Performance

Report

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| Name of service: | Blue Care Star of the Sea Elders Village |
| Service address: | 121 Waiben Esplanade THURSDAY ISLAND QLD 4875 |
| Commission ID: | 5373 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Site Audit |
| Activity date: | 21 March 2023 to 23 March 2023 |
| Performance report date: | 15 May 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 Star of the Sea Elders Village (**the service**) has been prepared by Stewart Brumm, 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.
* the provider’s response to the assessment team’s report received 27 April 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | 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.

* Ensure 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.
* Ensure 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.
* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care.
* Ensure effective management of high-impact or high-prevalence risks associated with the care of each consumer
* Ensure 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.
* Ensure 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.
* Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Ensure effective organisation wide governance systems relating to information management, regulatory complaint, continuous improvement.
* Ensure effective risk management systems and practices, including managing and preventing incidents, including the use of an incident management system.
* Ensure an effective clinical governance framework.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | 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

The Assessment Team provided information that consumers/representatives advised consumers are treated with respect and dignity and their diversity and culture is valued within the service. Staff were observed using respectful language in verbal and written communication in relation to consumers and staff addressing consumers by their preferred names.

Consumers/representatives advised staff are respectful of consumer individual culture, beliefs, and values and consumers feel culturally safe in the service. The service provides a guide booklet to new and agency staff on commencement which informs of the cultural heritage and significance of the Torres Strait, its people and culture. Care documentation described consumer background, beliefs, needs and preferences.

Consumers described who they nominate to be involved in their care decisions and different ways the service supports them to maintain personal relationships within and outside of the service. Care documentation demonstrated who and what is important to the consumer and the consumer’s choices were regularly reviewed and updated to reflect any changes.

Consumers/representatives expressed satisfaction with support provided by staff for consumers to take risks and live the best life they can. Staff were able to describe ways in which consumers take risks, and how the consumer is supported to understand the risks involved to help them make informed decisions about taking these risks.

Consumers/representatives said information provided to them is timely, clearly communicated, and easy to understand enabling them to exercise informed choice. Consumer care planning documentation demonstrated consumers’ needs and preferences are effectively communicated and updated when their needs change.

Consumers/representatives confirmed consumers’ personal privacy is respected. Staff were observed knocking, waiting for response, requesting permission to enter prior to entry, and to be providing personal care to consumers with the doors closed.

I have considered the information provided by the Assessment Team and I am persuaded by the Approved Providers ability to demonstrate compliance and the consumer/representative positive feedback in my determining my findings.

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

# Standard 2

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

Findings

The Assessment Team provided information that consumers/representatives said care planning documentation demonstrates consumers’ current needs, goals and preferences, including advance care planning are identified on entry to the service and discussed as part of the review process or as required. Staff could describe what is important to the consumer in terms of how their care is delivered.

Consumers/representatives confirmed they are involved in the assessment, planning and review of consumers’ care and services. Care planning documents reflect the consumer and others involved in assessment and planning, including the medical officer, and podiatrist.

Most consumers/representatives said staff have discussed the care needs and information in the consumer’s care plan with them. Staff advised they have access to care planning documentation for consumers through the electronic care management system, paper-based records and handover notes.

In relation to Requirement 2(3)(a) the Assessment Team provided information that assessment and care planning processes are completed to identify the needs, goals and preferences of consumers; however, care goals were identified as generic and the same for each consumer. Care documentation did not consistently include identified risks or changes to consumers care and service needs. Behaviour management assessments and care planning are not consistently completed and reflective of the consumer’s needs or updated when conditions change, or incidents occur. Care plans have not been reviewed to identify the use of restrictive practices or that risk assessments have been completed or informed consent obtained and documented. And care plans have not been reviewed to assess risk in relation to falls and mobility. The Approved Provider was unable to provide the Assessment Team with consistent wound care plans and did not demonstrate regular review of wound and pressure area care to ensure care is effective.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, restraint documentation, the psychotropic register and handover sheet example.

