Performance

Report

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| Name: | BlueCross The Boulevard |
| Commission ID: | 3827 |
| Address: | 70 Heaths Court, MILL PARK, Victoria, 3082 |
| Activity type: | Site Audit |
| Activity date: | 1 October 2024 to 3 October 2024 |
| Performance report date: | 20 November 2024 |
| Service included in this assessment: | Provider: 3061 DPG Services Pty Ltd  Service: 5926 BlueCross The Boulevard |

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 BlueCross The Boulevard (**the service**) has been prepared by N Chahal, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 5 November 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not 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.

**Standard 6**

* Requirement 6(3)(c) ensure appropriate actions are taken after a complaint is raised by a consumer or representative.
* Requirement 6(3)(d) complete the implementation of feedback and complaints systems to ensure that all feedback and complaints are captured, reviewed and used to improve the quality of care and services.

**Standard 8**

* Requirement 8(3)(c) ensure implementation of governance systems is complete to support effective management of 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 indicated consumers are treated with respect and feel valued. Information about consumers’ backgrounds and preferences is recorded in care planning documents, and staff get to know consumers and understand what is important to them. The service has policies and procedures to guide staff on what it means to treat consumers with dignity and respect.

There was evidence staff respect consumers’ cultural backgrounds and provide care and services in a culturally safe manner. The service celebrates days of cultural significance such as Australian and New Zealand Army Corps (ANZAC) Day and Bastille Day, along with Mardi Gras and National Aborigines and Islanders Day Observance Committee (NAIDOC) week. The service has policies in place to guide staff in supporting consumers from diverse backgrounds.

Consumers were satisfied the service supports them to exercise choice and independence and make decisions about their care and services. An example was provided of a consumer retiring for the night and getting up at times of their choosing, and being assisted with care only as needed. Consumer relationships are supported, staff assisting consumers to sit with friends and choose who they socialise with at the service.

Consumers confirmed they are supported to engage in activities involving risk where this enhances their quality of life. Examples were provided of consumers being supported to continue driving and going for walks alone. The service organises assessments such as physiotherapy assessments where indicated and puts in place strategies with consumers to optimise safety. The service has a policy on dignity and choice which directs that assessment must occur to support consumers to engage in any chosen activities with associated risk.

Consumers and representatives described receiving information relating to activities and the day’s menu. Staff explained they use language-appropriate material and display activity schedules around the service. Staff communicate with consumers in their native languages where possible to ensure understanding of the information provided and speak clearly and slowly with consumers living with sensory or cognitive impairment.

Consumers and representatives were satisfied that consumer privacy is respected, and information kept confidential. They described staff closing doors and waiting until visiting family have left before assisting with personal care. Staff ensure handover sheets are not visible to others and dispose of them securely at the end of their shifts. Staff do not discuss consumers in public spaces, and they ensure they log off computers after completing their work. The service has policies in place in relation to security of information.

With consideration to the available information summarised above, I find the service compliant with Standard 1.

# 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. | 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

The Assessment Team recommended Requirements 2(3)(a) and 2(3)(b) as non-compliant. After considering the available information and the Approved Provider’s response, I have formed a different view and find the service compliant with these Requirements.

Requirement 2(3)(a)

Overall, consumers and representatives were satisfied with the care received. Some staff demonstrated awareness of risks to consumers. However, the Assessment Team report reflected that documentation did not always contain comprehensive information regarding consumer medical histories and associated risks. Care documentation for a consumer living with diabetes indicated the need for a diabetic diet and staff supervision during mealtimes. The consumer reported eating sandwiches and takeaway meals in his room, however, staff did not demonstrate an awareness of potential risks associated with poor nutrition or eating meals in isolation. Care documentation for a consumer living with epilepsy did not reflect the role of anti-seizure medications or risks relating to seizures and falls. In response to feedback from the Assessment Team, management acknowledged the deficits and implemented corrective actions, including updating the staff handover to include risks. The service’s plan for continuous improvement (PCI) was also amended.

The Approved Provider disagreed with the findings of the Assessment Team. The Approved Provider submitted a written response with clarifying information and supporting documentation, including assessment and planning documentation, progress notes, and evidence of reviews by the medical practitioner and allied health specialists.

Regarding the consumer with diabetes, the Approved Provider submitted additional evidence and specialist review records demonstrating appropriate management of diabetes and blood glucose levels. There is evidence of medical practitioner and allied health review and completion of a nutritional assessment in relation to the consumer's nutritional status. The consumer progress notes reflect the consumer's psychological well-being.

