Performance

Report

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| Name of service: | Blue Haven Bonaira |
| Service address: | 14 Bonaira Street KIAMA NSW 2533 |
| Commission ID: | 0094 |
| Approved provider: | The Council of the Municipality of Kiama |
| Activity type: | Site Audit |
| Activity date: | 13 September 2022 to 16 September 2022 |
| Performance report date: | 28 October 2022 |

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 Haven Bonaira (**the service**) has been prepared by K. Spurrell, 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 12 October 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | 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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 2(3)(d) – The Approved Provider ensures 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 3(3)(a) – The Approved Provider ensures 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

* Requirement 3(3)(g) – The Approved Provider ensures 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.

* Requirement 4(3)(f) – The Approved Provider ensures where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 4(3)(g) – The Approved Provider ensures where equipment is provided, it is safe, suitable, clean and well maintained
* Requirement 6(3)(c) – The Approved Provider ensures appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d) – The Approved Provider ensures feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(a) – The Approved Provider ensures 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.
* Requirement 7(3)(e) – The Approved Provider ensures regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Requirement 8(3)(a) – The Approved Provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Requirement 8(3)(c) – The Approved Provider ensures 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.

# 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

Consumers and representatives felt they are treated with dignity and respect and staff value their identity, culture and diversity. Staff described how they treat consumers with respect by using their preferred name, acknowledging their choices and knocking before they enter their room. Care planning documents included information about consumers’ preferred names, background, work history, important associations, and religious affiliations.

Care plans included information about cultural background and practices, staff explained the cultural background of consumers and described care requirements that aligned with the consumers’ care plans. The Assessment Team observed provisions within the service to allow for cultural practices such as a peaceful chapel and various quiet spaces.

Consumers said they were able to make decisions and exercise choice and independence about the way care and services are delivered. Care planning documents identified the consumers’ individual choices around when care is delivered, who is involved in their care and how the service supports them in maintaining relationships. Staff described how they support consumers to exercise choice and independence in line with care planning documents. The Assessment Team observed staff offering choices to consumers and seeking consent before providing care.

Staff demonstrated they are aware of risks taken by consumers and said they support the consumer’s wishes to take risks. Staff said they are guided by policy and procedures to support consumers’ dignity of risk taking and were able to describe practices in line with policy and procedure. The Assessment Team viewed care files with signed Dignity of Risk forms. Consumers confirmed that they were aware of the risks they were taking to live the life they choose.

Consumers and representatives reported that they are kept updated by management and staff when changes occur via phone, email, and the service’s newsletter. Lifestyle staff and management described and demonstrated various modes by which information is communicated to consumers and representatives including newsletters, emails, phone and verbally. The Assessment Team observed information available in newsletter, activities schedules, and on whiteboards throughout service.

Staff described how they protect consumers’ personal information and show respect for their privacy. The service has policy and procedures in place to ensure confidentiality and privacy of personal information. The Assessment Team observed staff to be adhering to privacy practices, such as knocking on doors before entering consumers’ rooms and closing doors when providing personal care.

# 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. | 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. | Non-compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-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.

Most consumers and representatives expressed satisfaction with how the service maintains communication with them, particularly around changes in care and medication, or if an incident occurs. While the service communicates the outcome of assessment and planning to consumers and representatives, not all consumers and representatives were aware that the service keeps records of care for each consumer and were not aware of their formal care and services plan. Management and staff were not aware of the requirement to ensure that consumers have a readily available documented care and services plan. The Assessment team spoke with six named consumers and representatives who advised they had either not seen or not been offered a copy of their care plan.

The Approved Provider’s written response of 12 October 2022 acknowledged there may have been inconsistencies in the offering of care plans to consumers and representatives, however, provided evidence of representatives being offered plans prior to case conferences in June. The Approved Provider further advised that greater management oversight has seen a change in process, planned staff education regarding the offering of care plans and additional communication to consumers and representatives via the resident and relative meeting planned for October 2022.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider to address the deficiencies, I consider that at the time of the Site Audit the Approved Provider was unable to demonstrate effective communication regarding assessment and planning. I find Requirement 2(3)(d) is non-complaint.

I am satisfied the remaining four requirements of Quality Standard 2 are compliant.