With regard to the named consumer with consideration of pain as a trigger for behaviours, restraint use, and falls management I have considered the clinical records extracts provided by the Approved Provider. In relation to consideration of pain as a trigger to behaviours, I note that Approved Provider has been monitoring pain, in progress notes pre site audit and through assessment and monitoring post site audit, and through medical officer reviews. The consumer is on regular analgesia, has not required narcotic medication for pain and pain scores indicate that pain is managed. The Approved Provider does not consider pain is an additional trigger to behaviours of concern. I note that consent for the use of mechanical restraint had been obtained and the risks associated had been discussed with the representative. There has been ongoing review of need for restraint by both registered staff and the medical officer. With respect to post falls management, I am satisfied that the consumer was monitored and assessed post fall. I note the behaviour support plan has been updated post the site audit to reflect current care needs and management.

With regard to the named consumer and use of mechanical restraint, I note the authorisation and consent for restraint form has been completed and consent recorded as being received from the representative. I note this referred to 1 bed rail on one side of the bed and the document refers to crash mats on both sides of bed, indicating that the consumer has been identified as being able to still move out of the bed. However, the form does not document the associated risks with the use of bed rails and it is not clear if these risks were discussed with the representative.

With regard to the named consumers and the use of chemical restraint. I accept that staff at the service had not identified that the medicines in use constituted restraint. I note the psychotropic register was updated during the site audit when the matter was clarified by the Assessment Team, and I note additional training has been arranged for staff on restrictive practices. For one consumer I note the medication in use has been prescribed to treat a known diagnosis. I note there are ongoing discussions planned with medical officers for some named consumers and the medications in use and chemical restraint. The Approved Provider has indicated that consumer documentation will be updated as required following the medical officer reviews.

I note for one named consumer, whilst information has been provided to the representative, consent had not been obtained for the use of chemical restraint.

I also note for one named consumer the use of bed rails complies with the *Quality of Care Principles 2014* and the use of mechanical restraint. I accept that for this consumer, the bed rails did not constitute restraint.

In relation to the named consumer with wound/skin care issues and inconsistent wound care and pressure area care documentation and reviews, I have reviewed the related clinical records extracts. I note that the medical officer and wound consultants are monitoring the wound and the most recent provided information (post site audit) identified some improvement in the wound, also noting the medical staff have recorded that the wound may never heal. However, I note that repeatedly in the information provided, the medical staff have requested and instructed for strict pressure area care to assist in the prevention of further wound breakdown. The Approved Provider has not demonstrated that the pressure area care was being consistently provided in the months leading up the site audit or post the site audit in the Approved Provider response. I note the wound deteriorated significantly during this time. I note the inconsistent information identified by the Assessment Team in planning care directions related to the timing of pressure area care. I note one progress note entry related to refusal of care (pressure area care), but I do not consider this demonstrates a pattern of refusal for care by the consumer for not performing pressure area care. I note that the handover sheets dated 19 April 2023 and 20 April 2023 (post the site audit) both record pressure area care to the consumer being provided 2nd hourly for two of the three shifts each day. There is no indication provided by the Approved Provider as to how they are monitoring planned pressure area care is being delivered consistently each day.

I have considered the information from the Assessment Team as well as the Approved Provider response and I find that the Approved Provider has not demonstrated 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. Planning the delivery of pressure area care has not been effective.

I find this Requirement is non-compliant.

In relation to Requirement 2(3)(e) the Assessment Team provided information that the Approved Provider is unable to demonstrate restrictive practices, behaviour management, pressure injuries, wound care and skin care are effectively documented or reviewed for effectiveness. A review of consumers’ electronic care plan and paper-based charts showed inconsistencies in information documented and information on paper-based charts was not transferred to the electronic care plan in line with the service’s processes to allow appropriate review of changes in consumers’ needs or circumstances.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, email correspondence, monitoring report and restraint records.

With regard to named consumer and use of mechanical restraint and chemical restraint, I am satisfied that the mechanical restraint meets the definition as per the Quality of Care Principles 2014, and whilst I note the psychotropic register was updated to reflect the use of chemical restraint during the site audit, I am not satisfied that consent had been obtained, I note an email sent post the site audit informing the representative of the medication and requesting consent, however no response from the representative was provided.

With regard to the named consumer and review of falls and behaviour I note with respect to post falls management, I am satisfied that the consumer was monitored and assessed post fall. I note the behaviour support plan has been updated post the site audit to reflect current care needs and management.

