and high prevalence risks to consumers are managed effectively via clinical review, which includes other health professionals when required. Staff could describe the main risks to consumers and the risk mitigation strategies used in relation to these. Management review, trend and analyse clinical incident and quality indicator data which is discussed at staff meetings and reported both within the organisation and externally.

Consumers and representatives said they felt confident in the service’s ability to manage consumers’ end of life needs and wishes. Staff could describe how they support consumers at the end of life stage to ensure their comfort and dignity.

Staff were able to describe, and review of care documentation confirmed, changes in consumers’ condition is identified and responded to in a timely manner. Most consumers and representatives confirmed consumers’ care needs and preferences are communicated between staff. Staff confirmed they receive up to date information about changes in a consumer’s care needs and condition via handover and notes in the daily register.

The service has an outbreak management plan, policies and procedures to guide staff in infection prevention and control, and antibiotic management. The service has appointed an infection prevention and control lead who conducts weekly staff training on infection control practices and the use of personal protective equipment. Infections are reported, analysed and reviewed via monthly reports.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 said consumers are supported to engage in activities of interest to them and are provided with relevant supports to promote their well-being, independence, and quality of life. The assessment team observed consumers participating in a range of activities including exercise-based programs and social gatherings such as sing-along activities during the Site audit.

Consumers and representatives said the service provides emotional, spiritual, and psychological support to consumers when needed. Care planning documentation identified information regarding the emotional, spiritual, and psychological needs of individual consumers. The organisation engages a full-time Pastor who visits the service twice a week, facilitates non-denominational religious services, and provides consumers with one-on-one support.

Consumers and representatives described how the service supports consumers to participate in the community and do things of interest to them. Various activities such as bus trips, concerts, and happy hour are available to encourage consumers to socialise within the service. Staff demonstrated awareness of those consumers who have developed a friendship and relationships of importance, which aligned with information under care planning documentation.

Consumers said services and supports are consistent and staff know their individual preferences and other organisations that may be involved in their care and services. Staff described how they are updated on the changing condition, needs or preferences of consumers as they relate to services and supports for daily living, including via staff handover and notifications under the electronic care management system.

Care planning documentation reflected the involvement of others in the provision of services and supports for daily living. Staff were able to describe how the service partners with and organises referrals to various individuals and providers and gave examples of where consumers have been supported such as by organising volunteers through local community organisations.

Overall consumers and representatives said the meals are satisfying, varied and of suitable quality and quantity. Consumers have input into the menu through monthly consumer meetings and food focus groups. Alternative meal options are available for consumers if they do not prefer a meal offered on the menu. Care planning documentation identified dietary needs and preferences for consumers.

Consumers reported having access to equipment, including mobility aids and wheelchairs which are safe, and they were aware of how to report any issues with equipment. The service has processes for purchasing, servicing, and replacing equipment. Equipment used to support consumers to engage in lifestyle activities was observed to be suitable, clean, and well-maintained.

I find this Standard compliant as I find all Requirements are compliant.

# Standard 5

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

Findings

Consumers and representatives said they find the service welcoming and enjoy the covered courtyard and outdoor areas. The service has 3 levels of residential areas accessible through a centralised lift system. Each floor has an area for activities and a dining room, with the first floor providing space for religious services. The service has wide hallways with signage to assist with navigation.

The service’s internal and external environment was observed to be clean, safe, comfortable, and well maintained for consumers to move freely and enjoy. Consumers described how they like to spend time in these areas and celebrate special occasions with family and friends and said they were satisfied with the cleanliness of the environment, including their room. Cleaning tasks are scheduled and monitored daily, and cleaning audits occur. Whilst malodour was observed in 2 consumer rooms due to the presence of a urinary incontinence device, management confirmed carpeting in the room is scheduled for replacement with vinyl, and additional measures have been implemented such as odour neutralisers, weekly steam cleans and daily spot checks.

The service’s equipment, fittings and furnishings were observed to be well maintained, clean and safe for consumer use. Staff described how shared equipment is cleaned between use and confirmed processes are in place to promptly identify and attend to maintenance issues or hazards. Maintenance staff have preventative and reactive maintenance schedules in place.

