Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Calvary Ryde Retirement Community - Mary Potter Residential Care |
| Service address: | 678 Victoria Road RYDE NSW 2112 |
| Commission ID: | 2818 |
| Approved provider: | Calvary Retirement Communities Limited |
| Activity type: | Site Audit |
| Activity date: | 18 April 2023 to 21 April 2023 |
| Performance report date: | 31 May 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Calvary Ryde Retirement Community - Mary Potter Residential Care (**the service**) has been prepared by Melissa Buhagiar, 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 conducted 18-21 April 2023, 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 22 May 2023
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances date 25 November 2022.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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 1(3)(a) The approved provider must ensure that staff provide each consumer with assistance with their personal care and other assistance as required and treat each consumer with respect.

Requirement 1(3)(d) The approved provider must recognise, discuss, assess and document risks for consumers and support consumers to take risks to enable them to live the best life they can.

# Requirement 1(3)(f) The approved provider must ensure that staff respect consumer’s privacy and do not enter rooms unannounced or without greeting the consumer. The provider must develop strategies to keep consumer’s personal items secure.

# Requirement 2(3)(a) The approved provider must demonstrate that all assessment and planning for new admissions is conducted in a timely manner and identifies the risks associated with the consumer’s condition.

# Requirement 2(3)(e) The approved provider must ensure that assessment and planning is reviewed regularly, and 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. That recommendations from specialists and organisations are documented and followed to meet the needs and preferences and to manage risks to consumers.

Requirement 3(3)(a) The approved provider must ensure that staff provide safe and effective personal care and clinical care, and that the recommendations from specialists are followed and documented to mitigate issues related to consumer’s pain, skin integrity deterioration and behaviour support concerns and that staff understand the importance of following these recommendations.

Requirement 4(3)(a) The approved provider must demonstrate that consumers are provided with a range of stimulating and meaningful activities and that staff are available to assist consumers to attend activities or go out to the garden to optimise their independence, health, well-being and quality of life.

Requirement 4(3)(c) The approved provider must demonstrate that staff enable and support consumers who have personal and social relationships and want to spend time together the opportunity to do so, and support consumers with daily living assist to do things of interest to them and spend time in their community both within and outside the service environment.

Requirement 4(3)(f) Then approved provider must demonstrate that feedback is considered and actioned appropriately and that changes to meals are in consultation with consumers and meet the nutritional, varied, quality and quantity requirements for consumers. That improvements to food service delivery are sustainable.

Requirement 6(3)(c) The approved provider must demonstrate that appropriate action is taken in response to complaints and that the actions are visible and sustainable, and feedback of the actions are provided to the complaint.

Requirement 6(3)(d) Then approved provider must demonstrate that all feedback and complaints are reviewed, considered and transferred to the Continuous Improvement Plan and actioned and discussed at resident meetings or personally to the complainant. That review and evaluation is also completed on any improvements to demonstrate sustainability and used to improve the quality of care and services.

Requirement 7(3)(a) The approved provider must demonstrate that there is an effective mix of staff to provide safe and quality care to consumers and to reduce the risk of consumers falling whilst seeking out personal care. That staff are available to provide personal care and for consumers not to have to wait unnecessarily to go to the bathroom or leave the bathroom/shower as no assistance is provided.

Requirement 7(3)(b) The approved provider must demonstrate that all staff interactions with consumers are courteous and are kind, caring and respectful of each consumer’s identity, culture and diversity.

Requirement 7(3)(d) The approved provider must demonstrate that staff are supported to undertake the training to effectively deliver the outcomes of these standards. That mandatory training and legislative training related to the Quality Standards is completed in a timely manner and any education highlighted in Continuous Improvement Plan is delivered and attended with practical competence demonstrated.

Requirement 8(3)(c) The approved provider must demonstrate that there is effective organisation wide governance systems to address the gaps identified in particular in relation to information management to provide staff with knowledge of consumer’s needs; continuous improvement to be demonstrated from internal and external audits and consumer and representative feedback; regulatory compliance for staff to have the practical knowledge of the Quality Standards and compliance in relation to incident management, SIRS, neglect and abuse and Code of Conduct; and to ensure that feedback and complaints are managed effectively with actions taken and communicated to complainant.

Requirement 8(3)(d) The approved provider must demonstrate that there are effective risk management systems and practices, to managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

# Standard 1

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

Findings

The Quality Standard has been found to be Non-compliant as three of the six specific requirements have been assessed as Non-compliant.

The following requirements 1(3)(b), 1(3)(c) and 1(3)(e) were found to be Compliant.

The Assessment Team identified that the organisation has a diversity and inclusion statement and related policy, which includes a commitment to cultural safety and how this is to work in practice at the service. There has also been cultural diversity and inclusion training for the staff. Consumers shared with the Assessment Team information about their backgrounds and life experiences. They thought that the staff knew about them as a person and what is important to them. The consumers provided information indicating culturally safe care is being provided to them. Interviews with staff and review of consumer care and service records confirmed this.

The Assessment Team interviewed consumers and representatives who said that they have been supported to make decisions about their own care and services and who should be involved in the decision making, although some decisions are not always respected. Some thought they have been supported to maintain relationships with others, but a consumer shared information about this not being optimised. Management and staff described the processes for identifying decision makers, involving the consumer and others in decisions, and supporting relationships. Review of consumer care and service records and observations showed in the main this is occurring. At a resident meeting in February 2023 the consumers in attendance said their choices were being respected.

The Assessment Team observed at lunchtime across multiple days of the Site Audit it was observed that consumers were being asked their choice of drink and meal. For example, a consumer was observed to approach the servery and request which meal she preferred to eat for lunch. The staff member served the meal the consumer chose and took it to the table for her to eat. While many consumers had concerns about meal temperature, quality and variety, they confirmed they have choice when it comes to the meals.

Some consumers and representatives provided information about consumer choices not always being respected, such as in relation to showering/bathing and not being supported to spend time to maintain relationships. This has been considered below under requirements, such as Standard 1 Requirement (3)(a).

The Assessment Team interviewed consumers and representatives who mostly advised that information is provided to them which is easy to understand and helps them to make choices for them-self or on behalf of the consumer.

Some consumers advised they do not find the resident meetings useful or helpful, so don’t go to them all. This was mainly due to lack of improvement from feedback they or other consumers provided. Review of the meeting minutes over the last six months shows information is being provided and explained to consumers on a range of relevant topics. For example, about the partnership in care approach, consumer care plan reviews and being able to personalise the care plan.

The Assessment Team reviewed other documentation including the resident handbook, newsletters and the activity programs and menus. Information is provided to new consumers during the admission process and management explained how the activity programs are shared with consumers. The Assessment Team observed the menu was readily accessible to consumers in the dining rooms and staff were helping by informing consumers of the meal choices on offer.