With regard to the named consumer and pressure area care, I note the clinical records provided did not demonstrate that reviews of the consumers care needs identified if pressure area care was being completed as requested by the medical officer, and I note the wound deteriorated during the period of clinical records provided and the medical officers were regularly requesting strict pressure area care. I do note that since the site audit, the wound appears to have stabilized and shows some signs of improvement.

In relation to the updating of the electronic care management system, I accept the Approved Providers response that the this is often due to technically difficulties experienced as a result of the remote location of the service.

I have considered the information presented by the Assessment Team and the Approved Providers response, I find that the Approved Provider did not demonstrate that the care review process has been consistently effectively in identifying changes in consumer care provision or the effectiveness of existing care delivery.

I find this Requirement is non-compliant.

In Summary:

The overall Standard rating is non-compliant, as two requirements are non-complaint.

I find Requirements 2(3)(b), 2(3)(C), and 2(3)(d) complaint,

I find Requirements 2(3)(a) and 2(3)(e) non-compliant.

# Standard 3

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

The Assessment Team provided information that

Consumers’ care plans reflect their end of life needs and wishes. Advance health directives are documented in the electronic care management system. Staff demonstrated an understanding of processes to support the needs, goals, preferences including cultural needs of consumers nearing their end of life. Clinical management staff said advanced care planning is discussed on entry to the service and during care plan review processes.

The Approved Provider has documented policies, procedures and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control and for the management of a COVID-19 outbreak. The Assessment Team observed clinical and care staff completing hand washing when providing consumer care.

In relation to Requirement 3(3)(a) the Assessment Team provided information that identified consumers are not receiving effective care that is being tailored to their needs and optimises their health and well-being, particularly in relation to the management of pressure injuries, wound care, falls, restrictive practices, behaviour management, skin care and pressure area care. These deficiencies are due to gaps in staff knowledge inconsistent application, monitoring and review of care, not in accordance with the organisation’s established clinical governance framework. The Approved Provider was unable to demonstrate consistent practices for the management of pressure injuries and wounds. Consumers’ wound management documentation did not include consistent photographs, measurements or observations of wound progress in accordance with the organisation’s wound care pathway. The Approved Provider did not demonstrate assessment or informed consent has been completed for any consumers subject to restrictive practices.

Behaviour support plans did not include individualised strategies for consumers and were identical in each consumer’s behaviour support plan with strategies listed as one on one engagement, include consumer in decisions and ensure needs are met.

The service did not ensure pressure area directions were completed as per medical officer recommendations for a named consumer and did not demonstrate appropriate skin care for another named consumer.

The Assessment Team observed call bells not within reach of some consumers during the site audit.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, medical officer notes, wound photographs and duties lists.

With regard to the named consumer are wound care, including regular wound photography, I note the Approved Provider has acknowledged that wound photographs have not been taken in line with organisational procedures. I note that the medical officer is reviewing wound regularly, often weekly, and I note from the recent medical officer reviews the wound is stable and showing some signs of improvement. I find that in the absence of consistent wound photographs for this consumer, that the wound is being monitored, the absence of photographs has not resulted in a deficit in monitoring of this consumers’ wounds.

In relation to restrictive practice, as noted in Standard 2, I am satisfied that for mechanical restraint, there has been consent for use obtained, and ongoing review for continued use by both registered nurses and medical officers. I note the psychotropic register has been updated at the time of the site audit to reflect those consumers subject to chemical restraint. However, I am not satisfied that the process to obtain consent prior to the introduction of chemical restraint is consistently occurring.

In relation to behaviour support plans, I note the Approved Provider has supplied examples of the revised plans that were updated post the site audit and now reflect individual strategies for the named consumer.

In relation to named consumers and effective monitoring and provision of pressure area and skin care, I am not satisfied that the Approved Provider was effectively monitoring the provision of pressure area care, despite repeated requests from medical officers for strict pressure area care for a named consumer. I find it reasonable to expect that with increase medical officer requests for strict pressure area care, that the Approved Provider would have ensured that the delivery of care was subject to increased monitoring and recording of cares being delivered. I note during March 2023, there is inconsistent recording of the provision of pressure area care.

With regard the Assessment Team observation of call bells not within reach of some consumers, I note the approved Provider has updated duties lists to include monitoring of access to call bells.

I have considered the information presented by the Assessment Team and the Approved Provider response and I find that consent for the use of use of chemical restraint is not consistently obtained and that monitoring of the delivery of pressure area care is not consistently occurring.