Consumers and representatives expressed satisfaction with the assessment and care planning processes, which commence upon admission and continue at routine review or when changes are needed. Care documentation evidenced examples of how the Care and Services Plan includes input from a multidisciplinary team to assist in managing or minimising risk to meet consumer’s needs, goals, and preferences. Staff described the assessment and planning process and confirmed their role in supporting consumers in taking risks and described how they work and involve others as applicable to minimise risks.

Consumers expressed satisfaction with how they are involved in their assessment and care planning and confirmed that the service consults and informs them regularly in relation to consumer care needs and end of life preferences if they wish to discuss these. Clinical management and staff were able to describe the service process in determining what is important to the consumer by utilising their assessment tools, regular communication and consultations, care planning and staff observations.

The service partners with consumers and others who the consumer wishes to involve in the planning and assessment of care. Consumers are supported to make their own decisions, as well as to take part as much or as little as desired in the assessment and planning process. Physiotherapy, occupational therapy, podiatry, speech pathology and dietitians are involved in care planning as needed.

Care and services are regularly reviewed in line with organisational policy for effectiveness that occurs every three months for each consumer. A review may also happen when circumstances change such as consumer deterioration, infections, falls and wounds, or when incidents impact the needs, goals, and preferences of consumers. Consumers advised that staff regularly discuss their care needs and that their care and services are reviewed regularly or when changes occur. Registered staff demonstrated their care planning and evaluation processes on the electronic care management system, which automates an alert to all relevant users whenever care plans and assessments are due.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are 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.

* 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.

Some consumers were satisfied with the clinical care provided by the service and gave positive feedback regarding the way the service manages skin integrity, restrictive practices and pain management. Other consumers expressed dissatisfaction with the personal and clinical care provided and raised concerns around how safe some of the practices are.

Consumers described staff as ‘busy’, ‘rushing’ and said they cannot attend to consumer’s personal care needs all the time’ in line with their preferences. The Assessment Team reviewed nine consumers’ care documentation and noted that whilst all consumers have individualised care plans with identified preferences, three consumers’ care records did not contain sufficient evidence that the service provides tailored personal and clinical care to meet the consumer’s identified needs and preferences.

The Assessment Team identified one named consumer who reported that they did not receive hygiene care in line with their preferences, advised that they were required to use a bed pan due to a lack of staff to assist with toileting and had to wait for an extended period for it to be attended to, a representative further advised that their named consumer does not receive a shower daily in line with their preferences and despite this being raised with management continues to receive sponge baths on alternate days. A further named consumer advised of a situation where they were unable to reach their medication to administer it themselves and had to wait for an extended period for staff to attend and assist, causing distress.

In its written response of 12 October 2022, the Approved Provider acknowledged the deficits identified by the Assessment Team and identified staffing issues as a root cause to the issues raised. The Approved Provider advised that since the Site Audit, a dedicated human resource position has been appointed to assist with the recruitment of managers, registered and care staff. The Approved Provider also stated that daily huddles to assist with staff communication and handover will be further embedded by the service to ensure consumer needs are met.

I have considered the evidence brought forward in the Site Audit report and the additional information provided in the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider in response to the Site Audit, I have also considered the consumer feedback and the impacts to care experienced as a result of the deficiencies. Based on the totality of evidence I find Requirement 3(3)(a) is non-compliant.

The Assessment Team found that the service did not have effective and appropriate infection control measures in place. The Assessment team observed the absence of a donning and doffing station at the exit door to dispose of used personal protection equipment and some staff that were not following infection minimisation and control measures such as incorrect hand washing techniques and improper wearing of face masks.

Observations made by the Assessment team included; five staff members exiting the service still wearing face masks as there was nowhere to dispose of them at the service exit, two staff members who were observed wearing their face masks under their nose while on shift, there was a lack of Infection, Prevention and Control lead in place onsite and the outbreak management plan did not include guidance on how the service would manage a gastroenteritis or influenza outbreak.

The Assessment Team raised some of these issues with management during the Site Audit and noted that a doffing station had been installed at the service’s exit. Management also advised that there are electronic procedures in place to guide staff, however only one out of four staff members could demonstrate to the Assessment team how to access these procedures in the online system.