The following requirements 1(3)(a), 1(3)(d) and 1(3)(f) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives with some representatives providing feedback about the consumer being treated with dignity and respect at the service and the consumer being accepted and valued by the staff. However, some information gathered from interviews with consumers, representatives and staff and the documentation reviewed shows that some consumers are not treated with dignity and respect. Some of this relates to how staff have treated the consumer, some to a lack of assistance from staff to consumers, and some is about how other consumers have treated the consumer.

The service’s complaint records over the last six months include five complaints about staff being rude, and two complaints about consumers not being assisted to shower regularly. Some of these complaints were closed and others had not been followed up or remained open well after being made and investigated.

Documented guidance for management and staff about how to support consumers to take risks was not demonstrated. Key staff were not able to provide any examples of consumers being supported to take risks. The consumers sampled were not aware of being supported to take risks to live their best life and their care and service records did not reflect this. Three consumer examples were provided late in the Site Audit, however had only been recognised, assessed and documented the previous day. Consumer care plans have a section about quality of life, however for the consumers sampled this did not include information about supporting them to take risks to live their best life. There has not been a focus on supporting consumers to take risks to enable them to live the best life they can. This has not been promoted to consumers or incorporated into staff day to day practice as a focus of their work.

The Assessment Team found that some consumers and representatives provided feedback that the consumer’s personal and information privacy are respected and maintained. The Assessment Team observed consumer records were kept secure and confidential, and staff interactions with consumers were respectful of their privacy. Staff interviewed spoke about ways they respect consumer privacy. One consumer provided feedback to the Assessment Team that there is a notice on the room door to knock before entering with a door knocker on the room door, however a couple of evenings prior, a staff member came into the room around 8 pm. The staff member did not knock, did not ask for permission before entering and did not announce themselves. The staff member turned off the consumer’s television, without saying anything or requesting that it be turned down if it was too loud. When asked if the staff member noticed the consumer was there the consumer advised that they did and felt the staff member was just being rude.

Consumers spoke of other consumers coming into their rooms uninvited and felt that their personal space is not respected by other consumers.

The approved provider responded to the Assessment Team’s report advising that they did not agree with the Assessment Team’s report. Overall, the provider advised that the incidents of rough handling by staff did not demonstrate that consumers are not treated with dignity and respect and that investigation of these incidents were found to be unsubstantiated. The provider advised that there had been no previous complaints raised in relation to the matters raised with the Assessment Team, which included staff being rude to consumers, consumers having concerns for the lack of personal care or consumers verbally or physically abusing other consumers. Then provider advised that there were 49 Dignity of Risk forms completed over the previous year, however it was not evident that they included a consumer choice focus or any detail about supporting positive risk taking so consumers can live the best life they can or that Dignity of Risk were reviewed. Three Dignity of Risk forms were completed during the Site Audit when the risks were raised with management, which does not demonstrate that these risks were previously or proactively identified and discussed with the consumers and representatives prior to the Assessment Team raising this. The provider furnished documentation including training documentation, consumer experience survey results, policies and procedures to support their compliance with these requirements, however this documentation did not convince me that the training and education had previously been effective, or the updated forms would demonstrate sustainable compliance with consumers being treated with dignity and respect and having their privacy respected.

I find that the approved provider is non-compliant with requirements 1(3)(a), 1(3)(d) and 1(3)(f).

# Standard 2

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

Findings

The Quality Standard has been found to be Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

The following requirements 2(3)(b), 2(3)(c) and 2(3)(d) were found to be Compliant.

The Assessment Team spoke with staff who outlined the processes for general assessment and planning and noted there is an organisational assessment and planning policy and procedure. Review of care and service records shows assessment and planning for the consumers sampled identifies and addresses the current needs, goals and preferences of most consumers.

The staff member outlined the processes for palliative and end of life assessment and planning and that there is organisational palliative and end of life care policy and procedure. For the consumers sampled advance care and end of life planning is in place. Each consumer sampled had medical orders for life sustaining treatment documented and consumers, where relevant, had a palliative care plan. The staff member said an end-of-life care pathway is not in use for consumers who require end of life care, but there are plans to develop and implement this. There were some gaps identified in care planning information, however this was addressed in requirement 2(3)(a).

The Assessment Team interviewed consumers and representatives who confirmed they were provided information about having an ongoing partnership with management or staff at the service and being given opportunities to be involved in consumer assessment and care planning. Several staff member explained how relationships with consumers and representatives are managed to engage them as partners in care. Review of consumer care and service records showed through case conferencing and other discussions consumers and representatives have been treated as partners in care and involved in assessment and care planning. Also, that other individuals and organisations involved in the care of consumers have input to consumer assessment and care planning.

Consumers and representatives provided feedback that the specific things of importance to them are reflected in their assessments and care plans, with some consumer focussed goals evident, and that they have been engaged in discussions about consumer’s end of life care wishes. Case conference records confirm this.

Staff interviewed by the Assessment Team described the processes for making consumers and representatives aware of the outcomes of assessment and care planning and making the consumer’s care plan available to them, such as through case conferencing and care plan review discussion every four months. Consumers and representatives said, in the main, they are updated when the consumer is reviewed by a doctor or another health/allied health practitioner and when there are changes in the consumer’s condition or care needs. Consumer representatives consistently provided information about being offered a copy of the consumer’s care plan, and also most consumers. Review of consumer care and service records confirmed all of this.

The following requirements 2(3)(a) and 2(3)(e) were found to be Non-compliant.

The Assessment Team interviewed staff who described and outlined the processes for initial assessment and care planning for new consumers and the ways risk to consumers’ health and well-being is incorporated into assessment and care planning. The assessment information when completed auto populates to generate a care plan. The organisation has a documented admission protocol setting out when assessments and other tasks are due to take place for new consumers. It was explained that there is a registered nurse dedicated to completing admissions for new consumers, so the assessments and initial care plan mostly get completed well ahead of time.

The Assessment Team reviewed the assessments undertaken for a consumer who had recently moved into the service. The Assessment Team found that the admission protocol was not followed and some initial assessments, including in relation to risks to the consumer’s health were not completed in a timely manner. Some assessments were completed; however, medication management and pressure injury assessments were not completed within the timeframes.

The Assessment Team noted that assessment and planning showed some consideration of risk for consumers health and well-being, however this was not always the case with Behaviour Support Plans not including all relevant information to meet the needs and preferences to manage risks to the consumer or to others. Recommendations from Dementia Services Australia were not in place and the interventions in the care plan for behaviour support are not consistently used by staff. The assessment and planning about behavioural risks does not inform the delivery of safe and effective care and services.

