Blue Care Shalom Elders Village

Performance Report

190 Hervey Range Road   
CONDON QLD 4815  
Phone number: 07 4722 7100

**Commission ID:** 5753

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

**Site Audit date:** 31 May 2022 to 2 June 2022

**Date of Performance Report:** 1 July 2022

# Performance report prepared by

Susan Turner, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information has been taken into account in developing this 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 and representatives and others
* the provider’s response to the Site Audit report received 23 June 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers and representatives considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Consumer and representatives said they feel safe at the service.

Consumers and representatives were satisfied that staff respect their cultural needs and individuality. Consumers said they can decorate their rooms with items that are significant to them. They said staff speak to them in a kind respectful manner, ‘take time to yarn’ with them and address them by their preferred name or title including Aunty and Uncle.

Consumers and representatives described how consumers are supported to make decisions about their care and services, including in relation to meals, personal care, and activities. Consumers described maintaining relationships of choice through receiving visitors to the service and accessing home stays. Staff described how they supported consumers to maintain relationships with family/significant others and friends, and access the local community.

Staff consistently spoke about consumers in a way that indicated respect and an understanding of their personal circumstances and how they wish to be treated. Staff did not have concerns about the way staff treat consumers and said, if they did, they would report to management.

Care staff demonstrated they are familiar with consumers’ culture and backgrounds and gave examples of how that influences the care they provide, including cultural preferences for personal care, languages spoken and celebration of culturally significant events.

Consumers and representatives gave examples of where consumers have chosen to take risks and staff described how they support consumers to take risks. This was consistent with information in consumers’ care documentation which demonstrated risk assessments had been completed and strategies to managing risks identified. Information brought forward by the Assessment Team about consumers not following strategies to minimise risks to them for chosen activities has been considered under Standard 2.

Consumers and representatives were satisfied with the information provided to them and said generally staff verbally communicate information to them each day. The Assessment Team observed staff adjusting their communication style when engaging with consumers, and various information displayed throughout the service such as lifestyle activities (including in picture form), the daily menu, feedback mechanisms and consumer rights. The consumer handbook provides consumers with various information about the care and services available.

Consumers and representatives provided examples of how staff respect consumers’ personal privacy, such as knocking and announcing themselves before being given consent to enter their rooms and allowing them privacy when spending time with significant others. Staff described the practical ways they respect the personal privacy of the consumers. Staff were observed to be discreet when offering assistance to consumers.

Consumers’ care documentation generally reflected what is important to the consumer and provided information to guide staff in delivering care in accordance with consumers’ need and preferences.

Governance documentation describes actions taken in response to feedback provided about culturally significant events and incidents.

Staff are guided by organisational policies relevant to this Quality Standard and have received education, including on topics such as dignity and choice.

The Quality Standard is assessed as compliant as six of the six specific requirements have been assessed as compliant.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Overall, consumers and representatives felt involved in the ongoing assessment and planning of their care and services. Consumers and representatives expressed confidence in the workforce to support them and advised staff are responsive to their needs and preferences.

Whilst most consumers and representatives did not have a copy of a care plan, they felt involved in planning consumers’ care and were confident staff would provide them a copy if requested. Most consumers and representatives advised staff discuss consumers’ care and services with them and would approach staff if they had questions or concerns about care needs or delivery.

Consumers advised they were confident talking to staff about their changed care needs and were aware of changes made to their care and services as directed by medical officers or other health professionals, including in relation to medication, diet and mobility. Representatives said the service informs they about any changes or when incidents occur.

Management and staff advised that registered staff undertake comprehensive assessments on admission to the service and ongoing assessments and planning, which informs care plans. Registered staff described how other health professionals are involved in assessment and care planning processes.

Care staff reported they receive information about consumers’ needs and preferences via consumer care plans, shift handovers and talking to consumers at the time of care delivery. Care staff advised they would inform registered staff if they identified a change in care needs for a consumer.

Care documentation included, but was not limited to, assessment and planning in relation to pain management, skin integrity, behaviour management, nutrition and hydration and mobility and risks to consumers. Most consumers’ care plans demonstrated involvement of consumers and representatives in assessment and planning and other health professionals such as medical officers, allied health professionals and the National Disability Insurance Scheme (NDIS) where appropriate. Whilst needs and preferences of some consumers were not documented, staff demonstrated understanding of these consumers’ needs and preferences and consumers reported high levels of satisfaction with their care.