In its written response of 12 October 2022, the Approved Provider acknowledged some of the deficits identified by the Assessment Team and advised that it is conducting ongoing education in relation to hand hygiene and donning and doffing competencies. The service has also undertaken to revise its outbreak management plan to capture the management of Influenza, Gastroenteritis and Scabies outbreaks and has also identified two staff members who are currently training as Infection, Prevention and Control leads.

I have considered the evidence brought forward in the Site Audit report and the additional information provide in the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider in response to the Site Audit, I have also considered that these actions will take time to implement and measure their effect. Based on the totality of evidence I find Requirement 3(3)(g) non-compliant.

I am satisfied the remaining five requirements of Quality Standard 3 are compliant.

The service demonstrated an effective process to manage high impact or high prevalence risks associated with the care of each consumer which ensures safety and quality of personal and clinical care including weight loss, falls, and complex health management, as guided by the organisation’s range of clinical policies and procedures in managing high impact and high prevalence risks. Consumers and representatives expressed satisfaction with the service management of high impact risks in relation to their clinical and personal care.

Care planning documentation reviewed for consumers who were nearing end of life showed their needs, goals and preferences are recognised, and their comfort maximised. Consumer clinical records indicates regular monitoring by registered staff and if deterioration or change of a consumer’s mental, cognitive, or physical function, capacity or condition occurs, it is recognised and responded to in a timely manner and representatives are notified. Staff described how the care service delivery changes for consumers nearing end of life.

Staff explained different situations where a change in consumer’s condition, ability and health should be identified, communicated and what response they should take. Representatives stated that they are given timely information when changes occur in the consumer’s condition. Care planning documentation showed identification of triggers to escalate concerns and their response as a service when a consumer deteriorates.

Care planning documents showed adequate information to support effective and safe sharing of consumer information in relation to the provision of care. Staff described their role to communicate changes in a consumer’s condition that can be triggered by consumer deterioration, clinical incident, change in medication, or changes as per request by the consumer or representative. Management said information is documented in consumer’s progress notes, assessments and care plans that are shared to other health professionals as applicable to direct care.

Care planning documents of sampled consumers showed referrals were made by the service as needed by the consumer. The Assessment Team noted referral services occurring for consumers including consultation or review from dietitians, physiotherapists, occupational therapists, speech pathologists, dementia specialists, clinical nurse consultants, diabetes specialists, geriatricians, and medical officers.

# 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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Where meals are provided, they are varied and of suitable quality and quantity.
* Where equipment is provided, it is safe, suitable, clean and well maintained.

Feedback from consumers was that the meals were not of sufficient quality or variety to meet their needs and preferences. The Assessment Team spoke with 12 consumers, six of whom spoke negatively about the food within the service. Feedback included one named consumer who advised that the meals were unsuitable to manage their gastric condition, a further named consumer with chewing difficulties for who, no suitable alternatives were provided, consumers reported that meats are often tough and overcooked and there was a general lack of choice to the meals. Management acknowledged the feedback and discussed several strategies that were planned to improve the meal service, including, satisfaction surveys, the engagement of a food consultant and support for consumers to undertake their own cooking.

In its written response of 12 October 2022, the Approved Provider acknowledged the gaps in the quality and quantity of meals provided and further advised the service is working with a caterer to resolve the issues and advised that following an audit the service has created a plan to focus on both food safety and quality. Actions include the development and implementation of documented procedures covering the storage and preparation of food, including puree’s, Fresh meals to be prepared offsite and delivered as an interim measure to meet quality expectations and a review and overhaul of the cleaning procedures and full clean of the kitchen that was finalised in early September 2022

I have considered the evidence brought forward in the Site Audit report and the additional information provide in the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider in response to the Site Audit, I remain of the view that at the time of the Site Audit the Approved Provider did not demonstrate that meals were of a suitable quality and quantity, which impacted consumers as a result. Based on the totality of evidence I find Requirement 4(3)(f) non-compliant.

The Assessment Team spoke with staff and consumers who described instances where insufficient or inappropriate equipment was available. The Assessment Team inspected the minutes from recent meetings and found that one named consumer was required to wait for over nine days for a replacement shower chair, impacting their ability to shower in this time. A staff member explained to the Assessment Team that if a sling is required in the instance of a fall, the equipment needs to be obtained from the laundry in order to be used, impacting the timeliness of response. Staff also raised the issues of a lack of personal hygiene equipment on each floor, which impacted their ability to meet the personal hygiene preferences of consumers.