There are processes for regular review of care and services, such as through reassessment and care plan updates, and when the consumer’s circumstances change, or incidents occur impacting on needs, goals or preferences. This was consistent with information in organisational policy and procedure about assessment, care planning and incident management. Review of consumer care and service records and discussions with management about individual consumers showed review occurs for some consumers, but not consistently for others.

The Assessment Team reviewed consumer’s files and found that although the behaviour chart had extensive information about changed behaviours, the effectiveness of interventions was not being consistently evaluated. Also, there was a lack of behavioural incident reporting to inform evaluation of care and service delivery, noting that when staff do document the effectiveness of interventions, they consider them to be mostly ineffective. This was also identified for consumers who were experiencing pain, where pain management was not reviewed for effectiveness and wound care not being reviewed regularly for effectiveness.

The approved provider responded to the Assessment Team’s report advising that for the vast majority of consumers at the service, and in the small sample reviewed by the Assessment Team, that this assessment occurred appropriately, however, did acknowledge that the pain assessments, mobility assessment, skin integrity assessment and diabetic assessments had not been completed within the timeframes are they are committed to improving their admission and ongoing assessment documentation process and minimising these gaps occurring.

The provider also acknowledged that in some instances there were no preventative strategies identified and documented for consumers, however had reviewed Behaviour Support Plans for consumers identified with non-pharmacological interventions documented and evaluated, this has been updated in the Continuous Improvement Plan.

I acknowledge the actions that the provider has commenced, however feel it will take some time for these actions to reflect sustainable compliance.

I find that the approved provider is Non-compliant with requirements 2(3)(a) and 2(3)(e).

# Standard 3

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

The following requirements 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) were found to be Compliant.

The Assessment Team reviewed consumer care and services records, conducted interviews with management and staff and undertook observations which demonstrated the effective management of high-impact and high-prevalence risks associated with the care of consumers.

The Assessment Team noted for one consumer who experienced an unwitnessed fall, the consumer was transferred to hospital for observations and review and on return to the service a falls risk assessment, skin assessment, frailty scale and a holistic pain assessment were completed. The physiotherapist conducted a review of mobility, and a reassessment was updated to reflect the changes to mobility needs. A consumer who had experienced weight loss had a fluid and food intake chart commenced for five days, a referral to the medical officer and dietician with a plan developed to minimise further weight loss. The consumer has since been found to be back to their normal healthy weight range.

Documentation for the consumers sampled who are on a palliative care pathway or who have recently passed away showed the consumers’ goals and preferences have been identified and their wishes and directives have been incorporated into their care and services plan. Consultation occurs with consumers and representatives when a consumer commences a palliative pathway and/or is receiving end of life care.

Two staff interviewed were able to explain how they support someone that is receiving end-of-life care. They said they are guided by the consumer’s wishes and preferences. In the past they have done things such as playing the consumer’s favourite music or putting on their favourite television program in the room. They said that the service has a pastoral care worker who also supports the consumers who are receiving palliative care. They said the consumer’s comfort is very important and they monitor the consumer for any indication of pain and report to the registered nurse. They said they provide pressure area care, oral care and ensure the consumer’s lips are kept moist to prevent them cracking.

The service demonstrated consumers who have experienced a deterioration or change in their cognition, mental health or physical function have their needs recognised and responded to in a timely manner.

Documentation sampled and interviews with consumers, representatives and staff show overall information about the condition, needs and preferences of consumers is communicated among staff and with others where responsibility for care is shared. Consumer care plans and handover meetings show there is communication between registered nurses and care staff about the condition, needs and preferences of consumers. Allied health services have access to the consumers’ electronic clinical file where they can add progress notes or conduct assessments as appropriate. For example, the physiotherapist reviews all consumers after they have a fall and updates their mobility assessment if required and documents into the consumer’s electronic clinical file.

The Assessment Team interviewed representatives who mostly felt consumers’ needs and preferences were being effectively communicated between staff. They said all staff are familiar with their relative’s care needs and are aware when care needs change. The consumers’ representatives said staff notify them of any changes in their relative’s health.

Review of the care and service records for the consumers sampled shows referrals are made for consumers when needed, and the results of assessment and recommendations made are updated in the consumer’s care and services plan. However, timely referral to Dementia Services Australia or to another individual or organisation for specialist behavioural advice for one consumer was not considered until recently with behaviours impacting on the individual consumer and others some time prior to that. Although gaps were identified for the timely referral for one consumer the service was able to demonstrate that overall, timely and appropriate referrals to individuals, other organisations and providers of other care and services are made when required.

The service has organisational policy and procedure regarding infection prevention and appropriate antibiotic use. During the Site Audit, it was observed that there is effective management of standard and transmission-based precautions to prevent and control infections. Staff interviewed were able to describe how they prevent and control infection in the service and demonstrated understanding of how they minimise the need for or use of antibiotics and ensure they are used appropriately. The Assessment Team observed sound infection control practice by staff, such as staff correctly wearing personal protective equipment (PPE) for a consumer suspected as having an infection. clinical staff member explained when a consumer is suspected of having an infection that pathology is ordered to ensure that antibiotic treatment is appropriate. Care staff interviewed explained how they help minimise infections within the service, including hand hygiene, wearing appropriate PPE, good consumer personal hygiene and ensuring adequate hydration for the consumer.

The following requirement 3(3)(a) was found to be Non-compliant.

The Assessment Team identified that some consumers do not always receive safe and effective care that is best practice, tailored to their needs or which optimises their health and well-being. Some consumers and representatives raised concerns about the personal and clinical care provided and the negative impact other consumers’ behaviour has on them. Deficiencies were identified in relation to a range of care areas including behaviour support, wound care, personal care and pain management.

The Assessment Team spoke with consumers and representatives and reviewed documentation and identified for one consumer, information about behaviour support was not best practice, the consumer had not received care and services tailored to their needs that was safe and effective, therefore having an impact on the consumer and other consumers.

A number of consumers spoke of the impact that some consumers were having on them, such as intruding into their room and making noise disturbing their rest and peace and quiet with their unmanaged behaviours. The Assessment Team observed one consumer repeatedly calling out and another consumer wandering and taking items from the dining rooms tables. This was observed by the Assessment Team over a 40-minute period, with no staff present in the vicinity to observe or intervene.

The Assessment Team reviewed wound care documentation and noted there was a lack of identifying information in wound charts in relation to the size of the wounds and clear photographs to review the progress of the wounds for consumers. Although a wound consultant reviewed the wounds and provided instructions for dressing and managing the wounds every second day, wound chart entries did not demonstrate that this had always been followed, with a lack of measurement of size recorded.

Some consumers spoke of their personal care not being attended to and the Assessment Team found that personal care has not been tailored to the individual needs of consumers and has not optimised their health and well-being.