Care planning documentation was available in electronic and hard copy formats. Care documentation was observed by the Assessment Team to be readily available to staff and visiting health professionals relevant to their role. The Assessment Team observed hard copies of the consumers’ summary care plans available to care staff in the nurse’s station.

The Assessment Team observed care staff to be regularly engaging with NDIS care staff about relevant consumers.

Organisational policies and procedures and a suite of evidence-based assessment tools are available to guide staff practice. Staff advised they have access to the organisation’s policies and procedures.

However, consumers’ care and services were not routinely or regularly reviewed.

The Quality Standard is assessed as non-compliant as one of the five specific requirements have been assessed as non-compliant.

## Assessment of Standard 2 Requirements

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

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

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

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

Some consumers interviewed described their preference for a specific gender of staff to deliver their care. While these preferences were not documented in their care plans, male care staff interviewed by the Assessment Team identified male consumers with preferences for a male staff to deliver their care and stated there is generally male staff on every shift.

Staff advised they know the consumers really well and described sampled consumers’ needs and preferences. Staff said they receive information about consumers’ needs and preferences at handover or directly from consumers.

Consumers’ care documentation did not consistently include detailed information to guide staff practice, including details about changing equipment associated with two consumers’ complex care needs. However, one consumer reported high levels of satisfaction with the care they receive and said staff change their clinical equipment regularly.

The Assessment Team generally found consumers at the service have a cultural preference not to discuss end of life care until the final week of life. Registered staff advised that whilst the service attempts to discuss end of life wishes with consumers and representatives on admission and at care plan reviews, culturally this is not acceptable until the final week of life.

Two consumers at the service had statements of choice in place that identified their end of life preferences and the majority of consumers had an advanced health directive in place. Whilst the service does not have policies and procedures relevant to end of life care, staff interviewed by the Assessment Team were aware of the process to identify and document consumers’ end of life care needs and preferences.

Information brought forward by the Assessment Team about consumers’ documented care and service not being current or regularly reviewed and smoking assessments for two consumers not being reflective of current smoking practices has been considered under requirement 2(3)(e).

While I note that the needs and preferences of some consumers were not documented in care plans, I am satisfied that staff were aware of those consumers’ needs and preferences and no adverse outcomes for the consumers were identified.

The approved provider’s response to the site audit report stated that a clinical meeting was held to discuss strategies to ensure care plans contained current information specifically in relation to:

* discharge summaries
* specialised nursing care needs, and
* advance care planning.

With respect to consumers’ preferences regarding the gender of staff who care for them, the approved provider’s response states that consumers’ preferences are documented on the handover sheet. The service is though taking action to include this information in care planning documentation.

Based on the information in the site audit report, the approved provider’s response to the site audit report and feedback from consumers and representatives, I am satisfied that consumers’ needs goals and preferences are generally identified and addressed.

I find this requirement is compliant.

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

*The organisation demonstrates that assessment and planning:*

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

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

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

### Requirement 2(3)(e) Non-compliant

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

The Assessment Team found that whilst the service had a documented schedule for consumer care plan reviews and a resident of the day process, these were not occurring and consumers’ care plans were not regularly reviewed and updated.

Three named representatives advised that whilst they were involved in initial care planning processes when the consumer entered the service, they had not been involved in review of care and services over the past three years, or had conversations with the service about their loved one’s care and services.

Consumers’ care documentation reviewed by the Assessment Team identified care and services had not been regularly reviewed, including for consumers with complex care needs. Clinical incidents were followed up. I have also considered information brought forward by the Assessment Team under other requirements about two consumers’ smoking assessments not being reflective of their current smoking practices or regularly reviewed.

Registered staff advised they are responsible for reviewing care plans every three months or when changes in health or care needs occur, however, stated that whilst they update care plans in response to changes or incidents, routine reviews of care plans have not occurred.

Staff advised the shift handover process is used to communicate changes in consumer’s health status and they were aware of the service’s incident reporting process and how incidents may trigger a reassessment or review of a consumer’s needs.

In response to the Assessment Team’s feedback, management acknowledged consumers’ care plans had not been reviewed regularly and in accordance with the organisation’s policy and advised additional registered staff would be employed to ensure reviews are completed by the end of July 2022.