I find this Standard compliant as I find all Requirements are compliant.

# Standard 6

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

Findings

Consumers and representatives said they feel encouraged, safe and supported to provide feedback and make complaints, and could describe the various methods available to do so including speaking to management or staff directly, during consumer meetings, and through the use of feedback forms. The assessment team observed feedback forms and return boxes located in common areas throughout the service.

Consumers and representatives said they are aware of advocacy and language services available to them and referenced the promotional material displayed at the service. The service utilises staff to provide translation for a small number of consumers and advised they were aware of how to access interpreter services for consumers, should this be required. The assessment team observed information about advocacy, language services and external complaints mechanisms displayed around the service.

Consumers and representatives expressed confidence management would address complaints and attempt to resolve any concerns promptly. Management and staff demonstrated a shared understanding of processes to follow when a complaint is received and of open disclosure principles. Staff advised they initially try to resolve any issues and report it to the registered staff or management. The service has policies and procedures on feedback and complaints management, and open disclosure.

Management advised the service trends and analyses complaints and feedback and uses this information to inform continuous improvement activities which are documented under the service’s plan for continuous improvement. Consumers and representatives expressed confidence in the service utilising feedback to make improvements, and review of the service’s plan for continuous improvement reflected this.

I find this Standard compliant as I find all Requirements are compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Having considered the Site audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not ensuring staffing levels are sufficient to provide care and services in a timely manner specifically to meet the toileting and hygiene care needs of consumers.

I have made this decision based on the following analysis.

*Requirement 7(3)(a)*

**Site audit report**. The assessment team's audit report evidenced deficiencies specifically in relation to the following:

* Three consumers and one representative expressed concerns regarding having to wait long periods of time for toileting assistance from staff, including experiencing episodes of incontinence.
* Staff confirmed they are unable to meet the toileting and hygiene needs of consumers, particularly in peak periods.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider advised meetings have been arranged with the identified consumers and representative in the Site audit report to provide an apology and discuss their feedback in relation to continence care.
* Further improvement actions planned include daily monitoring of call bell response times and investigation of overlength call bells; review of the call bell escalation process; review of shower lists and duty guide lists; and ongoing monitoring of consumer and staff feedback received via different avenues.

**Assessment**. Having considered the Site audit report and the Provider's response, I am not satisfied the service has demonstrated staffing levels are sufficient to ensure the timely provision of toileting and hygiene care needs of consumers. I have based this decision on the following:

* I note the negative impact extended wait times have had on consumers; whilst their complaints have been logged by the service, nil evidence has been provided to demonstrate these complaints are now resolved and the issue is no longer occurring.
* Improvement actions have not been fully implemented and will require testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 4 requirements of Quality Standard 7 are compliant as:

Consumers and representatives considered consumers are treated kindly and with respect. Management said they use consumer/representative feedback through complaints and surveys to monitor staff behaviour and to ensure interactions between staff and consumers meet the organisation’s expectations. Staff were observed assisting consumers with their meals with patience and speaking to consumers in a kind and caring manner.

Consumers and representatives said they felt the workforce is competent and staff have the knowledge to deliver care and services that meets consumer needs. Staff reported receiving support to ensure they have the skills and knowledge to undertake their roles. Management discussed processes in place to ensure criminal record checks and qualifications of staff prior to commencement. Review of the service’s police check register identified all staff criminal record checks are up to date.

Consumers and representatives were satisfied staff are trained to provide safe and effective care. Staff considered they are appropriately trained, supported, and equipped to perform their roles. Management monitor staff compliance with mandatory training through an electronic learning management system and provide staff additional training where the need is identified. Review of training records identify staff receive training on a range of topics including but not limited to consumer protection, hand hygiene, infection control, code of conduct and privacy awareness.