One consumer spoke with the Assessment Team about their pain and how it is not minimised by medication or other treatments which impacts on the consumers mobility. Interventions documented include use of medication and medicated creams rubbed into the consumers skin and massaged for 5-10 minutes daily, the care plan instructs staff to document the massages provided in a pain chart. The pain chart showed that the consumer received massages on four days with care staff members interviewed said they do not have enough time to provide massage to consumers.

|  |
| --- |
| The approved provider responded to the Assessment Team’s report with copies of wound charts and updated documents to support consumers behaviours. The provider advised that since the Site Audit that a number of actions have been addressed including engaging with pastoral care and having GP review and the Behaviour Support Plan was updated with all of the non-pharmacological interventions documented and evaluated. The provider has commenced education for staff on non-pharmacological interventions, specifically: hunger & thirst, pain, toileting (assistance). Toolbox education on behaviour management, importance of documenting accurately in behaviour charts (behaviour, trigger, interventions, evaluation) and pain charts. Dementia essential course – is being arranged for staff. Dementia Services Australia referrals will be completed for consumers with ongoing behaviours. The provider also advised that they are committed to improving staff knowledge in wound care, and the Continuous Improvement Plan will address this with improvements in the knowledge and competency in documenting skin injury and wound care.  I have considered the providers response and documentation and acknowledge the actions that the provider has initiated, however understand that it will take some time to reflect compliance in these areas.  I find that the approved provider is Non-compliant with requirement 3(3)(a). |

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Non-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. | Non-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. | Compliant |

Findings

The Quality Standard has been found to be Non-compliant as three of the seven specific requirements have been assessed as Non-compliant.

The following requirements 4(3)(b), 4(3)(d), 4(3)(e), and 4(3)(g) were found to be Compliant.

The Assessment Team found that there is a co-located chapel where religious services are regularly held and there is a pastoral care team who provide religious and spiritual services and supports to consumers within the service. Most consumers and representatives provided positive feedback about the spiritual and religious support for consumers. This was corroborated through observations, review of care and service records and/or interview with staff.

Emotional and psychological services and support are made available to consumers. Some consumers (and representatives on their behalf) provided feedback about staff support for the consumer, such as by being kind and caring. Review of consumer care and service records show care staff write in progress notes, activity charts and behaviour charts about providing general emotional support to consumers, such as reassurance. The Assessment Team recognises the role of the leisure and lifestyle and pastoral care teams in providing consumers with emotional support. Also, a psychologist has been engaged to provide psychological support to some consumers.

The Assessment Team interviewed consumers and representatives who did not raise any concerns about information sharing. Management and staff described ways that information about consumers and their condition, needs and preferences are communicated among the staff and with others who share responsibility for consumer care. These include, for example, access to read consumer care and services records in the electronic care planning system, the shift handover sheet and meetings, referral processes and other discussions. Review of documentation confirmed this.

The leisure and lifestyle coordinator showed the Assessment Team a detailed profile about each consumer with information about their cultural background, language/s spoken, their religion (if any) and what is important to them in relation to cultural and religious observance. This information is reflected in the ‘5 things about me’ on the front page of the consumer’s electronic care and services record for staff to access. Staff knew about the cultural backgrounds of the consumers sampled and what is important to them in relation to their culture and language and their spiritual and religious needs and preferences.

Consumers and representatives provided information about timely and appropriate referrals being made for consumers. Management and key staff spoke about a range of individuals and organisations to which referrals can be made to support consumer daily living. Review of consumer care and service records confirmed appropriate referrals are being made and, in the main, that this occurs in a timely manner.

The pastoral care team said sometimes they receive a referral to see a consumer from the staff, but in the main they are pro-active and seek to engage with consumers so they can identify those who may need and who want their support.

The Assessment Team observed that equipment to support the provision of catering, cleaning, maintenance services and the recreational and social activities is safe, suitable, clean and well-maintained. The Assessment Team observed wheelchairs and walking aids were clean and in good working order. Game equipment, puzzles and bingo cards and buttons were clean and in good condition and televisions in the common areas were in working order. Staff interviewed said they have enough equipment to carry out their jobs and described how they ensure equipment that is provided is safe, suitable, clean and well maintained. Staff were able to describe the processes involved in reporting and managing faulty equipment. Staff said if equipment is found to be faulty, it is reported in the electronic maintenance request system and quarantined or reported to the registered nurse.

The following requirements 4(3)(a), 4(3)(c) and 4(3)(f) were found to be Non-compliant.

The Assessment Team found that the organisation has policies and procedure about enabling and supporting consumer independence, health, well-being and quality of life as this relates to daily living.

The Assessment Team interviewed consumers and representatives who provided some positive information, the Assessment Team sought to corroborate this for the consumers sampled. Much of this has been captured under other requirements in Standard 4, about consumer well-being and quality of life. Consumers and representatives also provided some negative information about safe and effective services and supports for daily living impacting on consumer well-being and quality of life.

One consumer provided feedback that they are lonely because there are not many people living at the service who the consumer can speak with (due to the prevalence of dementia), the consumer’s family are busy and cannot visit often and COVID-19 has also impacted on visiting arrangements. The consumer named some of the activities offered and said they are ‘not for me’. The consumer said the e-tablet device is mostly used in the consumer’s room, including to listen to classical music, and watches movies on a streaming service on the television. When asked if the consumer feels there is enough to do of interest? The consumer responded, ‘what can I do?’ explaining there aren’t a lot of options and does not like what is offered at the service and reduced mobility means the consumer cannot do things for themselves like go out into the garden, stating staff do not have time to take consumers out to the garden.

One consumer representative stated that the consumer had lost interest in things and while the representative encourages the consumer to get involved in activities, the consumer does not, and the representative feels that the consumer needs more support. The feedback from consumers and representatives did not include positive examples relating to consumer independence, most consumers advised they try to do things for them-self but linked this to a lack of staff and lack of assistance received from the staff.

The Assessment Team interviewed staff who work on levels one and two spoke about a lack of time and having to rush to complete their duties. They said they are not able to spend quality time with consumers who need it. The staff said they said they used to have time to spend 5-10 minutes talking with a consumer or taking them out into the garden. One of the staff spoke about the importance of this for consumers who do not have any family or family members nearby who can visit them. The staff said some of the consumers feel lonely and they ‘do not have a voice’.

An effective laundry service to optimise consumer well-being and quality of life was not demonstrated. There has been a trend in complaints to the service about the laundry service, in particular missing clothing, with six complaints made in 2023 to date. While some consumers interviewed by the Assessment Team provided positive feedback about the laundry service, others provided negative feedback.

The Assessment Team interviewed consumers and representatives who provided feedback about consumers being engaged in community life. Staff interviews, observations and consumer care and service records reviewed confirmed this. The activity programs include bus outings, and some consumers go on the bus out into the community. Consumers are being involved in the planning for ANZAC day commemorations 2023, including playing an active role on the day.