The approved provider’s response to the site audit report acknowledges that care plan reviews had not occurred as planned and attributed this to changes in staffing including unplanned leave due to illness. The approved provider has commenced the following actions to address this:

* a clinical meeting was held to discuss strategies to ensure care plans contained current information and the formalisation of care partnership discussions
* staff meetings are to include an agenda item that relates to the timing of care plan reviews and resident of the day processes
* additional clinical staff have been employed to support the care plan review process
* a plan has been established to ensure all assessments for consumers who smoke cigarettes are current by 30 June 2022
* a refreshed ‘resident of the day schedule’ has been established
* the agency staff orientation booklet is under review to ensure information that guides temporary staff is accurate
* all care plans will be reviewed and updated by 31 July 2022.

For the reasons detailed above I find this requirement non-compliant.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Most consumers considered they receive personal care and clinical care that is safe and right for them. Consumers and representatives provided examples of how staff provided care including wound care, diabetes management and specialised nursing care; some consumers and representatives said the consumer’s health and well-being had improved while residing at the service. Consumers and representatives were confident that staff would be able to support consumers as they approached end of life.

Consumers’ care plans and related documentation demonstrated that consumers are seen regularly by their medical officer and that changes in health care directives are documented. High impact and high prevalence risks are identified and managed and where appropriate advance care planning and preferences relating to end of life care are documented. Allied health providers and specialist services are accessed to support the delivery of safe and effective personal and clinical care.

Management staff said they monitor consumers’ health care needs through care plan review processes, resident of the day, clinical indicators and feedback and complaints. Clinical indicator data is analysed to identify trends and is reported to the organisation.

Registered staff explained how they enlist support from a physiotherapist in relation to falls management and wound care specialists for wound management advice.

Care staff said they access information about consumers from handover, and from care and service plans. Care staff said that they know the consumers ‘so well’ that they feel confident they would know how to care for the consumer as they approach end of life and provided examples of the comfort cares they would implement. Care staff advised that if they have any queries or concerns about a consumer’s care needs they would seek advice from a registered nurse.

Staff have received education and training in relation to infection control and were observed by the Assessment Team washing their hands and wearing personal protective equipment appropriately.

The service supports access to vaccinations and management advised all staff have been vaccinated against COVID-19. Consumers are temperature checked each day and visitors and staff undergo regular rapid antigen testing. The service has a check in process and the Assessment Team observed signage and handwashing stations throughout the service and cleaning occurred frequently in all high touch areas.

Policies, procedures and guidelines are available to guide staff and include skin integrity, pain management, restrictive practices, end of life care and infection control. Where appropriate, documentation includes reference to legislation, research and other resources.

However, the management of restrictive practice was not best practice and did not optimise consumers’ health and well-being.

The Quality Standard is assessed as non-compliant as one of the seven specific requirements have been assessed as non-compliant.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that the organisation has contemporaneous evidence-based policies, procedures and guidelines relating to clinical care, including skin care, pain management and restrictive practices. However, for some consumers, legislative requirements relating to the use of restrictive practices were not being met, assessments and authorisations were incomplete and staff failed to demonstrate a shared understanding of legislative requirements and organisational procedures relating to the use of restrictive practice.

The Assessment team found deficiencies in the application and management of restrictive practice for approximately 13 consumers. Deficiencies included:

* consents and authorisations were in place when not required
* consent and authorisation were not documented for one named consumer who was receiving chemical restraint
* consent and authorisation were not documented for one named consumer who had a form of mechanical restraint in place
* a number of consumers who were subject to restrictive practice had not had a clinical review for more than six months, and
* a number of consumers did not have alternative strategies that were to be trialled prior to the use of restrictive practices documented.

With respect to other aspects of personal and clinical care, the Assessment Team found consumers were satisfied with the personal and clinical care they received and provided examples of how consumers’ health and well-being had improved while residing at the service.

Registered staff and care staff demonstrated an understanding of consumers’ individual personal and clinical care needs and explained how they prioritised care for consumers who had appointments outside the organisation or who had NDIS outings arranged.

Care planning documentation demonstrated that care delivery for consumers with complex wounds, weight loss, pain, diabetes and specialised nursing care needs is generally safe, effective and tailored to the individual needs of the consumer.

The approved provider’s response to the site audit report states that the following actions are being taken to address the deficiencies brought forward by the Assessment Team in relation to restrictive practice:

* clinical and general staff meetings will include an agenda item relating to restrictive practice
* all staff will be required to complete additional training relating to this by 30 September 2022
* additional toolbox talks are being delivered and will be completed by 31 July 2022 (education will include when consent is required)
* consents have been removed from the files of those consumers who do not require them
* where consent and authorisation for restrictive practice is required these are being completed
* monitoring processes have been established, whereby senior management staff and the clinical leader will monitor restrictive practice to ensure it is line with legislative requirements
* review of restrictive practice for named consumers has occurred and as an element of the review process strategies to minimise use have been explored and documented in the consumer’s care plans, and
* senior management staff are reviewing information management relating to restrictive practice and are establishing a consistent process and approach.