Regarding the documentation of anti-seizure medications, the Approved Provider has submitted clarifying information, including a snapshot of the medication management system. The risks and symptoms associated with the high-risk medications are documented in care documentation to guide staff practice. I note that during the Site Audit, there were information and communications technology (ICT) challenges due to a transition process impacting the Assessment Team’s ability to access information which may have contributed to discrepancies in accounts.

After reviewing all the available information, I have placed weight on the Approved Provider’s response and submitted evidence. Therefore, I find Requirement 2(3)(a) compliant.

Requirement 2(3)(b)

Overall, consumers and representatives indicated the service discusses consumer needs and preferences and could recall being offered information regarding advance care planning and end-of-life planning. However, the Assessment Team report reflected that for one consumer, advance care wishes were not accurately recorded within care documentation, and appropriate care interventions were not implemented in line with the consumer's advance care wishes following a medical emergency. Another consumer representative expressed that following a change in the consumer's care needs, appropriate interventions were not implemented to ensure comfort. In response to feedback, management acknowledged the deficits in the management of this information.

The Approved Provider disagreed with the findings of the Assessment Team and submitted a written response with clarifying information and supporting documentation, including assessment and planning documentation, progress notes, evidence of reviews by the medical practitioner and correspondence from representatives.

Regarding the incorrect documentation of the advance care directive, the Approved Provider has submitted care documentation for the consumer demonstrating appropriate completion of the advance care directive. The service, in the written response, has also provided further context relating to the concerned treatment during the episode of medical emergency. I acknowledge this was in line with the consumer's recorded advance care directives.

Regarding the dissatisfaction expressed by a consumer representative, I acknowledge the further clarifying information submitted by the Approved Provider, including the consumer's palliative care needs and the evidence of email correspondence from the consumer's authorised representative. Following the Site Audit, the service has also introduced a supportive and palliative care indicators tool and provided further education to staff.

After reviewing all the available information, I have placed weight on the Approved Provider’s response and submitted evidence. Therefore, I find Requirement 2(3)(b) compliant.

In relation to the Requirements 2(3)(c), 2(3)(d) and 2(3)(e), I agree with the Assessment Team recommendations and find the service compliant with these Requirements.

The Assessment Team report reflects that consumers and representatives, and others who provide care to consumers, are involved in assessment and care planning. Representatives are contacted regularly by the service and clinical staff collaborate with consumers, representatives and external service providers when planning consumer care. Management advised the service conducts monthly meetings attended by a general practitioner, pharmacist, clinical staff and the consumer and/or their representative to discuss care matters.

Overall consumers and representatives were satisfied staff communicate the outcomes of assessment and planning to them, and they receive copies of the consumer’s care and services plans. Formal care conferences with consumers and/or their representatives occur as part of quarterly ‘resident of the day’ reviews and annual care plan consultations. Staff have access to care plans through the service’s electronic care system and receive information through handovers.

Staff explained consumer care plans are reviewed quarterly and if a change occurs. There was evidence of regular reviews by general practitioners and dietitians, along with physiotherapist reviews following falls.

With consideration to the available information summarised above, I find the service compliant with Standard 2.

# Standard 3

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

Findings

The Assessment Team recommended Requirements 3(3)(a), 3(3)(b) and 3(3)(c) as non-compliant. After considering the available information and the Approved Provider’s response, I have formed a different view and find the service compliant with these Requirements.

Requirement 3(3)(a)

Consumer and representative satisfaction with the personal and clinical care provided at the service varied. One consumer reported pain and difficulty sleeping but mentioned that staff do not often check on them, and they feel uncomfortable calling for assistance. A representative expressed concern regarding the competence of clinical staff to manage complex care needs. Documentation review demonstrated that wounds and pressure injuries are identified in a timely manner and effectively managed, with wound charting including wound photography and registered nurse reviews. However, the Assessment Team found that pain and changed behaviours are inconsistently identified, assessed, and managed. For one consumer living with pain and insomnia at the end of life, staff described repositioning, maintaining the consumer’s legs in an elevated position, ensuring the provision of continuous oxygen, and managing pressure injuries. However, progress notes did not reflect that staff were aware of or monitoring pain and sleep, providing comfort care, or consistently recording vital signs.

The Approved Provider submitted a written response disagreeing with the findings of the Assessment Team. The response included further clarifying information and supporting documentation, including care documentation, a behaviour support plan, and progress notes.