I find this requirement is non-compliant.

In relation to Requirement 3(3)(b) the Assessment Team provided information that the Approved Provider was unable to demonstrated it consistently and effectively manages the risks to named consumers in relation to pressure injuries, wounds, pain, falls and behaviour management. Monitoring and clinical governance processes have not identified that staff are not following the organisation policy and procedures for the management of high impact or high prevalence risks.

The representatives for two named consumers said the consumers are in pain, and it is contributing to changing behaviours.

The Assessment Team identified two incidents of unreasonable use of force that were not reported to the Serious Incident Response Scheme that met the reporting criteria.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, medical officer notes, wound photographs and duties lists.

In relation to the named consumers and falls management, the clinical records extracts provided demonstrate that the consumer has been monitored post fall and a review of the falls risk assessment had occurred. Staff duties lists have been updated to include regular monitoring of call bell access for consumers.

In relation to named consumers with wounds and ongoing pressure area care. Whilst I note the medical officers are monitoring the wounds on a regular basis, and wounds have recently improved or stabilised, I note inconsistency in the monitoring of pressure area care, despite regular requests from the medical officer for strict pressure area care. I also note the significant deterioration that has occurred to the wound during the consumers residency.

In relation to named consumers and monitoring for pain, I note clinical records extracts provided demonstrated for one of the named consumers, pain was being monitored prior to the site audit. For the second named consumer the pain monitoring has occurred after the site audit, however I note the consumer is recorded as not being in pain.

I also note the Assessment Team identified two incidents that were not reported to the serious incident report scheme.

I have considered the information presented by the Assessment Team and the Approved Provider and I find that process to ensure consistent management of high-impact or high-prevalence risks to consumers has not been effective. I was persuaded by deficits in the management of pressure area care and wounds.

I find this requirement is non-compliant.

In relation to Requirement 3(3)(d) the Assessment Team provided information that the Approved Provider was unable to demonstrate effective monitoring or processes to identify when a consumer’s condition is changing or deteriorating. Staff advised consumer’s condition is not regularly monitored and consumer care documentation is not monitored for signs of change of consumer condition. Some consumers/representatives were not satisfied the service was identifying consumer’s deterioration or responding in a timely manner. The service was unable to demonstrate pressure injuries, wounds, behaviours, falls or pain are being managed effectively or referred to external specialists in a timely manner.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, and medical officer notes.

In relation to named consumer with wounds and ongoing pressure area care. I note the significant deterioration that has occurred to the wound during the consumers residency. I note the inconsistent compliance with the organisation processes for wound photography and monitoring and recording of pressure area care. Whilst I note recent stabilisation of the wound, I am not convinced that consistent effective processes have occurred to ensure ongoing recognition of deterioration. I also note the delays in timely actioning of weight loss.

In relation to the named consumer and changed behaviours, the consumer was reviewed by the specialists in December 2022 and care documentation updated. I note that there has been reoccurrence of aggressive behaviours in January and February 2023.

In relation to the named consumer and wound and skin care, I note the Approved Provider has demonstrated that the consumers records were updated with the change to wound care. However, I do note for additional wounds, these were identified by the medical officer during a review and not identified by the registered staff or care staff during the provision of care.

I have considered the information presented by the Assessment Team and the Approved Provider and I am persuaded by the significant deterioration in a consumers wound, with the absence of consistent monitoring of wounds and pressure area care, as well as staff not consistently identifying wounds.

I find this Requirement is non-compliant.

In relation to Requirement 3(3)(e) the Assessment Team provided information that the Approved Provider was not able to demonstrate effective processes are in place to ensure consumer’s information is documented, communicated accurately and is reflective of the consumer’s current care needs. Care documentation was recorded inconsistently or not updated therefore did not consistently provide current consumer care needs.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts.

For the named consumer, clinical records extracts identified that the medical officer had updated the consumer wound care, and staff had recorded these changes.

I note that there has been inconsistent documentation related to the provision of care, in particular the management of wounds and pressure area care. The Approved Provider has acknowledged delays in updating clinical records and staff not consistently following organisation processes for documentation. I note the deficits identified by the Assessment Team in the recording of pressure area care and wound care.

I am persuaded by the ongoing deficits in the recording of care provision to consumers and the potential risk this possess to registered staff not having accurate information consistency available in relation to consumers.