I am satisfied that the management of restrictive practices was not best practice and did not optimise consumers’ health and well-being.

I find this requirement is non-compliant.

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

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

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers and representatives were generally satisfied that consumers receive the services and supports for daily living that are important to their health and well-being and that enable them to do the things they want to do. They said that:

* consumers are supported to do the things they like to do and services provided are safe and effective and optimise consumers’ independence
* consumers’ emotional, spiritual and psychological needs are being met and that they are supported when feeling low or experiencing an emotionally difficult event
* consumers are supported to keep in touch with family and significant others
* the menu is varied and they receive sufficient food
* timely referrals are made to other organisations and providers of other care and services, and
* equipment provided was safe, suitable, clean and well-maintained.

Care plans included information about the types of services and supports consumers need to help them do the things they want to do. For example, assistive cutlery for consumers with limited dexterity, assistance required to support consumers’ independence when eating, and equipment needed to mobilise and engage in activities. Care plans included strategies for supporting consumers who experience episodes of low mood and strategies to support consumers with complex behaviours.

Care plans included information about consumers’ individual dietary needs and preferences including allergies, specialised diets (gluten free, diabetic and high protein). Care documentation aligned with the information held in the kitchen which is referred to by the Chef.

Progress notes and other related documentation demonstrated consumers are supported to engage in the community both within and outside the service. Referrals and involvement of other providers of care and services including NDIS, pastoral support and hairdressers were evident.

Management staff said the activity program is developed in conjunction with consumers and in consideration of their preferences. Management described how the activities meet the needs of consumers with various levels of functional ability including vision and hearing impairment.

Staff were familiar with consumers’ preferences and were aware of the various appointments consumers were required to attend and those who receive support from the National Disability Insurance Scheme (NDIS).

Management and staff described the way the service supports consumers emotionally, including when a consumer passes away. They said a pastor conducts a cultural smoking ceremony and provides other services that can include music and singing. The pastor visits consumers privately to provide emotional and spiritual support. Staff said they support consumers by singing cultural songs and spending time chatting with consumers.

Staff said the service celebrates and observes various spiritual and cultural events including for example Christmas Day and National Aborigines and Islanders Day Observance Committee (NAIDOC) week.

The Assessment Team observed religious verses displayed on notice boards, consumers watching spiritual and cultural programs on television, and consumers in the rotunda listening to music, playing instruments and participating in arts and crafts. Consumers were observed visiting with their family and liaising with NDIS support staff. Staff were observed spending time with consumers and having conversations with them.

A range of equipment was observed to be available for consumers and was clean and well maintained. Management and staff said they have access to the equipment they need and that additional equipment or resources can be sourced as required. Staff said the maintenance team are supportive and provide assistance where required.

The Quality Standard is assessed as compliant as seven of the seven specific requirements have been assessed as compliant.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

Information brought forward in the site audit report under this and other requirements demonstrated that information about consumers’ condition, needs and preferences is generally communicated within the organisation.

The Assessment Team found that care plans and related documentation generally provided sufficient information to guide staff. Care plans included information about the types of services and supports consumers need to help them do the things they want to do. For example, assistive cutlery for consumers with limited dexterity, assistance required to support consumers’ independence when eating, and equipment needed to mobilise and engage in activities. Care plans included strategies for supporting consumers who experience episodes of low mood and strategies to support consumers with complex behaviours.

Management and staff demonstrated a sound knowledge and understanding of consumers’ needs and preferences and consumers were satisfied with the services and supports they received.

The Assessment Team found that care related documentation did not include current information relating to the support some consumers receive from NDIS staff. Additionally, the Assessment Team found that documentation relating to consumers’ lifestyle had not been reviewed since 2021.

Management staff advised that the service had been without a lifestyle officer for some time and that planned actions to ensure consumers’ needs, goals and preferences were documented, had not been completed. The Assessment Team reviewed the service’s plan for continuous improvement and noted it included actions to improve documentation related to services and supports for daily living.