Regarding the management of pain and sleep for a consumer, the Approved Provider has encouraged the consumer to call the care team whenever they have a concern or need assistance. The response also included evidence of progress notes demonstrating overnight monitoring of the consumer's care needs associated with pain, comfort, and sleep. Further context was provided in the response relating to the consumer's end-of-life care needs, along with ongoing involvement of a medical practitioner, in-reach team, and consumer representative. I have considered this information under Requirement 2(3)(b).

In relation to concerns raised by a consumer representative regarding the management of complex care needs, the Approved Provider provided further context on the communication arrangements in place for the consumer. The response outlined a detailed description of the multidisciplinary approach to the consumer’s care, involving medical specialists for the management of pain, changed behaviours, and continence needs. The Approved Provider submitted evidence demonstrating reviews and ongoing consultations regarding the consumer's changing care needs. The service is currently transitioning its clinical documentation system, and the response included a behaviour support plan for the consumer, demonstrating improvements to the care documentation following the implementation of the new system.

After reviewing all of the available information and noting that during the Site Audit there were challenges for the Assessment Team in accessing information due to the transition process and ICT cutover, I have placed weight on the Approved Provider’s written response and submitted evidence. Therefore, I find the service compliant with Requirement 3(3)(a).

Requirement 3(3)(b)

Most consumers and representatives provided positive feedback regarding the care provided. Information regarding consumer needs and preferences and effective individualised interventions are shared at handovers and available within electronic care plans. Physiotherapy review occurs following consumer falls, recommendations for falls prevention are documented, and training is offered to staff. However, the Assessment Team found that for a consumer with a history of seizures and falls, care documentation lacked alerts and information regarding risks, including risks related to medications. Additionally, another consumer's care documentation included standardised interventions that did not inform an effective falls risk minimisation strategy. In response to feedback, management added an alert to the consumer’s file.

The Approved Provider submitted a written response disagreeing with the findings of the Assessment Team. The response included further clarifying information and supporting documentation, including care documentation.

Regarding the consumer care documentation lacking alerts for high-risk medication, the Approved Provider submitted care planning documentation and a snapshot of the medication management system outlining that risks related to high-risk medication are captured. The care documentation guides staff on the symptoms and monitoring requirements associated with the administration of high-risk medications.

The Approved Provider also submitted further clarifying information and disagreed with the Assessment Team’s findings of standardised care interventions relating to an ineffective fall’s mitigation strategy. The response provides further context on the consumer's care needs relating to mobility, including reviews undertaken by allied health specialists over a period. The Approved Provider outlined that the falls management strategies in the consumer care documentation supports the consumer to safely ambulate, with no falls recorded since 2023.

After reviewing all of the available information and noting that during the Site Audit there were challenges for the Assessment Team in accessing information due to the transition process and ICT cutover, I have placed weight on the Approved Provider’s written response and submitted evidence. Therefore, I find the service compliant with Requirement 3(3)(b).

Requirement 3(3)(c)

The service has policies and procedures to guide staff in providing palliative and end-of-life care. Clinical staff explained they refer to consumer care documentation for guidance regarding end-of-life wishes, specifically whether a consumer wishes to be resuscitated in the event of an emergency. However, the Assessment Team identified that for 2 consumers nearing the end of life, the service did not demonstrate that pain was effectively monitored and managed, and comfort care consistently provided.

While staff described providing pressure area care and ensuring continuous oxygen therapy for a consumer, documentation evidenced inconsistent recording of vital signs and did not reflect the provision of comfort care or administration of ‘as needed’ (PRN) medications to ensure effective management of symptoms of distress. I also note information recorded in the Assessment Team report under Requirement 2(3)(b) indicating representative dissatisfaction with the consumer’s care.

Additionally, a representative described a consumer being provided with emergency medical treatment that was not in line with their advance care directive.

The Approved Provider submitted a written response disagreeing with the findings of the Assessment Team. The response included further clarifying information and supporting documentation, including care documentation and medication administration records.

Regarding the inconsistent consumer documentation concerning comfort care, medication administration, and vital signs, the Approved Provider submitted evidence of medication administration with a review for effectiveness. The response also included further context on the consumer's palliative care trajectory and interventions implemented following the change in consumer care needs after the Site Audit. I also take into account the information under Requirement 2(3)(b) relating to consumer representative arrangements relevant to this Requirement.