I find this Requirement is non-compliant.

In relation to Requirement 3(3)(f) the Assessment Team provided information that the Approved Provider did not demonstrate timely and appropriate referrals occur for consumers requiring care and services from other organisations and providers of care. Management reported due to the remote location of the service, they rely on Queensland Health on the Island for support which at times results in delay of additional care and services. Management was unable to describe processes to follow up on referrals submitted to other organisations.

The Approved Provider clarified information in the Assessment team report, including which allied health professionals the consumers have access to. Consumers have access to dentist services, podiatry, dietetics, and speech pathology. The Approved Provider is in the process of contracting a physiotherapist. Additional referrals are made to the local health service and the Approved Provider is reliant on the Allied Health staff being available at the local health service. It is noted that the local health service has secured the services of a wound specialist since the site audit and consumers have since been reviewed by the wound specialist.

In regard to the named consumer are referral to a dietitian, I note the referral from January 2023 to the local health services has not occurred. The medical officer has reviewed the consumer since the site audit, and I note a referral to a private dietitian has been provided. I also note the medical officer considers the weight loss is due to a known medical condition. Whilst I acknowledge the weight loss may be related to a known medical condition, I do note the delay in the referral and the absence of follow up by the registered staff at the service.

For the named consumer and referral to dementia specialist. The Approved Provider indicated that the referral had been actioned following the incidents in January 2023. The consumer has been reviewed by a dementia specialist since the site audit and a comprehensive report with management strategies has been provided. I do note a delay of three months to action this referral.

For the named consumers and referral to wound specialists. I note that the medical officer was overseeing the management of the wounds on a regular basis and since the site audit the local health services has recruited a wound specialist and consumers have since been reviewed by the specialist.

I have considered the information provided by the Assessment Team and the Approved Provider, I note the remote location of the service and the challenges this has caused the Approved Provider in the management of referrals. On balance, I am satisfied that there is a process for referrals, and the consumers are generally being referred to allied health staff and specialists. Whilst I note a delay in the actioning of the referrals, I have considered the ongoing oversight and management by the medical officers in my findings.

I find this Requirement is compliant.

In Summary:

The overall Standard rating is non-compliant, as four requirements are non-complaint.

I find Requirements 3(3)(c), 3(3)(f) and 3(3)(g) compliant.

I find Requirements 3(3)(a), (3(3)(b), 3(3)(d) and 3(3)(e) non-complaint.

# Standard 4

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

Findings

The Assessment Team provided information that consumers said the service provides lifestyle activities that meet their needs and preferences. Care documentation recorded consumers’ preferences for activities and personal care, and things of interest to them to guide staff in providing appropriate supports for daily living.

Consumers could describe how the service supports them in attending religious services within the chapel, the community or individual religious practice within their room. Staff demonstrated knowledge of local language and customs, and how to fluently communicate with consumers.

Consumers are supported to participate in their community through visiting family, shopping, attending their local church and doing their own banking. Consumers also described how the service supports them to maintain relationships. The Assessment Team observed consumers participating in group and individual activities, sharing meals together, and receiving visitors. Consumers were utilising the large dining/activities room as well as indoor and outdoor areas.

Consumers’ care documentation contained information about the consumer’s condition, needs, and preferences and where required, this information is made available to other organisations or individuals who share the responsibility for the consumer’s care.

Overall consumers/representatives expressed satisfaction with the meals provided to consumers. Consumers stated the meals provided by the service were varied and of suitable quality and quantity. Hospitality staff were able to explain the process used to communicate the consumers’ needs and preferences to the kitchen. The chef described processes of designing and planning menus that met the preferences of the consumer cohort. Staff were observed to be assisting consumers with meals in a gentle and respectful manner.

Equipment used to support consumers to engage in lifestyle activities was observed to be suitable, clean, and well-maintained.

I have considered the information provided by the Assessment Team and I am persuaded by the Approved Providers ability to demonstrate compliance and the consumer/representative positive feedback in my determining my findings.

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

# Standard 5

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

Findings

The Assessment Team provided information that the Approved Provider was able to demonstrate a welcoming environment. The environment of the service is open, well-lit, and spacious. The central ‘ocean view room’ has full glass/ window exposure to expansive ocean views and has ample, comfortable areas for dining, relaxing, socialising and activities. Consumers have personalised rooms decorated with furnishings and personal items which reflect their individual character and preferences.