The approved provider’s response to the site audit report asserts that information about NDIS participants is held in consumers’ lifestyle and wellbeing care plans and that consumers’ goals and activities are recorded in a specific NDIS diary that is held on site. The organisation however has taken action to strengthen communication processes, specifically in relation to NDIS participants, actions include:

* recruitment processes have commenced to engage a lifestyle officer
* management staff are liaising with NDIS Support Coordinators to review communication processes, and
* the resident of the day process and checklist has been amended to include NDIS activities and review of lifestyle care plans has commenced.

Consumers reported satisfaction with staff knowledge of their needs and preferences and were generally satisfied with the services and supports they received for daily living. Staff demonstrated an understating of consumers’ needs and preferences relating to services and supports for daily living, including the needs of those consumers who were NDIS participants and had provided information under other requirements as to how they prioritised consumers’ care in order to accommodate the consumers’ NDIS activities.

For the reasons detailed above, I am satisfied that information about consumers’ needs and preferences is communicated within the organisation and that staff have the information they require to deliver safe, quality services and supports.

I find this requirement is compliant.

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Consumers and representatives expressed satisfaction with the service environment. Consumers said they felt they belonged in the service and that it was safe and comfortable. Consumers particularly enjoyed the outdoor areas, gardens and the rotunda and said that this area is used as a meeting space. Representatives said they are made to feel welcome when they visit.

Staff demonstrated an understanding of consumers’ needs and preferences and explained how they provide a safe, clean and well-maintained environment.

There are systems and processes to support the completion of maintenance issues. Preventative maintenance is scheduled throughout the year and an on-site maintenance officer completes corrective maintenance as required.

Management said there are processes to monitor the service environment and this includes feedback processes such as surveys and one on one discussions with consumers.

The Assessment Team observed the environment to be welcoming, clean and comfortable and consumers were able to move with ease both inside and outside. Consumers’ rooms were personalised with furniture, photographs and craftwork. The service had communal indoor and outdoor areas including a dining room, kitchenettes, gardens and a central rotunda. A secure perimeter fence surrounds the service and access to and from the service is monitored.

Equipment was observed to be clean, well-maintained and appropriate for consumers’ needs. Equipment requiring repair is logged in a maintenance request book and actioned promptly. Faulty equipment is removed from service until repaired.

Consumers were observed engaging with each other, using paths to move through the service and accessing external areas of the service.

Staff were observed welcoming visitors to the service and assisting them with COVID-19 screening processes.

The Quality Standard is assessed as compliant as three of the three specific requirements have been assessed as compliant.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers and representatives were generally satisfied with feedback and complaints processes and most said that staff work with them to achieve a satisfactory outcome. Some consumers had an understanding of feedback forms and access to advocacy services. Consumers and representatives said they can speak to staff who are familiar with their traditional language if they wish to provide feeback.

Staff could explain how they would support consumers, including by using consumers’ preferred language, to provide feedback or make a complaint and were aware of the service’s complaints and feedback forms.

Management said complaints can be received verbally or can be written and that they are recorded on the feedback management system. Examples of complaints received were provided to the Assessment Team. They described the open disclosure process and how an apology or expression of regret is made. Management said a full open disclosure process for serious incidents includes a briefing to the executive management team.

Management described how advocacy groups can be accessed and demonstrated that this information was displayed within the service.

Policies and procedures relevant to feedback and complaints are in place to guide staff.

The Assessment Team observed feedback and complaint forms and secure feedback boxes located within the service. The consumer handbook includes information relating to complaints mechanisms including access to advocacy services.

However, while the service has systems and processes for managing complaints and consumer feedback, these were not consistently applied and the Assessment Team found deficiencies in the way feedback and complaints were recorded and in how they were used to inform continuous improvement.

The Quality Standard is assessed as non-compliant as one of the four specific requirements have been assessed as non-compliant.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

The service was not able to demonstrate how feedback and complaints are used to drive improvements to the quality of care and services provided to consumers.

Some consumers were not confident that their feedback had resulted in improvements to care and service delivery and provided examples of where this had occurred. Food was raised by one consumer as an example of a complaint that had not resulted in improvements. Further to this the Assessment Team reviewed consumer surveys completed in March 2022 and identified that food dissatisfaction was identified by a number of consumers.

The consumer surveys that were completed included evidence of dissatisfaction with other aspects of care and service delivery including lack of engagement in providing feedback about care and services, lack of participation in care plan reviews and staff interactions including feeling rushed. The Assessment Team found that the service’s feedback management system and the plan for continuous improvement did not include consumer dissatisfaction and feedback arising from consumer surveys. Nor did these documents include verbal feedback that consumers and their representatives said they had provided to the service that related to significant aspects of their care.