The activity calendars include activities and events on Monday to Friday and have time allocated for one-to-one support to consumers at around 8-9:00 am. On weekends resources are made available for consumers to use to engage in self-initiated activities and a movie is played each day. The leisure and lifestyle coordinator said in the MSU the care staff who work there, one of whom also works as a leisure and lifestyle officer during the week, run activities for the consumers. This information, and observations made during the Site Audit (such as of drumming, a singalong), show that there is social support and recreational activities which are of interest to some consumers.

However, the feedback from some consumers and representatives, feedback from other staff and review of consumer care and service records shows some consumers are not receiving social support and recreational activity services which meet their needs and are of interest to them. Feedback from consumers and representatives included that the activities are not meaningful, such as the drumming which is not stimulating and there are some ‘silly activities’ for older people living with dementia. A couple of consumers said that there is not enough to do, and they get bored, there are no structured activities on weekends for consumers to do and the activity calendar says that there are puzzles and boardgames available but there are no staff to direct the activities. Review of activity charts and progress notes for a sample of consumers who provided feedback about a lack of social support and recreational activities shows limited engagement with and by those consumers.

The service’s Continuous Improvement Plan includes an entry made on 19 December 2022 about a lack of activities identified upon internal review with the recreational activities team. The entry includes new activities that were added from January 2023. The Continuous Improvement Plan includes a prompt for information about evaluation of the actions taken; this field is left blank. The improvement was closed on 10 February 2023. Resident meeting minutes for the last six months show consumers are invited to make suggestions and give feedback about the activities. The Assessment Team notes the feedback from some consumers they do not find the meetings useful; that included three of the four consumers who gave feedback the activities are not of interest to them as detailed above.

The Assessment Team interviewed consumers and representatives with some consumers and representatives providing positive feedback about the meals. However, overall consumers interviewed stated they are not satisfied with the variety, taste and quality of meals and feel the food needs improvement. Most consumers said the food is not hot enough or to their taste. Documentation in the serveries designed to ensure that food is served in a timely manner has not been completed consistently and complaints raised by consumers in the food focus meeting were not addressed.

Two consumers interviewed provided positive feedback about the food. However, 10 of 10 consumers interviewed about the meals provided negative feedback about the variety, quality and/or quantity of the food. Some consumer representatives also provided negative feedback on behalf of their partner or relative. Documentation in the serveries used to record the time the food arrives at the servery and the time the last plate is served, which is designed to ensure the food is served in a timely manner to ensure it remain hot has not been completed consistently. For example, between 1 April and 20 April 2023 the form was not completed for dinner on 18 occasions on level two and seven occasions on level one.

A food focus meetings held on 7 February 2023 identified issues raised by consumers which were the breakfast toast was not cooked properly, the tea and coffee is not hot enough, the soup is not hot enough and the consumers requested more fruit to be available. The only item that was addressed in the meeting minutes was the availability of fruit with an action being to order extra fruit and instruct the catering staff to fill up the fruit bowls twice a day. The other issues raised by the consumers were not addressed during the meeting or actions taken were not documented in the meeting minutes.

Management said they were surprised at the level of negative feedback from consumers and their representatives. They said the service has worked hard at providing quality food to the consumers and the service is the only site in the organisation that has developed a separate meal alternative menu for consumers to choose from if they do not wish to have the standard. Management said this menu was developed in consultation with the consumers.

The approved provider responded to the Assessment Team’s report and refuted the Assessment Team’s report stating that the service supports consumers to optimize their independence, health and wellbeing and quality of life by providing a range of leisure lifestyle interest activities that meet the physical, cognitive, social, cultural and spiritual needs of consumers. These activities provide consumers a sense of usefulness, importance and being part of the Service’s local Community. The provider also advised that they work in partnerships with consumers and representatives to identify the owners of unlabelled clothing items placed in lost property.

The approved provider advised they are committed to improving its Catering Service and Dining Experience and has taken a number of actions to improve this including staff training and education in food temperature checks during meals services, this includes training on the correct operation of induction hot plates, plate warmers and food transporters (Hot Boxes). The room service delivery process has also been reviewed and changes have been made to minimize the time spent between plating and delivery. The serving of the soup process has also been changed, soups are now being transported from the main kitchen to the servery using Gastronomic Containers and served directly from the bain-marie rather than using insulated jugs. This has improved the temperature of soups when being served. The service has also met with the individual consumers who provided negative feedback about the meals to address their concerns with positive feedback being received from these consumers.

I have considered the providers response and acknowledge the actions that the provider has implemented in relation to provide safe and effective services and supports for daily living, supporting consumers to provide services and support for daily living to assist each consumer to participate in their community within and outside the organisation’s service environment; and have social and personal relationships; and do the things of interest to them, and the provision of meals is varied and of suitable quantity and quality. I have considered the feedback from consumers that the issues of meals have been raised before and they are deemed satisfactory, however the same issues reoccur, and the solution is not sustainable, I therefore believe it will take some time to effectively reflect compliance in these areas.

I find that the approved provider is Non-compliant with requirements 4(3)(a), 4(3)(c) and 4(3)(f).

# Standard 5

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

Findings

The Quality Standard has been found to be Compliant as three of the three specific requirements have been assessed as Compliant.

The Assessment Team found that the service has a has a welcoming environment and observed consumers, visitors and staff interacting with each other in common areas both indoors and outdoors; providing consumers with a sense of belonging and independence.

Consumers were observed to be accessing the café area with their family members having morning, afternoon tea and conversing in the large seating area that opens up onto an outdoor courtyard.

Consumers provided feedback that they feel very comfortable at the service and feels free to decorate their rooms as they wish. Bedrooms were observed to have a homelike style with personalised items such as family photos, pictures or model aircraft providing a familiar environment for the consumers. Some consumers’ bedroom entries had a ‘memory box’ which were decorated with ‘picture triggers’ such as pictures from their country of birth, flowers and the consumer's names were displayed at the front of their doors to assist consumers to recognise their rooms. The dining areas were large and spacious and comfortably accommodated consumers and their mobility aids.

One consumer when interviewed provided feedback that there could be more space available such as a room for exercises to take place (noting where exercise classes happen it is crowded), a consumer laundry in the area where the consumer lives (noting there is one in another area on the same floor, but when consumers go to use it the consumers in that area complain) and a doctors’ consulting room for examinations (so this does not have to happen in the consumer’s own room). Although one consumer provided some negative feedback about the environment and dedicated spaces not catered for, it was demonstrated that the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

The Assessment Team found that overall, the service environment was observed to be safe, clean and well maintained with décor and comfortable furnishings. The layout of the service environment and the availability of easy access to outdoors promotes the free movement of consumers both indoors and outdoors. All courtyard, verandas and garden areas were observed to be well kept and maintained. Most consumers and representatives interviewed confirmed their satisfaction with the environment, that it is safe, clean and well maintained.