Consumers/representatives stated they felt the environment was safe, comfortable, and well-maintained, and they were able to move freely both indoors and outdoors. Consumers/representatives reported furniture and equipment is suitable, clean, and well-maintained; and they feel safe when using equipment.

The Assessment Team observed some areas of the service used by staff to be untidy.

In relation to Requirement 5(3)(b) the Assessment Team provided information that the Approved Provider was unable to demonstrate that the service environment is safe. One consumer was observed, and staff confirmed knowledge of the consumer smoking outside of the designated smoking area. One representative reported malodour in a consumers’ room.

The Approved Provider provided a response that included clarifying information and consumer smoking risk assessment. The Approved Provider contends that the consumer is of sound mind and able to make informed decisions about his smoking, including intermittent use of a smoking apron. The consumer is also provided a mobile pendant alarm to call for assistance. The consumer is aware of the need to smoke in the smoking area, however, was observed by the Assessment Team and confirmed by staff to also smoke outside their room on the veranda.

In determining my findings for Requirement 5(3)(b) I note that whilst the Approved Provider may not be complying with State based legislation around smoking at aged care facilities, I also note the management of risk to the consumer and other consumers residing at the home. I note the consumer is able to make informed decisions, has smoked for a long time without incident, the consumer was not seen smoking inside the building or their room, nor did staff report the consumer is smoking inside the building. The Assessment Team did not note any signs of increased risk such as burn marks on furniture or lit cigarette butts on the ground or near the building.

Based on the consumers capacity, the provision of a mobile alarm pendant to raise staff attention in an emergency and the absence of evidence of the consumer smoking inside their room or the building, I am satisfied that the Approved Provider is managing the risk to maintain a safe service environment.

I note the Approved Provider has cleaning schedules for consumers rooms, including for the management of malodour, and staff areas and has attended to the areas identified by the Assessment Team as being untidy.

I find this requirement is compliant.

I have considered the information provided by the Assessment Team and the Approved Provider and I am persuaded by the Approved Providers ability to demonstrate compliance and the consumer/representative positive feedback in my determining my findings.

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

# Standard 6

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

Findings

The Assessment Team provided information that Consumers/representatives said they feel encouraged, safe and supported to provide feedback and make complaints, and could describe the various methods available for them to do so. These included speaking to management or staff directly, during consumer/representative and food focus meetings or through the use of feedback forms. Consumers said they regularly attends consumer/representative meetings through which management encourages feedback from consumers and has participated in consumer feedback surveys conducted by the service. Complaints forms and information on how to make a complaint were observed on notice boards throughout the service.

Consumers sampled reported they have seen posters displayed with information on how to escalate complaints to external services such as the Aged Care Quality and Safety Commission (the Commission) and external advocacy services, including the Older Persons Advocacy Network (OPAN).

Most consumers/representatives said they had not lodged any complaints; however had confidence any complaints would be promptly addressed by management. Review of the compliments and complaints register identified complaints are recorded, investigated and addressed. Consumers/representatives said they are able to provide feedback and make suggestions through multiple forums which are taken into consideration and actioned by management.

I have considered the information provided by the Assessment Team and I am persuaded by the Approved Providers ability to demonstrate compliance and the consumer/representative positive feedback in my determining my findings.

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

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Assessment Team provided information that consumers/representatives provided positive feedback in relation to workforce interactions and confirmed staff are kind, caring and treat consumers well. The Assessment Team observed staff interacting with consumers respectfully and in a kind and caring manner. Consumers/representatives said staff have the knowledge and skills to provide safe and quality care and services that meets their needs and preferences.

Staff confirmed they have undergone regular performance appraisals that involved feedback from supervisors on their performance and an opportunity to identify areas for further improvement and/or training.

In relation to Requirement 7(3)(a) the Assessment Team provided information that the Approved Provider was unable to demonstrate the mix of staff enables the delivery of safe and quality care and services, noting adverse clinical outcomes for consumers and a failure to appropriately identify, risk assess, consult and monitor consumers subject to restrictive practices.

The Approved Provider provided a response to the Assessment Team report that included clarifying information as well as clinical records extracts, training records, memorandum, training and information material, and email correspondence.