In its written response of 12 October 2022, the Approved Provider acknowledged the gaps in reporting processes and ability for staff to report additional equipment needs and advised the service intends to revise the reporting and escalation process and provide additional training to staff. In relation to the named consumer, the Approved Provider acknowledged there had been some impact to consumer care as a result of the equipment issues, however this was five days, not the nine identified by the Assessment Team.

I have considered the evidence brought forward by the Assessment Team and the additional information provided in the Approved Provider’s response. Based on the totality of evidence, I am of the view that the service did not provide appropriate and sufficient equipment to staff and consumers at the time of the Site Audit. I find Requirement 4(3)(g) non-compliant.

I am satisfied the remaining five requirements of Quality Standard 4 are compliant.

Staff demonstrated knowledge of consumers’ needs and preferences, which was supported by care planning documentation that captured consumers’ interests and preferences and provided information about the services and supports consumers needed to do the things they want to do. The Assessment Team observed consumers engaging in a range of activities supported by lifestyle staff, care workers and volunteers such as playing cards, watching movies, knitting and singing, and one-on-one activities such as chatting, doing jigsaw puzzles and going to the cafe for coffee.

Care planning documents recorded consumers’ spiritual needs and religious associations and the service refers consumers to appropriate services to support their emotional, spiritual and psychological well-being, including religious and community-based events and services. Staff described how they supported consumers to engage in the community and maintain social and personal connections that are important to them and do things of interest to them.

Progress notes in the electronic records system recorded both routine services and changing conditions and support needs. Medical officers, allied health practitioners and lifestyle staff have access to timely and updated consumer information by accessing the electronic care management system. Care planning documentation showed the service collaborates with external providers and consumers and staff provided examples of referral to external providers such as physiotherapy services, dietitian, and medical officers.

# 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

Consumers and representatives confirmed that they find the service welcoming and directional signage makes it easy to find their way around. Staff described strategies to make consumers and representatives feel welcome such as being approachable, open, friendly and having knowledge of individual consumers preferences.

The Assessment Team observed consumers and representatives moving freely around the service, enjoying both indoor and outdoor areas. Consumers expressed satisfaction with the cleanliness and maintenance of the service and staff demonstrated cleaning schedules, preventative maintenance schedules and reactive maintenance processes that ensured a safe, clean and well-maintained service.

Furniture, fittings and equipment are maintained to ensure safety and cleanliness and consumers have access to furniture and equipment that suits their needs. Consumers reported that equipment was in working order and suited their needs, for example audio visual equipment, tea and coffee making equipment and lifestyle equipment. Staff described the process for reporting maintenance issues in a book located in the nurse’s station and said that reported maintenance issues are addressed promptly. The Assessment Team observed furniture, fittings and care equipment to be clean and in good repair.

# Standard 6

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Feedback and complaints are reviewed and used to improve the quality of care and services.

While the service could demonstrate evidence of an open disclosure approach related to incidents, it was unable to demonstrate that appropriate action is taken in response to complaints.

Staff explained the process followed when receiving feedback or a complaint and confirmed all complaints are escalated to management for investigation and follow-up, however, the Assessment Team found there are no records of complaints in the organisation’s complaints register since March 2022. The Service has policies and procedures that guide staff through complaints management and open disclosure process, but the Assessment Team could not identify that these policies are being effectively implemented by the staff and management team.

The Assessment Team spoke with four named consumers who described complaints they had raised either through resident meetings or formal feedback channels who said they had not had resolution to their issues. Complaints related to meals not meeting dietary needs, laundry being returned discoloured or damaged and the delivery of personal care not meeting needs or preferences.

In its written response of 12 October 2022, the Approved Provider acknowledge the deficits in the recording and management of complaints. The Approved Provider advised of actions planned in response to the Site Audit, which included education to be provided to staff in the complaints and escalation process, the complaints register will be maintained and audited regular for compliance in line with Policy and Procedure, complaints to be responded to in line with set time frames. Greater management oversight and presence at resident meetings and management of the complaints register will be undertaken to ensure all complaints are recorded and actioned appropriately.

In relation to the named consumer who raised issues relating to the laundering of their clothes, The Approved Provider advised that this complaint was recorded and responded to by the Hospitality manager and later followed up, with a positive response from the consumer and no further incidents since.