The Assessment Team observed the small verandas on levels one and two to be locked and only accessible with the use of a swipe card. Management was informed and said they would investigate it. The doors to the verandas remained open allowing consumers and their representatives access for the remainder of the Site Audit.

The service has systems in place to ensure fittings and equipment are well maintained and are safe for consumers. Documentation review verified that maintenance is completed in a timely manner and is up to date. Consumers generally thought that the furniture and equipment which they needed was available to them and was being kept clean and well maintained.

A preventative maintenance system is in place at the service and the maintenance officer showed the Assessment Team evidence where external contractors are engaged on an ongoing basis to provide regular maintenance such as for pest control, hot water system servicing, vehicle maintenance and electrical testing and tagging.

# Standard 6

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

Findings

The Quality Standard has been found to be Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

The following requirements 6(3)(a), and 6(3)(b) were found to be Compliant.

The Assessment Team interviewed consumers and representatives who said they are supported to provide feedback and make complaints. Care staff interviewed said they try and help consumers with their concerns and escalate complaints to the care team leaders, registered nurses or management if they are unable to.

The Assessment Team observed feedback forms with suggestion boxes located at reception and in common areas throughout the service. Posters on how to make a complaint were also displayed and complaint brochures were available in various languages.

While one consumer is unable to use the feedback form independently and one consumer said they did not receive feedback in relation to a complaint given, overall, it was demonstrated consumers are encouraged and supported to give feedback and complaints.

Consumers and representatives interviewed said they were able to communicate in English and did not require language services. Most consumers and staff were aware of advocacy services and have not needed to access them.

The Assessment Team interviewed staff who said that all consumers can communicate in English, and they have not needed to use any language services, however referred to the language service posters displayed in the lifts. Some staff were unaware of advocacy services and said they would ask their care team leaders or management if they needed to access these on behalf of a consumer. Management indicated the services of OPAN are accessible to all consumers and can be referred to the Commission for external complaints, however they have not been required to support any consumers to connect to either organisation.

While not all consumers, representatives and staff interviewed were familiar with advocacy services, advocacy services have been promoted to consumers and staff indicated they would raise any requests to management. Overall, it was demonstrated that consumers are made aware of advocacy services

The following requirements 6(3)(c) and 6(3)(d) were found to be Non-compliant.

The Assessment Team interviewed consumer and representatives who mostly said while attempts to resolve their complaints are made, some consumers said nothing is done or the actions do not last, and the same issue recurs. One consumer provided information that they had complained about the meals and not seeing sustained improvement. One representative said they had complained at times in the past and found that there is a change in practice for a short period of time and then things revert back to the way they were previously.

Most staff interviewed were unable to describe the open disclosure process, however demonstrated an understanding of the principles. Documentation reviewed provided evidence that an apology was provided to the consumers and their representatives, however this was not consistently documented and some complaints in the service’s complaints register did not include details about the complainant or the resolution of the complaint.

Review of the complaints register shows 27 complaints, 36 compliments and 12 suggestions have been recorded from 16 November 2022 to 4 April 2023, however it is not consistently demonstrated that appropriate actions have been taken in response to complaints. The complaints register shows 15 complaints have been closed with the remainder still open and eight showing no investigation or findings. Where outcomes have been documented, the majority indicated an apology by the service with no recorded details of the actions taken to resolve the complaint. However, complaints recorded as being closed show that these complaints were resolved in a timely manner. While most consumers and representatives said actions are taken in response to their complaints, some consumers said nothing is done or many others said actions do not last and the same issue recurs. Documentation does not show that appropriate action is taken in relation to some complaints.

The service is unable to provide evidence that feedback and complaints are reviewed and used to improve the quality of care and services provided to consumers. Four consumers said they have spoken up at resident meetings, however nothing is done and there are no improvements. Documentation review of minutes from four recent resident and relative meetings showed consumers repeatedly raised concerns about the same items.

One consumer said that they did not find the resident meetings they attended were very helpful because when the consumer suggested things, they have not been actioned. For example, for the catering staff to review the room service delivery times so consumers sitting in the dining room did not need to wait for their meals to be served. The consumer said they had suggested poetry or reading activities and planting or gardening activities, however nothing comes of it. The Continuous Improvement Plan documents an item dated on 18 December 2022 that there were limited vegetable beds for gardening for those consumers who are interested in gardening and additional garden beds were purchased in January 2023 with an expected completion date extended from 20 February 2023 to 30 April 2023. There was no further progress documented.

One consumer recalled having complained about the laundry service and also complained about the meals. The consumer said after complaining there is improvement for a while but then the standard declines again. One consumer said they go to some of the resident meetings and speak up, but not all of them as nothing changes such as in relation to the meals.

The Assessment Team reviewed the minutes from resident and relative meeting minutes held on 8 October 2022, 22 November 2022, 20 December 2022 and 6 February 2023. They each included the same information on the topics of the meal service, the dining experience, food focus groups and missing personal belongings. The regional general manager acknowledged the feedback provided by the Assessment Team and said the resident and relative meetings were not as effective as consumers would like and the service would follow-up on how to increase engagement.

A review of the service’s Continuous Improvement Plan does not reflect any improvements regarding meal related complaints. Entries related to staff communication with consumers, staff training schedule/tracker and review of feedback and complaints were added during the Site Audit following feedback by the Assessment Team. Actions to address missing laundry items were in the Continuous Improvement Plan, however the completion date was extended from 25 February to 30 April 2023 with the new process implemented only very recently on 17 April 2023.

The approved provider responded to the Assessment Team’s report and advised that all of the outstanding complaints had been updated in Riskman and feedback has been acknowledged and updated. The service advised that they would provide ongoing Staff Training and Education to strengthen staff knowledge and skills around Complaints Handling and Open Disclosure using the ACQSC Better Practice Guide to Complaints Handling and Calvary’s Feedback Management Policies and Procedures. The provider has also advised that they have commenced review of the outstanding items from the Residents and Relative’s meeting for the last six months and any outstanding items will be actioned. Whilst I acknowledge that the service has addressed some of the issues surround the meals, feedback from consumers does not satisfy me that these actions are always sustained. I therefore feel that it will take some time to demonstrate sustained compliance in these requirements.

I find that the approved provider is Non-compliant with requirements 6(3)(c) and 6(3)(d).

…

# Standard 7

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

Findings

The Quality Standard has been found to be Non-compliant as three of the five specific requirements have been assessed as Non-compliant.

The following requirements 7(3)(c) and 7(3)(e) were found to be Compliant.