The Approved Provider clarified the staffing arrangements for the service. Local staff are supported by a newly implemented fly in fly out model for additional staff. Staff are contracted to a minimum 12-month contract for the fly in fly out contracts. The Approved Provider acknowledged that some staff may not have been consistently following the organisations policies and processes, and refresher education has been arranged for staff. I note the compliance findings in relation to Standards two and three, however I find this is a deficit in the clinical governance framework, as opposed to sufficient numbers of staff and deployed staff skills mix. I acknowledge that in relation to restrictive practice, the clinical staff had not identified all consumers subject to chemical restraint, and I note that this was corrected when the Assessment Team provided clarification on what constitutes chemical restraint at the site audit. I note records were corrected at the time of the site audit and I note additional education is being provided to staff. I also note consumer satisfaction with skills and knowledge of staff and staff knowledge of consumers needs and preferences.

I have considered the information provided by the Assessment Team and the Approved Provider, and I am persuaded by the clarifying information in relation to the staffing model, as well as consumer satisfaction with staff. I have considered the deficits in care identified in Standards 2 and 3 related to clinical governance in Requirement 8(3)(e).

I find this Requirement is compliant.

In relation to Requirement 7(3)(d) the Assessment Team provided information that the Approved Provider was not able to demonstrate that the workforce is adequately trained to deliver safe and quality care and services. Staff reported they receive training pertaining to their roles, however despite an established mandatory training policy, review of records provided by the service demonstrated significant non-compliance.

The Approved Provider provided a response that included clarifying information as well as training records and training materials.

The Approved Provider has reviewed the records provided to the Assessment Team during the site audit and has noted that the records were not current and contained several staff who had left employment. This resulted in revised data on compliance with mandatory training. I note that there remains a range of training that has not been completed, including staff yet to complete consumer protection (2 staff), First response evacuation (3 staff), general evacuation (9 staff to complete, with a current completion rate of 58%) and one staff member to complete infection control training. A memorandum has been sent to staff and staff are expected to complete outstanding training by 31 May 2023.

With regard to training provided on restrictive practice, I note there are 2 staff yet to complete this training. Following feedback provided by the Assessment Team during the site audit, additional modules on restrictive practice have been added to the training calendar, with additional toolbox training sessions on restrictive practice to be delivered to staff.

With regard to staff knowledge of the serious incident response scheme, due to staff during the site audit not demonstrating knowledge of what constitutes and incident to be reported, I note the Approved Provider has identified that language used by the Assessment Team may have confused some staff. The Approved Provider is however providing updated training to staff on the serious incident response scheme. I note that the Assessment Team identified two incidents that were not identified by staff as requiring reporting to the scheme.

I have considered the information provided by the Assessment Team and the Approved Provider and note that mechanisms to monitor staff attendance at mandatory training has not been effective in ensuring staff complete all required training. I also note the low compliance rate with general evacuation training as well as the noted non-compliance of a consumer with smoking arrangements, I consider it reasonable to expect staff to have completed this training as an additional measure to manage the risk of the consumers’ smoking habits.

On balance I find that the Approved Provider did not demonstrate at the time of the site audit that staff were completing mandatory training as scheduled. I note the additional training being arranged; however, this has not been completed and the effectiveness of ongoing monitoring of compliance with training is yet to demonstrated as effective.

I find the Requirement is non-compliant.

I have considered the information provided by the Assessment Team and the Approved Provider and I am persuaded by the Approved Providers ability to demonstrate compliance and the consumer/representative positive feedback in my determining my findings.

In Summary:

The overall Standard rating is non complaint as one of the Requirements is non-compliant.

I find Requirements 7(3)(a), 7(3)(b), 7(3)(c), and 7(3)(e) compliant.

I find Requirement 7(3)(d) non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | 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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Assessment Team provided information that consumers said they have multiple opportunities to provide feedback on care and services and management demonstrated the multiple avenues for consumers to be involved in the evaluation of cares and services. Consumers said they considered the service is well run and they can provide feedback and suggestions to management through multiple forums available at the service and through other feedback mechanisms such as ‘room visits’ and feedback forms.

The Approved Provider was able to demonstrate how the organisation’s governing body promotes a culture of safe, inclusive and quality care. The monthly Operational and Quality committees report to the organisation’s Quality and Care Governance Committee which reports to the Board.