The service demonstrated systems are in place to regularly assess, monitor and review staff performance. Staff confirmed they are engaged in their professional development including opportunities to request specific training relevant to their role. Management advised staff performance is monitored through observations, analysis of clinical data and consumer and representative feedback. Any issues in performance identified through these monitoring mechanisms are addressed immediately and trigger a performance review.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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. | 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

Having considered the Site audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating effective organisation-wide governance systems for workforce governance and regulatory compliance.
* The service is not demonstrating effective implementation of a clinical governance framework in relation to identifying deficits in clinical care, timely and appropriate referrals, and management of restrictive practices.

I have made this decision based on the following analysis.

*Requirement 8(3)(c)*

**Site audit report**. The assessment team's audit report identified the following deficiencies:

* The assessment team brought forward information to evidence gaps in communication and recording of information have resulted in deficiencies in information management. Two representatives reported not receiving copies of consumer care plans despite multiple requests and staff were unfamiliar with how consumers and representatives could access care plans.
* The service was unable to demonstrate workforce governance in relation to appropriate workforce planning to ensure the number of staff deployed enables the delivery of care and services in a timely manner, specifically provision of toileting assistance and continence care. Refer to Requirement 7(3)(a) for information more broadly.
* Review of the service’s psychotropic register identified consumers subject to chemical restraint without appropriate assessment, consent, monitoring and review in place in compliance with regulatory obligations. Refer to Requirement 3(3)(a) for information more broadly.

**Approved Provider’s response**. The provider responded to the issues identified in the Site audit report as follows:

* The provider advised meetings have been arranged with the identified consumers and representative in the Site audit report to provide an apology and discuss their feedback in relation to continence care.
* Further improvement actions planned include daily monitoring of call bell response times and investigation of overlength call bells; review of call bell escalation process; review of shower lists and duty guide lists; and ongoing monitoring of consumer and staff feedback received via different avenues.
* The provider advised of additional actions implemented and planned as outlined under Requirements 2(3)(d), 3(3)(a) and 7(3)(a) above.

**Assessment**. Having considered the Site audit report and the provider's response, I am satisfied the provider has demonstrated improvement actions to rectify deficits in relation to information management as captured under Requirement 2(3)(d) above.

However, I am not satisfied the service has demonstrated effective organisation wide governance systems in relation to workforce governance and regulatory compliance with restrictive practice requirements. I have based this decision on the following:

* Improvement actions have not been fully implemented and will require testing to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

*Requirement 8(3)(e)*

The assessment team brought forward information to evidence implementation of the service’s clinical governance framework has been ineffective in identifying deficits in the provision of clinical and personal care, management of restrictive practices and timely and appropriate referrals as outlined under Requirements 2(3)(e), 3(3)(a) and 3(3)(f) above.

The provider in its response submitted additional information regarding actions implemented and planned as outlined under Requirements 2(3)(e), 3(3)(a) and 3(3)(f) above.

I have considered information submitted by the assessment team and the provider; I am not satisfied the provider has demonstrated effective implementation of the clinical governance framework. Improvement actions have not been fully implemented and will require testing for effectiveness and sustainability.

I, therefore, find this Requirement non-compliant.

I find the remaining 3 requirements of Quality Standard 8 are compliant as:

Management described various ways consumers are supported to be engaged in the development, delivery and evaluation of care and services, including via monthly consumer/representative and food focus meetings, quarterly organisational surveys, care plan reviews and through feedback forms. Consumers said they felt the service is well run and they can provide feedback and suggestions to management through multiple forums which is considered.

The organisation’s governance framework identifies a leadership structure with the governing body holding overall accountability for quality and safety. The service conducts regular quality audits and monthly quality meetings with reporting of information including but not limited to clinical indicators and operational risks, to the organisation’s Clinical and Quality Governance Committee. The governing body uses this information to identify the service’s compliance with the Quality Standards, enhance performance and mitigate risks, and to monitor overall care and service delivery.

The organisation has policies describing how to manage high impact and high prevalence risks, respond to abuse and neglect, support consumer choice and decision-making, and report and manage incidents. Staff were aware of these policies and able to describe what they meant for them in a practical way. Review of the service’s incident management system identified incidents requiring notification under the Serious incident response scheme were reported within regulatory timeframes. Management advised all incidents are recorded within the service’s incident management system and investigated to identify causes and implement actions to prevent recurrence.

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