Management said that where feedback is provided to the service, the policy is for the feedback to be recorded in the feedback management system where it can be actioned and reviewed. However, management confirmed that feedback and complaints are not consistently documented in the feedback management system and that they have been encouraging staff to use the established processes.

The Assessment Team were advised by management that the service’s plan for continuous improvement had not been revised since February 2022. The Assessment Team reviewed the document and identified that it did not include any action items that were sourced from consumer feedback or other feedback mechanisms. The plan for continuous improvement did not evidence planned actions for improvements following multiple examples of negative feedback received by the service within the last three months.

The approved provider’s response to the site audit report states that action has been taken to improve the service’s performance under this requirement; actions include:

* ensuring new management staff have training in the organisation’s complaints processes, quality framework and the electronic database
* survey feedback received in March 2022 relating to food satisfaction has been collated and progressed with catering staff and ongoing engagement with consumers has been planned
* the plan for continuous improvement has been updated to reflect current action items, and
* staff and consumer meetings will now include quality improvement and feedback on the agenda.

While I acknowledge that action is being taken to improve performance under this requirement, I am satisfied that for the reasons detailed above this requirement is non-compliant.

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Consumers and representatives generally felt that consumers receive care and services when they need them from people who are knowledgeable, capable and caring. They said they felt comfortable that staff were sufficiently skilled to meet consumers’ care needs. Consumers and representatives said staff are respectful of consumers’ identity and diversity and understand their background and cultural preferences. Consumers described how staff deliver care in a timely manner that ensures they receive assistance with their activities of daily living for example repositioning, mobilising and assistance with meals, and are free to attend appointments outside the service as planned.

The site audit report includes information demonstrating that overall, consumers are satisfied with personal and clinical care and services and supports for daily living.

Registered staff are available to provide clinical guidance and support to staff. They described the process for accessing additional education and said that their requests for additional training to support their skills development are supported.

Management were able to describe the organisational processes to ensure the competency of the workforce and staff advised they have received training to support them in their role. They said staff are trained to use equipment relevant to their role, including the use of lifting equipment and mobility aids.

Staff said they have completed training in COVID-19, infection control, manual handling, hand hygiene, the Quality Standards and the Serious Incident Response Scheme. On-line education modules and practical competencies support staff in relation to specific tasks including handwashing and manual handling. Position descriptions for each role guide staff practice. The Assessment Team reviewed the service’s education records and found that rostered staff had completed mandatory training modules.

While the organisation has a staff performance framework, staff performance and development opportunities are identified locally through an informal process of discussion with senior staff and management. Management said they receive feedback about staff performance through surveys, feedback forms and conversations with consumers.

While the Assessment Team identified some staff did not have a sound understanding of aspects of restrictive practice, the approved provider has taken action to improve staff knowledge and understanding in relation to this aspect of care and service delivery.

The Assessment Team observed staff interactions with consumers and found that they were caring and respectful.

The Quality Standard is assessed as compliant as five of the five specific requirements have been assessed as compliant.

## Assessment of Standard 7 Requirements

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

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

Information brought forward by the Assessment Team under this and other requirements demonstrates that overall, consumers and representatives were satisfied with care and service delivery. Consumers reported they feel safe and are confident the workforce can support their health and well-being. Consumers and representatives said they can tell the staff what they need and that staff will provide the requested care or service. Consumers provided examples of how staff ensured their care needs were met before transport arrived to take them to appointments external to the service. Consumers provided examples of staff attending to their massages, skin care, repositioning, mobility needs and assistance with meals. Some consumers and representatives said consumers’ health and well-being had improved whilst residing at the service.

Care planning documentation reviewed by the Assessment Team demonstrated wound care was being provided as planned, pain management is effective, medications are generally administered on time and consumers with specialised nursing care needs receive the care they require.

However, the Assessment Team found that assessment and care planning review processes were not current and registered staff confirmed they had difficulty with care plan reviews and attributed this to lack of staffing. I have considered this information under Requirement 2(3)(e) and note that negative outcomes for consumers arising from this were not identified.

The Assessment Team brought forward some feedback from consumers in relation to the availability of lifestyle staff and the suggestion that the service would benefit from additional care staff to assist with activities of daily living for example providing assistance with meals.

The approved provider’s response to the site audit report states that the electronic database has been reviewed and there have been no complaints raised or feedback provided about lack of lifestyle staff. Additionally, the approved provider asserts that recruitment is underway for a lifestyle officer and that management ensure staff provide activities for consumers. I have considered this information together with the positive consumer and representative feedback brought forward by the Assessment Team under Standard 4 and I am satisfied that staffing has been sufficient to ensure services and supports for daily living were provided to consumers.