The Approved Provider provided a response to the Assessment Team report that included clarifying information as well as handover sheets, referral information, clinical monitoring examples, training records and materials, Memorandum, clinical records extracts and the psychotropic register.

In relation to Requirement 8(3)(c) the Assessment Team provide information that whilst the organisation has established governance systems, gaps in communication and recording of information have resulted in deficiencies in information management, continuous improvement, workforce governance and regulatory compliance. The Approved Provider was able to demonstrate effective governance systems for financial governance and feedback and complaints.

In relation to information management the Assessment Team provided information that a review of consumer care documentation demonstrated that information regarding consumers’ care needs and treatment provided are not consistently documented, preventing continuity of care and appropriate oversight, and monitoring of consumers’ conditions.

I note deficits in the management of information related to the competition of care records for consumers with wounds and recording of pressure area care.

In relation to continuous improvement the Assessment Team provided information that deficiencies in recording consumer care information and gaps in staff knowledge have resulted in the Approved Provider failing to identify opportunities for improvement related to deficiencies in the provision and monitoring of clinical care and management of risk, including recognising and responding to clinical deterioration.

I note the processes used to monitor ongoing compliance with Aged Care Quality Standards had not identified the deficits in systems and processes that lead to the findings of non-compliance identified in this report.

In relation to workforce governance the Assessment Team provided information that gaps in the continuity of staff, staff understanding of organisational policies and procedures and low training compliance rates have resulted in adverse outcomes in the clinical care and management of risk to consumers.

The Approved Provider has demonstrated that there are workforce governance processes established and has recently introduced a new staffing model combining local staff with fly in fly out contracted staff to ensure continuity of staff. However, I also note the deficits in monitoring compliance with mandatory training.

In relation to regulatory compliance the Assessment Team provided information that a review of psychotropic register identified multiple consumers subject to chemical and mechanical restrictive practice without consent, assessment or appropriate monitoring and review. And that not all required incidents were reported to the serious incident response scheme.

I note that whilst generally consent is obtained for the use of restraint, for one consumer consent had not been obtained for the use of chemical restraint, and I note the Approved Provider acknowledged that two incidents had not been reported to the serious incident response scheme as required.

I have considered the information presented by the Assessment Team and the Approved Provider and I find that the Approved Provider has not demonstrated effective governance systems for information management, continuous improvement or regulatory compliance.

I find this Requirement is non-compliant.

In relation to Requirement 8(3)(d) the Assessment team provided information that a review of documentation and interviews with management and staff demonstrated an inconsistent understanding amongst staff of what constitutes a serious incident, resulting in incidents requiring notification not being identified or notified within reportable timeframes. The Assessment Team also reported a named consumer and the management of high impact care related to inconsistent wound and pressure area care.

The Approved Provider provided a response that acknowledge that that two incidents had not been reported to the serious incident response scheme as required. I note additional training and education materials are being provided to staff. The Approved Provider also supplied clarifying information and clinical records extracts.

I have considered the information provided by the Assessment Team and the Approved Provider, and I find that the incident management system had not been effective in ensure all required incidents were reported to the serious incident response scheme, and I note the significant deterioration in a consumers wound and deficits in demonstrating effective pressure area care has been maintained.

I find this requirement is non-compliant.

In relation to Requirement 8(3)(e) the Assessment team provided information that whilst implementation of clinical governance framework has occurred, monitoring of the framework has not identified deficits in the provision of clinical care, and deficits in the management of restrictive practice. For named consumers this was in regard to the use of restraint and wound management.

I also note open disclosure is practiced as part of the complaints process and staff could describe ways they can minimise infection within the service and reduce the need for antibiotics such as through encouraging fluids for consumers, hand hygiene practises and using appropriate personal protective equipment.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts.

I note the identified non-compliance in Standards two and three and deficits in the assessment and management of consumers care needs related to wound and pressure area care, and the use of chemical restraint.

I have considered the information provided by the Assessment Team and the Approved Provider, as well as the non-compliance identified in this report. I find that the processes to monitor the clinical governance framework has been effectively deployed. I note the deficits in the management of clinical care related to pressure area care and wound management and the identification and authorisation for chemical restraint.

I find this Requirement is non-compliant.

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