Regarding the incorrect documentation of the advance care directive, the service provided further context in the written response relating to the concerned treatment during the episode of medical emergency. I acknowledge this was in line with the consumer's recorded advance care directives submitted by the Approved Provider.

After reviewing all the available information and noting that during the Site Audit there were challenges for the Assessment Team in accessing information due to the transition process and ICT cutover, I have placed weight on the Approved Provider’s written response and submitted evidence. Therefore, I find the service compliant with Requirement 3(3)(c).

In relation to Requirements 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g), I agree with the recommendation of the Assessment Team and find the service compliant with these Requirements.

Most consumers and representatives were satisfied with actions taken by the service when there was a change in consumer health status. Care staff report changes in consumers’ physical state or presentation to clinical staff, and any changes are discussed with a multidisciplinary team at daily huddles. Visiting health professionals and a local residential in-reach service are available to assess consumers during working hours if needed. A locum service and virtual emergency department consultation service is available to provide assessment and recommendations out of business hours. Documentation supported that staff take appropriate action in response to change or deterioration, including following falls.

Consumers and representatives expressed satisfaction that consumer needs are communicated. Feedback indicated staff are mostly aware of consumer needs and preferences. Information is recorded within handovers, electronic care plans, progress notes, and an electronic dashboard which alerts staff to tasks requiring completion. Verbal handovers occur at each change of shift and provide guidance to staff.

The Assessment Team report indicates consumers and representatives are satisfied with the referrals made to general practitioners, allied health professionals and specialist health care providers. Consumer feedback and review of care documentation confirmed timely and appropriate referrals to external providers including optometrists and audiologists.

Consumers and representatives were satisfied with the service’s management of infection-related risks. The service has an infection prevention and control (IPC) lead, and staff undergo training and competency assessment in relation to infection control practices including the use of personal protective equipment (PPE). Clinical staff follow the Australian Government pathway for consumers with suspected urinary tract infections, and pathology samples are collected prior to the commencement of antibiotics. Daily health checks are conducted and consumers exhibiting respiratory symptoms or other signs of ill-health are isolated as a precautionary measure while testing for COVID-19 is conducted. Staff are required to test if feeling unwell and to avoid the workplace if symptomatic of infectious illness. The service has an outbreak management plan and monitors its PPE supplies. There is an antimicrobial stewardship policy in place.

With consideration to the available information summarised above, I find the service compliant with Standard 3.

# Standard 4

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

Findings

Consumers were satisfied that the service supports them to engage in preferred activities and do things of importance to them. They indicated the services and supports provided help maintain their quality of life. Examples were provided of consumers being supported to continue driving and accessing the community and being able to clean their own rooms and change their own beds if they wish. The service offers activities based on consumer needs and preferences, and activity packs are available in different languages for consumers who do not wish to participate in group activities. Activities were observed by the Assessment Team to reflect the diverse range of consumer functional and cognitive abilities.

Consumers indicated their emotional, spiritual and psychological well-being is supported at the service. Consumers and representatives described staff providing emotional support by respecting the need for time alone, offering activity, spending time talking with consumers, and engaging in small acts of kindness. Consumers are supported to engage in activities which bring them pleasure such as visiting shops and gardening. Religious services are provided in the service’s chapel.

The Assessment Team found consumers are supported to participate in the community, maintain relationships and do things of interest to them. Lifestyle staff refer to consumer documentation in order to schedule activities of interest. Outings to local shopping centres are offered. Staff demonstrated an awareness of relationships and activities of importance to consumers.

Consumers and representatives were satisfied consumer needs and preferences are community effectively within the service and with others involved in care. Feedback confirmed representatives are kept informed regarding changes in consumer condition. Consumer information is recorded and available within the service’s electronic health information system in the form of care plans, progress notes and charts. Changes in consumer dietary requirements are documented in a food and fluids list which is available to kitchen staff.

The Assessment Team report reflected that while consumers are referred to external health providers such as allied health professionals, other support and lifestyle activities are mostly accessed within the service rather than via referral to external services. However, during the Site Audit a referral was made to a psychologist following a consumer request and feedback from the Assessment Team. The service also plans to re-engage with local schools regarding visits to the service.

Consumers and representatives reported satisfaction with the meals provided, indicating they are of a high standard. Consumers indicated the food is plentiful and consumers have choice. The menu is developed and reviewed by a dietitian seasonally, and aspects can be modified based on consumer feedback, needs and preferences. Meals were observed by the Assessment Team to be generous in size and to have an appealing aroma.