The Assessment Team found that the service demonstrated that staff have qualifications to perform their role. Management could not show the Assessment Team a sufficient sample of recent competency checking documentation, however management and staff said competency checking occurs and review of two personnel files showed they include some competency checks. Most consumers and representatives thought staff knew the consumer and how to meet their care needs, however two did not. Most staff knew about most of the consumers they care for and how to meet their needs, but not in relation to one consumer.

The Assessment Team sighted job descriptions, professional qualifications, police checks and visa requirements for staff were in place. The service has been using temporary (agency) staff. Management advised the agency staff are from approved providers and quality checked. If it is the first time the agency staff member has worked at the service, they will complete an orientation and allocate shifts to have a mix of experienced regular staff and agency staff.

There was positive feedback from most consumers and representatives about the staff knowing them and their care needs and how to meet them. However, one consumer spoke of the need for non-experienced staff to be paired to work with an experienced staff member, which does not always happen. The consumer spoke of having to educate the staff about needs and how to provide the consumer’s care. This was reiterated by a representative in relation to the consumer’s personal care needs.

The Assessment Team identified that staff lacked knowledge about assessed behaviour support needs to inform the delivery of safe and quality care tailored for one consumer, to optimise the consumer’s health and well-being. Overall, it was shown that staff are qualified, competent are knowledgeable about most consumers, their care needs and how to meet them.

The Assessment Team found that the service is unable to demonstrate regular assessment, monitoring and review of the performance of staff with annual appraisals. Most staff interviewed indicated they have not completed their annual performance appraisals. Management acknowledged performance appraisals are behind schedule, however indicated regular assessment and monitoring is conducted with day-to-day observations. Most staff interviewed indicated they have not completed their annual performance appraisals, however, were able to describe the process of completing their self-assessment prior to their appraisal meeting.

Management advised the Assessment Team that that staff performance appraisals are behind schedule, with 46% completed as of 6 April 2023. This was identified as a gap by the service and added to the CIP on 21 November 2022 when around 40% staff had completed their appraisals and a tracker was developed. This shows minimal progress. The initial expected completion date of 17 February 2023 has been extended to 30 June 2023. The approved provider responded to the Assessment Team’s report and provided updated information to support that 96% of the performance appraisals have now been completed and the staff appraisal tracker is up to date. This requirement was previously found to be Not Met by the Assessment Team, however the further evidence that has been provided, has allowed me to find this requirement 7(3)(e) as Compliant.

The following requirements 7(3)(a), 7(3)(b) and 7(3)(d) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives and found that the vast majority of consumers and representatives interviewed indicated that there is not enough staff to provide safe and quality care to consumers. Feedback from consumers included that the service is understaffed – they can see it – in care and catering as staff rush and don’t take the time to do things properly. Two representatives said there is not enough staff especially at night, however most of the staff are trying. One consumer said that they need assistance from staff to help for showering including due to falls risk, but staff set the consumer up for the shower and into the shower then leave and do not return for some time. The consumer said more recently they have stopped returning at all and the consumer gets out of the shower and dried as best as possible, which often means the consumer is still wet when putting on clothes. This was also raised by another consumer, had a shower when no one came to assist, and pressed the wrist call bell when the consumer thought they would fall, and staff did not come to the consumer’s aid.

The Assessment Team reviewed the activities of daily living (ADL) charts for two consumers, which show they are not regularly showered at their preferred time of the day.

Staff interviewed also raised issues with the Assessment Team about the staff shortages, advising the consumer showering system is not working and needs to be reviewed so that it is achievable, and showers can consistently be provided to consumers. They said some consumers who like a shower every day sometimes don’t get a shower for three days. It was also discussed that staff are not able to provide personal care in accordance with consumer preferences. In one area there are six consumers who want to be bathed/dressed before breakfast, but this is not possible with the current staffing levels. Taking short cuts such as not doing all tasks expected on a consumer’s ‘resident of the day’, such as tidying their wardrobe, and not being able to give consumers their massages.

While most consumers and representatives interviewed provided positive feedback that staff are kind and caring, some consumers spoke of incidents when staff have been rude, and this has been reflected in the complaints register and serious incident records. Some also provided information about staff lacking empathy or a caring approach. A consumer said that about 70% of the time staff are kind, caring and respectful. When asked what happens the other 30% of the time, the consumer said they prefer not to say. While most consumers and representatives interviewed provided positive feedback that staff are kind and caring, there have been reported complaints and incidents of staff being rude and the rough handling of consumers.

The Assessment Team found that the service was unable to provide evidence that the workforce is trained, equipped, and supported to deliver safe and quality care and services to consumers. Most care staff interviewed said there is enough training, however they have not completed all of the mandatory training or taken up additional training opportunities to support them to perform their role effectively. Some staff were inexperienced and/or lacked knowledge on some topics or about the care of some consumers. Some staff also spoke of a lack of support to deliver the outcomes required by the Quality Standards.

The Assessment Team reviewed the mandatory face to face training records, which only demonstrated a National Induction program as being fully completed and noted in addition to mandatory training two out of 124 staff completed Quality Standards training, 60 out of 124 have completed dignity of risk training and there has been no training conducted about open disclosure. In addition, training records show 15 staff have completed the face-to-face training about behaviours; and writing in SIRS, incidents and Riskman (incident management system). The Manager indicated more staff should have completed this and would check for additional training records, however, did not show them to the Assessment Team during the Site Audit.

Some staff interviewed indicated they do not have enough time or the computers to complete documentation and they will complete the important charts, such as bowel charts, repositioning charts and food and fluid charts, however they may leave out the activities for daily living notes. They also said they do not feel supported for their hard work.

Management acknowledged the trend in complaints about communication related to staff rudeness and indicated coaching on the spot was conducted to change the perspectives of staff to be there for consumers. The manager advised of proposed training and information for staff to embed the organisation’s mission and values. Also, staff would be supported to undertake reflective practice in relation to incidents and complaints, so they are not just ticking the box. However, no additional information was provided to the Assessment Team in relation to the proposed training.

The approved provider responded to the Assessment Team’s report and provided updated information to support the staff training records. The provider advised that when the service has vacant shifts, they fill these with casual staff or agency personnel. The provider acknowledged the gap in ADL documentation and has installed two new computers in the Nurse’s station and the service will work with staff to rectify this. I acknowledge the actions that the service has taken, however find that the feedback from staff and consumers about the shortages of staffing, gaps in training and impact on consumers due to the lack of awareness and practical knowledge of not attending to consumers and assisting them with their personal care reflects on the current staffing levels. I acknowledge it will take some time for the training and reflective practice to demonstrate the compliance of these requirements.

I find that the approved provider is non-compliant with requirements 7(3)(a), 7(3)(b) and 7(3)(d).

# Standard 8

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

Findings

The Quality Standard has been found to be Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

The following requirements 8(3)(a), 8(3)(b) and 8(3)(e) were found to be Compliant.