While I note the Approved Provider has acted in response to the findings of the Assessment Team, these improvements are still being implemented and will take time to establish and measure for effectiveness. I therefore find Requirement 6(3)(c) is non- compliant.

The service was not able to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. Consumers and representatives described raising issues in meetings, focus groups and with management but reported the issues remain ongoing and no improvements made in response to the feedback and complaints. Issues raised related to the quality of meals provided and the provision of personal care and services.

The Plan of Continuous Improvement (PCI) register demonstrates actions to be addressed in relation to clinical care, however, it does not evidence that consumer feedback, complaints and incidents are used to inform continuous improvement.

In its written response of 12 October 2022, the Approved Provider acknowledged the issues raised by the Assessment Team and advised that a Quality & Compliance Coordinator has since been appointed to monitor complaints, analyse trends, and provide reporting to consumers and management. The service will also undertake a review of the complaint handling policies to further support staff in the handling of complaints.

While I acknowledge the actions taken by the Approved Provider in response to the Site Audit report, these processes are still being established and were not in place at the time of the Site Audit and will take time to implement. I therefore find Requirement 6(3)(d) non- compliant.

I am satisfied the remaining two requirements of Quality Standard 6 are compliant.

Consumers and representatives are aware of the avenues available to raise feedback and were supported to provide feedback and make complaints. Consumers and representatives can raise feedback or complaints anonymously or with the assistance of staff. Staff could describe the process they follow should a consumer or representative raise an issue with them directly and the Service has established processes and systems in place for consumers, representatives, visitors, and staff to provide feedback or make a complaint.

Staff demonstrated a shared understanding of the advocacy services available for consumers and representatives and were able to describe how they assist consumers who have a cognitive impairment and difficulty communicating.

# Standard 7

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team spoke with consumers and representatives who felt there were not enough staff to provide care in line with their needs and preferences. This feedback was supported by staff who reported there are several unfilled shifts each week and that the workforce feels exhausted from the workload. The Assessment Team identified seven named consumers and representatives who reported direct impacts to their care as a result of the staffing pressures. Impacts included a lack of cleaning of personal rooms, with beds unmade throughout the day, lengthy response times to call bells impacting hygiene and clinical care delivery and significant delays to the delivery of care for consumers requiring two-person attendance. The Assessment Team reviewed call bell data that demonstrated lengthy response times, in excess of ten minutes.

In its response of 12 October 2022, the Approved Provider acknowledge the gaps in the workforce numbers and the staff feedback in relation to fatigue. The service has appointed a dedicated human resource position to undertake a recruitment drive, that has so far seen twelve positions appointed. The Approved Provider has also reviewed the roster, undertaken forecasting to forward plan and commenced reporting on missed shifts to better manage gaps in rosters. The Approved Provider also undertook to review call bell response times and reviewed their reporting process to better investigate and understand delays.

I have considered the evidence brought forward by the Assessment Team and the additional information provided in the Approved Provider’s response. While I acknowledge the planned and commenced actions of the Approved Provider, I consider these changes will take time to measure for effect and am of the view that the service did not demonstrate a sufficient workforce at the time of the Site Audit. I find Requirement 7(3)(a) is non-compliant.

The Assessment Team found that the service had outstanding performance appraisals, of fifteen staff files reviewed by the Assessment Team, all fifteen had not received a performance review in the last 12 months. This was further confirmed by staff who reported outstanding probation reviews, and management who acknowledged that performance appraisals and probation reviews have not been completed since January 2022 and while this had been included in the plan for continuous improvement, there was no timeline currently settled to bring all outstanding plans up to date.

In its response of 12 October 2022, the Approved Provider acknowledged the delay in performance reviews, identified staffing pressures as a core issue and advised that it had developed a plan to attend overdue reviews within the next three months.

While I acknowledge the undertakings made by the Approved Provider, at the time of the Site Audit the service did not demonstrate an effective assessment and performance monitoring process. I find Requirement 7(3)(e) is non-compliant.

I am satisfied the remaining three requirements of Quality Standard 7 are compliant.