Consumers were satisfied the equipment used at the service is safe, clean and suitable for their needs. They confirmed staff check their personal equipment. Shared equipment is cleaned after each use, and any issues with equipment are referred to maintenance staff.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 4.

# 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 confirmed they feel welcome and at home at the service and provided positive feedback regarding the layout of the service and the space in which to walk around. Consumers are able to personalise their rooms with their own belongings. There is a room available for families to stay in when a consumer is nearing the end of life, and a dining room consumers and their families can dine in. The service has clear signage and rooms and pathways are free of hazards. I note also information contained in the Assessment Team report under Requirement 3(3)(a) regarding a relative lack of cues and signage to assist consumers with wayfinding in the service’s memory support unit.

The Approved Provider has submitted a written response acknowledging the Assessment Team’s observation of the memory support unit. The response outlined immediate actions taken by the service including working with consumers to utilise the memory cue box outside consumer’s bedrooms. The service has posted way finding signage and are consulting with specialists regarding the short, medium and long-term plans for the memory support unit.

Consumers were satisfied the service environment is clean, safe and comfortable and that they can access indoor and outdoor areas freely. While the Assessment Team observed some doors to outdoor areas were locked, this was immediately rectified by management in response to feedback. Staff report hazards immediately and regular maintenance occurs also. Cleaning occurs daily and increases during infectious outbreaks.

Consumers and representatives indicated consumers feel safe when using equipment. They were satisfied equipment and furniture are clean. All consumers had a working call bell in their room. Staff report faulty equipment and clean shared equipment after each use. The service has a small bus which was observed to be clean.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Standard 5.

# 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

The Assessment Team recommended Requirements 6(3)(c) and 6(3)(d) as non-compliant. After considering the available information and the Approved Provider’s response, I agree with the Assessment Team’s recommendations for Requirements 6(3)(c) and 6(3)(d) and find them non-compliant.

Requirement 6(3)(c)

The Assessment Team report indicated that consumers do not always feel the service addresses feedback and complaints or makes meaningful changes in response. One representative described making a complaint in March 2024 and receiving no explanation or resolution. This was supported by a review of the service’s complaints register, which showed no actions taken in response to the complaint. Another consumer representative raised a complaint with management in July 2024 about a delay in communication following a medication incident. The Assessment Team noted that this complaint was still ‘pending’ in the electronic system.

In response to the Assessment Team’s findings, management described the remedial actions taken during the Site Audit. Additionally, I have considered feedback and complaints information from Requirement 8(3)(c), relating to verbal complaints from a consumer about personal care provided by staff. Staff were not aware of the principles of open disclosure and indicated they had not received training on this topic.

The Approved Provider submitted a written response with clarifying information and supporting documentation, including complaints documentation, education records, and lifestyle information.

The response included information related to the actions implemented by the service following the Site Audit regarding the complaint raised by the consumer representative in March 2024. These actions include the commencement of bus outings and a review of the consumer’s lifestyle documentation. Staff have also received training on meaningful engagement with consumers.

Regarding the complaint about the delay in communication following a medication incident, the Approved Provider disagreed with the dates of the incident and provided further context. The service was undergoing an acquisition process during July 2024, which contributed to the incident. I acknowledge that the service has not had any further medication incidents of a similar nature.

The response also provided detail regarding actions taken following concerns raised by a consumer about personal care, recorded under Requirement 8(3)(c). These actions include obtaining further information from the consumer, offering an apology, documenting the issue in the complaint management system, and adding the consumer’s experience to the meeting agenda for discussion.

Regarding open disclosure, the Approved Provider has delivered additional training to staff on feedback, complaints, and open disclosure. The written response also noted that education records from 2023 showed several staff members attended open disclosure training.

I acknowledge the actions and improvements implemented by the Approved Provider in response to 3 complaints, following feedback and the Assessment Team’s recommendations following the Site Audit. In making my decision I continue to place weight on consumer and representative experience. While the identified complaints have been addressed, the service has not demonstrated that effective systems are in place to ensure appropriate actions are taken after a complaint is raised by a consumer or representative. Therefore, I find Requirement 6(3)(c) non-compliant.

Requirement 6(3)(d)

The Assessment Team report indicated that consumers and representatives were not aware of any improvements made at the service as a result of feedback or complaints. During the Site Audit management outlined how the feedback and complaints process informs service improvements but acknowledged that not all feedback and complaints, or their outcomes, are recorded. Management acknowledged that not recording all feedback and complaints may impact tracking and follow-up. An incident regarding staff behaviour was found by the Assessment Team to have been actioned but not recorded in the complaints register. Another incident related to a consumer’s advance care directive was also not recorded but was added to the complaints register during the Site Audit in response to the Assessment Team’s feedback.