With respect to a concern raised that staff may not have sufficient time to support consumers at meal times, the approved provider states that management and senior staff have observed meal times and found that staff provide appropriate support for consumers including those who are slow to eat. I note too that feedback was provided by consumers that staff provide assistance with this aspect of their care.

The approved provider acknowledges that care plan reviews scheduled for May 2022 were not completed at the time of the site audit and states that unplanned leave due to illness and staff resignations impacted this. Whilst agency staff were sourced there was a delay in experienced staff undertaking the review process. In response to this the approved provider has appointed additional clinical staff to assist and support the service while outstanding care plan reviews are completed.

I have considered information in the site audit report and the approved provider’s response and have particularly given weight to consumer and representative feedback. Consumers and representatives are satisfied with care and services and provided examples of care that was provided in a timely manner.

For the reasons detailed I find this requirement is compliant.

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

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

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

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

Consumers and representatives were satisfied with staff knowledge and skills. They said that staff know what they are doing and they did not think there were any areas where staff required more training.

Management staff were able to describe the organisational processes to support the competency of the workforce and staff confirmed they had received training that supported them in their role and ongoing development. Registered staff said they can request additional training to support their knowledge and skills.

Position descriptions for each role guide staff. On-line education modules and practical competencies support staff in relation to specific aspects of the role and the Assessment Team found staff participated in education relating to care related issues, COVID-19, restrictive practice, infection control, hand hygiene, manual handling, Serious Incident Response Scheme and the use of lifting equipment and other equipment relevant to their role.

The Assessment Team identified the service did not have an Infection Prevention and Control Lead. Additionally, the Assessment Team brought forward deficiencies in staff knowledge relating to mechanical restrictive practice. These matters were discussed with management at the time of the site audit. Management committed to engaging an Infection Prevention and Control (IPC) Lead from within the organisation’s network for one day per week. With respect to knowledge deficits relating to mechanical restrictive practice, management advised they planned to provide further education to care staff on this topic.

The approved provider’s response to the site audit report states that the service is taking action to ensure all staff receive refresher training in relation to restrictive practice and that clinical and general staff meetings will include this topic in the agenda. With respect to the IPC Lead, the approved provider states that a replacement person has been identified and their training has commenced. In the interim, the approved provider has confirmed that another IPC lead from within the organisation has been providing dedicated support to the service since 13 June 2022.

For the reasons detailed above I find this requirement is compliant.

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

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

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Consumers and representatives generally felt that the organisation is well run and that they can partner in improving care and service delivery through participation in surveys and by providing feedback to management.

Management said the service actively engages consumers in the development, delivery and evaluation of care and services and that information about aged care services and COVID-19 is communicated. Consumers and representatives confirmed they had been kept informed of changes in visitor restrictions during the COVID-19 pandemic.

The governing body promotes a culture of safe, inclusive, quality care and management supports consumers to maintain personal relationships with others.

Internal audits, consumer surveys, clinical indicators and clinical and quality care reports that include outcomes from visits by the Aged Care Quality and Safety Commission are used by the executive team to monitor compliance against the Quality Standards.

Overall, the organisation demonstrated effective risk management systems and processes that included identifying and responding to abuse, managing and preventing incidents, and supporting consumers to live the best life they can.

While there are governance systems in place these were not consistently effective in ensuring safe, quality care and improved outcomes for consumers. The Assessment Team found deficiencies in areas including in relation to continuous improvement, feedback and complaints and regulatory compliance.

The Quality Standard is assessed as non-compliant as two of the five specific requirements have been assessed as non-compliant.

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team brought forward information that some aspects of the organisation’s governance systems were not effective.

With respect to information management, consumers, representatives and staff were generally satisfied with the information provided to them by the service and staff felt they had access to the information they needed to support them in their role.

Management staff could explain how they are responsible for the day to day running of the service including management of the annual budget. They said that additional expenditure of changes to the budget are referred to the organisation’s head office for approval.

Workforce arrangements generally ensured there were sufficient staff to meet consumers’ care and service needs and consumers and representatives confirmed this. Staff could describe how they deliver care in accordance with consumers’ needs and preferences and how they prioritise care delivery accordingly. However, the service did not have an IPC Lead at the time of the site audit and registered nurses and management identified an inability to complete care plan reviews scheduled for May 2022 due to staffing impacts.