Workforce interactions with consumers are kind and caring, and staff are respectful of each consumer’s identity, culture, and diversity. Consumers and representatives considered that staff engage with consumers in a respectful, kind, and caring manner, and are gentle when providing care. Staff demonstrated personal knowledge and understanding of the individual characteristics, culture and diversity of consumers, including their needs and preferences. The organisation has a suite of documented policies and procedures that emphasises the importance the organisation places on a person-centred approach to the planning and delivery of care and services.

The workforce is competent, and members of the workforce have the qualifications and knowledge to effectively perform their roles. Consumers were confident that staff are trained appropriately and are skilled to meet their care needs. Management described how the service determines whether staff are competent, and capable in their role through the monitoring of online mandatory training modules and competencies for all staff.

Consumers expressed confidence in the abilities of staff in delivering care and services and said that staff are well trained and equipped to perform their roles. Staff described the training, support, professional development, and supervision they received during orientation and on an ongoing basis. Management described how the analysis of incidents, clinical indicators and feedback and complaints identify staff training needs. The service has processes and systems in place to support new and current staff and mandatory training is well tracked.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* 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 service could not demonstrate how it is supporting consumers in the development, delivery and evaluation of care and services. While the service has established processes to support how consumers should be engaged in the development, delivery and evaluation of care and services, the Assessment Team identified that these processes were not followed by the organisation. Feedback and complaints raised during residents’ meetings were not captured and addressed by the management team and internal audits and surveys were last completed in November 2021. The Assessment Team spoke with consumers and representatives who expressed frustration at the lack of response to feedback and consumers felt unheard at forums such as resident meetings and had a lack of faith in the feedback and complaints system.

In its response of 12 October 2022, the Approved Provider acknowledged the gaps in consumer engagement and contribution to the delivery of care and services. The service has undertaken to develop and monitor processes to reengage with consumers. The service is undertaking a quality and compliance review in relation to consumer satisfaction, with additional surveys and forums planned to engage with residents and capture feedback.

While I acknowledge the undertakings made by the Approved Provider, I have also considered the feedback from consumers who report a lack of faith in the system and find that at the time of the Site Audit the service did not demonstrate how it supported and engaged with consumers in the delivery and evaluation of care and services. I find Requirement 8(3)(a) is non- compliant.

The service was not able to demonstrate that there are effective organisation-wide governance systems in place which guide continuous improvement, the workforce, regulatory and legislative compliance, and feedback and complaints. The governing body monitors and reviews routine reporting and analysis of data related to the consumer experience; however, the organisation does not have a Board process in place to ensure the right care is being provided in accordance with the Aged Care Quality Standards.

Management and staff were able to describe processes and mechanisms in place for effective organisation-wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints, however, the Assessment Team observed these processes were not effectively applied or successfully delivered as intended.

In its response of 12 October 2022, the Approved Provider acknowledged the deficits in the governance systems within the service. The Approved Provider has proposed amendments to the advisory board and committee to bring a greater depth of experience and oversight. The service has commenced quality and compliance reviews specific to continuous improvement activities, incident reviews and reporting obligations to identify trends and improve performance and will provide education to key personnel to support these activities.

The Approved Provider has reviewed its financial governance processes to gain improvements in reporting and forecasting and has appointed new positions to address the workforce sufficiency, performance issues and establish better system to improve compliance and respond to feedback and complaints.

While I acknowledge the undertakings made by the Approved Provider, I have also considered the impact to consumers as a result of the deficits in the governance systems identified by the Assessment Team. I therefore find Requirement 8(3)(c) is non- compliant.

I am satisfied the remaining three requirements of Quality Standard 8 are compliant.

The organisation has implemented systems and processes to monitor the performance of the service and to ensure the governing body is accountable for the delivery of safe, inclusive, and quality care and services. Management was able to provide examples of changes driven by the governing body as a result of consumer feedback, experience, and incidents. Management could describe and demonstrate how the organisational structure and hierarchy support accountability over care and services delivered.

The service has established risk management systems and practices are in place to identify and manage risks to the safety and well-being of consumers. Staff could demonstrate a sound understanding of these policies and explain how incidents are actioned and managed.

The service has a clinical governance framework that ensures the quality and safety of clinical care, and promotes antimicrobial stewardship, the minimisation of restrictive practices, and the use of an open disclosure process. Staff had been educated about the policies and were able to provide examples of their relevance to their work.

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