The Approved Provider submitted a written response disagreeing with the Assessment Team’s findings regarding consumer incidents reported under this Requirement. The service conducted further investigation and described a different account of the behaviour incident involving a staff member. Regarding the consumer’s advance care directive, evidence was submitted demonstrating that appropriate care was delivered to the consumer in line with the completed directive.

The Approved Provider also provided further clarifying information in response to the Assessment Team’s findings of inconsistent documentation practices relating to complaints and feedback. The response included complaints and feedback documentation demonstrating a detailed tracking and follow-up process, along with a description of dedicated organisational systems in place to ensure consumer feedback informs improvements to care and services. Following the acquisition, the service has begun implementing these systems to enhance the effective management of feedback, complaints, and suggestions to inform the PCI. The service is also working with staff to ensure all complaints and feedback information is lodged into the complaints management system.

In making my decision, I am reassured by the clarifying information and further context relating to consumer incidents submitted by the Approved Provider. However, while the service has detailed and dedicated systems in place to ensure effective management of complaints and feedback, these processes are currently being implemented. The outcome of these systems is yet to be evaluated. Therefore, I find Requirement 6(3)(d) non-compliant.

In relation to Requirements 6(3)(a) and 6(3)(b), I agree with the Assessment Team recommendations and find the service compliant with these Requirements.

Consumers and representatives were satisfied they are encouraged and supported to provide feedback and make complaints. Feedback can be provided through feedback forms, email, resident and relative meetings or in person to staff or management. The service has a complaints management procedure and staff are aware of how they can support consumers wishing to provide feedback. Information regarding feedback options was observed to be displayed around the service in English and also other languages. Feedback boxes are located throughout the service.

Information regarding advocacy services, the Aged Care Quality and Safety Commission and interpreter services was observed to be on display at the service. Information packages and meeting minutes demonstrated consumers and representatives are informed about how to access these services. Consumers and representatives confirmed their awareness of these avenues to lodge complaints and provide feedback.

With consideration to the available information summarised above, I find the service non-compliant with Standard 6.

# 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. | 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 recommended Requirement 7(3)(d) as non-compliant. After considering the available information and the Approved Provider’s response, I have formed a different view and find the service compliant with Requirement 7(3)(d).

Requirement 7(3)(d)

Overall, consumers and representatives confirmed that staff are trained and supported to provide quality care and services. One consumer expressed the view that newer staff could benefit from further training in being gentle when providing care. The Assessment Team identified an opportunity for improvement where complex care needs are required. I have also considered additional relevant information provided under Requirement 7(3)(c), specifically, staff are required to undertake mandatory training which includes medication administration (for relevant staff), hand hygiene, infection control, Serious Incident Response Scheme (SIRS), elder abuse, and fire emergency training. Management monitor staff completion of scheduled training. The service has identified a need to extend training topics to align with the systems of the new provider.

The Approved Provider has submitted a written response with clarifying information and supporting documentation including care documentation and progress notes.

The response acknowledges the feedback from a consumer relating to further training for staff. The Approved Provider has also submitted evidence of a consultation with the consumer, and this has also been added to a meeting agenda for further discussion.

In relation to the management of complex needs the response included evidence of care documentation demonstrating appropriate management of complex care requirements. Refer to Requirement 2(3)(a) for further information.

After reviewing all the available information, I have placed weight on the Approved Provider’s response, submitted evidence and the positive feedback received from the consumers. Therefore, I find Requirement 7(3)(d) compliant.

In relation to the Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(e), I agree with the Assessment Team recommendations and find the service compliant with these Requirements.

Consumers and representatives indicated they are generally satisfied with staffing levels at the service when all rostered staff are working. Consumers confirmed they rarely wait longer than 10 minutes for a call bell response. This was supported by staff who indicated staffing levels are adequate when there is no unplanned leave and explained when an absent staff member cannot be replaced, they will request assistance from staff in other areas when needed or will agree to work a longer shift. Management outlined staff planning and recruitment initiatives and indicated replacement staff can generally be found when unplanned leave occurs. The roster is developed with consideration to funding, mandatory care minutes, skill mix and the number of consumers at the service. Work is underway to implement a new roster which will involve an additional registered nurse and an additional care staff member daily. The service also has a strategy to convert casual staff to permanent employees.