The organisation has policies, procedures and guidelines that reflect regulatory requirements and staff have received education and training including in relation to the Serious Incident Response Scheme, incident management systems and restrictive practices. However, the Assessment Team found that staff did not have a shared understanding of restrictive practice, specifically in relation to the definition of mechanical restrictive practice. Further to this, regulatory requirements relating to the use of restrictive practice were not being met and the service was not able to demonstrate assessment, trials of alternative strategies and authorisations were in place.

While opportunities for continuous improvement are identified through audits, surveys, complaints, incidents, meetings and feedback forms, the service did not demonstrate that this information consistently results in improvements to the quality of care and services that consumers receive. Consumers reported that the feedback they had provided to management had not been actioned and the Assessment Team found opportunities for improvement that were identified in consumer surveys or through other forums had not informed the service’s continuous improvement plan.

In response to the site audit report, the approved provider submitted the following information:

* The service experienced a shortage of clinical staff in May 2022 due to illness and resignations, this resulted in delays in care plan review processes. This is currently being addressed through the recruitment of an additional clinician who commenced 6 June 2022 to support the service in completing outstanding care plan reviews.
* The service has the support of a trained IPC Lead from another BlueCare site undertaking dedicated rostered shifts at the service and cover IPC led activities while a staff member completes the required training to fulfill the role.
* The service has a continuous improvement plan that has been reviewed and updated since the site audit and now incorporates improvements arising from consumer feedback/suggestions and the site audit.
* All staff are receiving additional training on restrictive practice and this is being added as an agenda item at clinical and general staff meetings.
* The management team is reviewing and updating the complaints process and continuous improvement practices. The cluster support team are reviewing complaints data for the previous 12 months to understand key themes and trends. The agenda for the consumers’ and representatives’ meeting now includes complaints and improvements.

I acknowledge the actions taken by the service however I am satisfied that the organisation’s governance systems were not effective and did not consistently contribute to improved outcomes for consumers.

For the reasons detailed, I find this requirement is non-compliant.

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

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

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

### Requirement 8(3)(e) Non-compliant

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

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

The Assessment Team brought forward information that clinical governance systems were not effective in ensuring that consumers received safe, quality clinical care, particularly with respect to the use of restrictive practices.

The Assessment Team found that the organisation has contemporaneous evidence-based policies, procedures and guidelines relating to a clinical governance framework, antimicrobial stewardship, open disclosure and minimising the use of restraint. However, for some consumers, legislative requirements relating to the use of restrictive practices were not being met, assessments and authorisations were incomplete and staff failed to demonstrate a shared understanding of legislative requirements and organisational procedures relating to the use of restrictive practice. The Assessment Team found deficiencies in the application and management of restrictive practice for approximately 13 consumers.

The Assessment Team found that the service had an outbreak management plan and that training in infection control was provided to staff. Staff practices reflected an understanding of infection control. The Assessment Team found that at the time of the site audit that the service did not have an appointed IPC Lead.

An open disclosure policy is an element of the service’s clinical governance framework and includes the provision of an apology when mistakes are made and explaining to consumers the steps that will be taken to prevent a recurrence.

The approved provider’s response to the site audit report provides the following information:

* The service did have an IPC Lead however the role became vacant following the resignation of the staff member. Another staff member is currently completing the required training and in the interim a trained IPC Lead is providing dedicated support to the service and undertaking IPC led activities.
* Staff are being provided with additional training is relation to restrictive practices and the service has established increased monitoring of restrictive practices by senior clinical staff.

While I acknowledge the actions taken by the approved provider, I am satisfied that the service has not had an effective clinical governance framework particularly in relation to minimising the use of restraint.

I find this requirement is non-compliant.

# 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.

* The organisation is required to ensure that care and services are regularly reviewed for effectiveness, including when circumstances change or there has been an incident impacting on the needs, goals and preferences of the consumer.
* The organisation is required to ensure that consumers, including those consumers subject to restrictive practices, receive safe and effective personal and clinical care that is best practice and optimises their health and well-being.
* The organisation is required to ensure that feedback and complaints are reviewed and used to improve the quality of care and services.
* The organisation is required to ensure effective organisation wide governance systems are in place relating to:
  + information management
  + continuous improvement
  + financial governance
  + workforce governance
  + regulatory compliance, and
  + feedback and complaints.
* The organisation is required to ensure that the clinical governance framework includes the following:
  + antimicrobial stewardship
  + minimising the use of restraint
  + open disclosure.