The Assessment Team found that management were able to demonstrate how they engage and support consumers in the development, delivery and evaluation of care and services.

The head of clinical governance aged care (HCGAC) indicated there are consumer representatives who attend the board and national aged care meetings, however none of the consumer representatives are specifically from this service. The HCGAC indicated information from consumers including complaints, compliments and resident and relative meetings are collated and passed to the consumer representative for the board meetings. The Assessment Team requested evidence of this correspondence; however, this was not provided during the Site Audit. The HCGAC indicated a consumer advisory panel would be setup by December 2023 to engage consumers in service improvements.

The Assessment Team sighted the clinical practice governance committee meeting minutes dated 10 March 2022 that are shared with the board to include a consumer experience report summary noting an overall drop in satisfaction, with the main complaints concerning food and communication.

The governing body was able to demonstrate accountability in how they promote a culture of safe, inclusive and quality care and services. The Assessment Team sighted communications via email and on the mobile application from the CEO in relation to updates about the aged care worker code of conduct and a change in PPE requirements memo sent by the national director clinical governance who sits on the board.

The Assessment Team were advised that a monthly home manager report is prepared by the residential services manager, and information contained in these reports are used by the regional general manager to generate a report at a national level for the board to review. The Assessment Team sighted the home manager reports titled ‘service quality, safety governance and risk report’ for January 2023, February 2023 and March 2023. Each contained a section called quality and safety indicators with the indicators including incident rates, falls, pressure injury, medication errors, behaviours of concern, acquired infection/infestation, stakeholder satisfaction score and SIRS.

The governing body promotes safe and quality care and services with the organisation’s policies and procedures and expectations communicated to staff through monitoring of clinical indicators, consumer feedback, internal audits and through performance management and education via mandatory training, plus additional training based on individual incidents.

The following requirements 8(3)(c) and 8(3)(d) were found to be Non-compliant.

The Assessment Team found that the organisation was not able to demonstrate effective organisational governance systems relating information management, continuous improvement, regulatory compliance and feedback and complaints for the delivery of safe and quality care and services. However, effective financial governance and workforce governance are provided by the organisation.

Staff interviewed indicated they do not have any challenges in accessing information required to deliver quality care and services to consumers, however the Assessment Team notes some information about individual consumers was not comprehensive or up-to-date and some staff were not familiar with the needs of a consumer. The Assessment Team noted a number of policies and procedures are not always available or current.

The management team experienced difficulties giving the Assessment Team access to consumer incident reports. There were problems with access to the system, Riskman. When incident reports were produced, they lacked detail to show the full cycle of incident management (from initial actions taken through to prevention and evaluation) for some consumers. Effective information management in relation to incidents, complaints and improvements was not demonstrated.

The Assessment Team noted that there was minimal information in relation to identifying opportunities for improvement. There is a leisure and lifestyle audit tool, however it has general questions and prompts and does not involve monitoring and review of the experience of lifestyle services and supports for individual consumers. There were minimal entries in the service’s Continuous Improvement Plan with a lack of addressing the issues related to Standard 1, the meals or staffing. It included some in relation to the leisure and lifestyle services, with one about a lack of activities identified which had been identified through internal review with the leisure and lifestyle team. That improvement is closed with a new activity plan noted to have been implemented from January 2023. There was no evaluation of the effectiveness of the activity and, there are also gaps in capturing information to assist with monitoring and review and help identify opportunities for improvement. This includes reporting incidents so they can be captured in the incident management system and recording complaints in the service’s complaints register.

The regional general manager explained the service was commissioned in 2022 and indicated for any unplanned capital expense, a request would be submitted to the regional CEO, and he has never seen anything that has not been approved.

The regional general manager indicated that rosters are analysed, and the identification of vacant shifts is populated into the dashboard for the board to ensure sufficient workforce to meet consumer needs.

The regional general manager spoke about workforce initiatives to support workforce governance. For example, mass recruitment including trainee incentive programs for nurses, university and TAFE placements, overseas recruitment, interstate relocation sponsorship and support packages, and new graduate placements.

The Assessment Team noted that sampled Behaviour Support Plans do not include all information required per clauses *15HB(b) and 15HB(e)(i), (ii) and (iii) of the Quality of Care Principles 2014 (Cth).* It has not been updated to include the assessment of the consumer by Dementia Services Australia or the best practice alternative strategies to the use of restrictive practices, taking into account the consumers preferences to improve the quality of life and engagement. It was not demonstrated that the consumer’s care has been optimised to meet the behaviour support needs at the service.

Legislative reporting timeframes for timely notification to the Commission have not been met for some recent Serious Incident Report Scheme (SIRS) incidents. Minutes of the monthly site care services governance meeting, dated 23 March 2023, document legislative/regulatory updates to include NQIP training sessions and Commission/industry updates with the Commission’s monthly bulletin to be made available to all staff in the staff room. The Assessment Team did not see any monthly bulletins from the Commission in the staff room, however, did observe aged care worker code of conduct information.

The HCGAC indicated consumer feedback and complaints are first managed at a local level to implement any activities and consumer feedback trends are presented in reports to the board. When asked to provide two examples of changes driven by the board as a result of consumer feedback, incidents or complaints, the HCGAC indicated she would follow up on this, however, did not provide examples to the Assessment Team during the Site Audit.

The organisation has a documented risk management framework and policies and procedures to guide management and staff in relation to the management of High Impact High Prevalence risks, identifying and responding to abuse and neglect, and incident management. The strategic plan included a commitment to supporting consumers to live the best life they can.

Management were asked what were the high impact, high prevalence risks at the service and responded that one was challenging behaviours from consumers. Review of the service’s serious incidents records shows three incidents in the last six months about staff rough handling of consumers.

For the consumers sampled, deficits were identified in the classification of incidents and the timely reporting obligations of incidents to the Commission. The Assessment Team identified that post-incident for some consumers there has been reassessment of their needs and risks associated with their care, but no new strategies to prevent recurrence of incidents.

The approved provider responded to the Assessment Team’s report and submitted copies of their policies and procedures that have recently been reviewed and updated or are currently under review. The provider also sent through their updated SIRS register and recent changes to priorities identified.

I acknowledge the actions that the provider has taken and the information that has been provided, however I understand that it will take time to embed the governance required where gaps have been identified and reflect the compliance from these measures including information management and staff having the appropriate information to provide quality care for consumers, the organisations continuous improvement, regulatory compliance and feedback and complaints and the effective risk management system to manage high impact and high prevalence risks, identifying abuse and neglect of consumers, supporting consumer to live the best life they can and managing and preventing incidents through the timely review and evaluation of strategies and investigation of incidents.

I find that the approved provider is non-compliant in requirements 8(3)(c) and 8(3)(d).

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