Consumers and representatives confirmed staff interact with consumers in a kind, respectful and caring manner. Staff were observed by the Assessment Team greeting consumers by name.

While 2 representatives voiced concern that some staff do not seem experienced in providing care to consumers with complex care needs, the Assessment Team report reflected consumers and representatives feel most staff are competent and have the knowledge to perform their roles. Positive consumer feedback was provided regarding staff provision of wound care. Position descriptions outline roles, responsibilities, and necessary qualifications. Clinical staff all hold professional registrations. New staff commencing at the service are generally partnered with a more experienced staff member for their first shifts.

The service has processes in place to assess, monitor and review staff performance. Performance appraisals occur 3 and 6 months after the commencement of employment and annually thereafter. Staff confirmed recently undergoing performance appraisals. Staff receive feedback in relation to their performance based on observations of their interactions with consumers, complaints, and audits.

With consideration to the available information summarised above, I find the service compliant with Standard 7.

# 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. | Not 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

The Assessment Team recommended Requirements 8(3)(c), 8(3)(d), and 8(3)(e) as non-compliant. After considering the available information and the Approved Provider’s response, I agree with the Assessment Team’s recommendation for Requirement 8(3)(c). However, regarding Requirements 8(3)(d) and 8(3)(e), I have formed a different view from the Assessment Team’s recommendation. I find the service compliant with Requirements 8(3)(d) and 8(3)(e).

Requirement 8(3)(c)

The Assessment Team report identified that 2 sets of policies and governance frameworks are currently operating at the service due to the transition to the new provider. In this context, the Assessment Team found that effective organisation-wide governance systems are not currently in place. New and updated policies and procedures are available to staff through a transition portal, and staff confirmed they can access consumer information through care plans and shift handovers. However, the Assessment Team were concerned that the clinical documentation demonstrated a lack of consistent recording of relevant and current information.

Continuous improvement opportunities are identified through consumer, representative, and staff feedback, surveys, and food focus meetings. Although, the Assessment Team found that some opportunities for improvement were not identified; in response to feedback, management-initiated strategies to address the identified deficits.

Capital expenditure is approved by corporate management, and requests for specialised equipment for consumer care are approved by clinical management in conjunction with allied health providers.

The service has policies and procedures in place relating to recruitment, workforce planning, orientation, training, performance review, and staff retention. Regulatory compliance is managed by the corporate quality and risk team, who advise the service of any legislative changes and arrange staff education. The Assessment Team report reflected that the service’s policies meet current legislative requirements.

While the service has feedback and complaints policies, not all complaints are recorded, analysed, or used to inform continuous improvement.

The Approved Provider submitted a written response with further clarifying information and supporting documentation, including a PCI.

Regarding information management, the Approved Provider explained that the availability of 2 sets of policies and procedures is to familiarise staff with these policies during the transition process. The Approved Provider disagreed that clinical documentation was inconsistent and lacked relevant and current information. The response described the communication process undertaken by the service during the transition to ensure safe and effective continuity of care. The Approved Provider also submitted further relevant evidence relating to inconsistent clinical documentation reported under Requirements 2(3)(a), 2(3)(b), 3(3)(a), 3(3)(b), and 3(3)(c).

Regarding the deficits in continuous improvement, the service has delivered training to ensure that all opportunities for improvement are recorded with subsequent actions and outcomes. The response also included a current PCI with various improvement opportunities identified from the Site Audit.

Regarding feedback and complaints, the Approved Provider described the organisational governance systems to ensure that feedback and complaints are captured, documented, and analysed. The response outlines that the service is undergoing a transition process and requires time to embed these systems and make comprehensive use of the complaints management system. The service has also implemented a PCI relating to feedback and complaints with various planned actions including review of current process and review of complaints documentation in the electronic system.

After reviewing all the available information, I am reassured that the Approved Provider has effective organisational governance systems in place relating to information management, continuous improvement, financial governance, workforce governance, and regulatory compliance. However, regarding feedback and complaints, while the service has detailed governance systems, these are currently in the process of implementation, and the effectiveness of these processes is yet to be evaluated. In making my decision, I have also considered the feedback and complaints information under Requirements 6(3)(c) and 6(3)(d) and have placed weight on the feedback received from consumers and representatives along with the Assessment Team’s findings. Therefore, I find Requirement 8(3)(c) non-compliant.

Requirement 8(3)(d)

The service has a documented risk management framework, including policies and procedures relating to risk, supporting risk-taking, abuse and neglect of consumers, supporting consumers to live their best lives, and incident management. Staff and management demonstrated an awareness of their responsibilities in these areas. However, the Assessment Team found that effective management of high-impact and high-prevalence risks was not demonstrated, highlighting a lack of clinical oversight to ensure risks are appropriately managed and consumers receive safe and quality care.

Staff receive training in abuse and incident reporting, and the Assessment Team’s review of the SIRS register evidenced that serious incidents have been reported. Dignity of risk authorisation forms are completed by consumers and/or representatives where indicated; however, the Assessment Team found that 2 consumers who choose to smoke did not have these forms. In response to feedback, management indicated they were unaware of this. Management reviews and reports high-impact and high-prevalence risks to the corporate clinical governance committee and receives guidance and advice from the director of clinical governance and quality team. Incidents are analysed and trended, resulting in management identifying falls, wounds, and medication errors as areas for improvement. Management indicated that the planned implementation of a new roster will ensure registered nurses have more time for assessing and monitoring consumers’ clinical care needs. The Assessment Team found that the service does not have a forum to discuss a comprehensive approach to falls and other high-risk and high-impact issues. Staff voiced concern that they are unsure if best practices are being followed due to a lack of direct handover and supervision.

The Approved Provider submitted a written response with further clarifying information and supporting documentation, including a risk register and monthly meeting agenda.

The response provided an overview of detailed organisational quality processes that have been implemented and are currently in the process of implementation. The service has established processes using trending and analysis to mitigate high-impact and high-prevalence risks, including falls, through weekly reporting and monthly multidisciplinary discussions. This was evident in the submitted risk register and monthly meeting agenda.

The Approved Provider acknowledged that ‘dignity of risk authorisation’ was not completed for 2 consumers. The service has investigated and provided further context regarding a consumer’s choice to smoke.

I have reviewed all the available information and acknowledge that the service has processes in place to manage high-impact and high-prevalence risks, including falls. I also note that the Approved Provider is currently undergoing a transition process and is working on strengthening these processes. In making my decision, I have placed weight on the Approved Provider’s response, submitted evidence, and further context provided regarding ‘dignity of risk’ authorisations. Therefore, I find Requirement 8(3)(d) compliant.

Requirement 8(3)(e)

The Assessment Team report indicated that the service’s clinical governance framework ensures the provision of safe and quality care in respect to antimicrobial stewardship and minimising the use of restraint. However, it does not ensure staff use open disclosure in accordance with their roles and responsibilities. The service has an antimicrobial stewardship policy, and the medication advisory committee meets quarterly to review all consumer antibiotic use. A restrictive practice minimisation policy is in place to guide staff, and restrictive practice is used as a last resort. Psychotropic medications are reviewed by a general practitioner every 4 months with a view to decreasing or ceasing medication. However, while the service has an open disclosure policy and management confirmed they support the practice of open disclosure, staff could not describe the principles of open disclosure and how they are applied.

The Approved Provider submitted a written response disagreeing with the findings of the Assessment Team. The response also included further clarifying information and supporting documentation, including education records.

The service described that training records from November 2023 showed several staff attended open disclosure training. Staff training records demonstrated that open disclosure training has also been delivered to staff following the Site Audit. I have also considered the information relating to open disclosure under Requirement 6(3)(c).

After reviewing all the available information, I have placed weight on the Approved Provider’s response and submitted evidence. Therefore, I find Requirement 8(3)(e) compliant.

In relation to Requirements 8(3)(a) and 8(3)(b), I agree with the recommendations of the Assessment Team and find the service compliant with these Requirements.

The service seeks input from consumers through surveys, feedback mechanisms, and meetings. Consumers confirmed that at resident and relative meetings they can make suggestions, contribute to discussion, and plan future events. Internal audits and surveys are undertaken annually, and the service’s leadership team frequently seeks informal feedback from consumers.

Overall consumers felt they live in an environment that provides quality care and services. The organisation’s Board meets bi-monthly and receives reports on quality indicators, feedback and complaints, incidents, audit results, and compliance issues. There is a clinical governance committee which has oversight for clinical care, monitoring risk at the service level. The service is currently in a transition phase following the acquisition of the service by a new provider, and upcoming changes include the introduction of a new model of care.

With consideration to the available information summarised above, I find the service non-compliant with Standard 8.

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)