Performance

Report

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| Name of service: | Carinya of Bicton |
| Service address: | 220 Preston Point Road BICTON WA 6157 |
| Commission ID: | 7230 |
| Approved provider: | Bansley Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 22 March 2023 to 24 March 2023 |
| Performance report date: | 11 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 Carinya of Bicton (**the service**) has been prepared by A. Kasyan, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 16 April 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **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 | **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.

* **Standard 1 Requirement 1(3)(c)** Ensure each consumer is supported to make decisions about their own care and the way care and services are delivered, and each consumer is provided an opportunity to choose the food they want to eat.
* **Standard 3 Requirement 3(3)(b)** Ensure use of psychotropic medication is assessed and monitored, including identification of psychotropic medications used to influence consumers’ behaviours, that is, as a chemical restraint.
* Ensure where restrictive practices are used, specifically chemical restraint, that is being used in accordance with the requirements and responsibilities outlined in the Quality of Care Principles 2014 in relation to use of restrictive practices.
* **Standard 4 Requirement 4(3)(a)** Ensure services and supports for daily living are provided to each consumer in line with their assessed needs, goals and preferences documented in care plans.
* **Standard 7 Requirement 7(3)(b)** Ensure all workforce interactions with consumers, including non-verbal interactions are kind, caring and respectful.
* **Standard 7 Requirement 7(3)(c)** Ensure there are effective monitoring processes of staff competency and knowledge and where deficits are identified that corrective actioned are initiated to enable staff to effectively perform their roles.
* **Standard 8 Requirement 8(3)(e)** Ensure the organisation’s clinical governance framework is implemented effectively, specifically in relation to minimisation of restrictive practices and that where restrictive practices are used that they are used in accordance with the requirements and responsibilities outlined in the Quality of Care Principles 2014 in relation to the use of restrictive practices.

# 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. | Non-compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the six specific Requirements has been assessed as Non-compliant.

**Requirement 1(3)(c)**

The Assessment Team recommended Requirement 1(3)(c) Not Met. The Assessment Team found the service was able to demonstrate consumers are supported to exercise choice in relation to making decisions about when family, friends, carers or others should be involved in their care, making connections with others and to maintain relationships of choice. However, the service was not able to demonstrate each consumer is supported to exercise choice and independence, specifically in relation to enabling each consumer to make decisions about their own care and the way care and services are delivered. The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* Staff said all consumers residing in one area of the service are not provided a choice of their meal for lunch and dinner. However, all other consumers are offered alternatives for lunch and dinner meals. The Assessment Team observed consumers in one area of the service were not given an opportunity to choose their meals.
* One consumer was observed not being supported to eat independently.
* The representative of one consumer said the service did not accommodate the consumer’s sleep patterns.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan which is being implemented to address the deficits with planned completion in June 2023.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 1(3)(c) Non-compliant.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report with continuous improvement actions commenced during the Site Audit. However, I find the service does not ensure each consumer is supported to exercise choice and independence, specifically in relation to making decisions about their own care and the way care and services are delivered.

I have considered information and evidence in the Assessment Team’s report showing many consumers in the service were not included in making decisions about what food to eat.

I have also considered an observation of one consumer not being supported to eat independently which indicates staff are not always respectful of consumers’ choice and independence.

Lastly, I considered a representative expressed their concerns that consumer was routinely put to bed not at the time of their preference, despite raising their concerns with staff in relation to this on multiple occasions. I consider the consumer’s choice was not recognised nor supported.

For the reasons detailed above, I find Requirement 1(3)(c) Non-compliant.

In relation to Requirements 1(3)(a), 1(3)(b), 1(3)(d), 1(3)(e) and 1(3)(f), the service was found to treat their consumers with respect and value their identity and culture, with positive feedback being received from consumers and their representatives. Staff were observed to interact with consumers and their representatives in a friendly and respectful manner, and care plans were tailored to reflect consumers’ preferences.

The service was also found to be culturally safe and inclusive. Staff members were able to identify and support consumers with specific cultural needs, and care planning documentation reflected this. Staff were able to describe and provide documented evidence of regular programmed events, activities, and themed lunches that were relevant to consumers, which helped to promote awareness and inclusion for differing cultural backgrounds.

Documentation showed consumers are supported to take risks in a safe manner, which was confirmed through interviews with consumers. Risk assessments were completed, and strategies to mitigate risks were implemented to ensure consumers’ well-being and safety. The service has a consumer choice and independence policy and procedure that outlined how consumers could be supported to exercise choice.

Staff described how they provide accurate and timely information to consumers, which was confirmed through interviews with consumers and their representatives. The service uses a range of mechanisms to ensure consumers are provided with current, accurate, and timely information to enable them to exercise choice. Staff described many ways in which they respect consumers’ privacy and confidentiality, which was evident from the positive feedback received from consumers and the observation of staff providing care in a way that maintained consumer privacy. Policies and procedures guide staff practice in relation to maintaining consumers’ privacy and confidentiality, and staff confirmed they participated in mandatory training on dignity, privacy, and confidentiality.

Staff advised they were required to sign a confidentiality and privacy agreement as a condition of their employment. This agreement outlined all staff’s responsibilities regarding consumer, staff, and organisational information. Furthermore, the Assessment Team observed clinical, care, lifestyle, and domestic staff knocking on consumers’ doors prior to entering rooms to attend to call bells or individual consumer needs.

Access to consumer personal information was found to be protected, and staff accessed the electronic care record system via password-protected logins. Handover sheets and consumer documentation were also observed to be secure in the nurses' stations.

For the reasons detailed above, I find Requirements 1(3)(a), 1(3)(b), 1(3)(d), 1(3)(e) and 1(3)(f) Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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

This Quality Standard is Compliant as five of the five Requirements have been assessed as Compliant.

The service demonstrated that it conducts assessments and care plans that consider the risk to each consumer's well-being. This was confirmed by six care plan reviews that indicated all consumers are assessed on entry and a care plan is developed to ensure the delivery of safe and effective care and services. Consumers and their representatives expressed satisfaction with the care they received, and staff were able to explain how care plans guide them when providing care to consumers.

The documentation of care for sampled consumers confirmed a comprehensive care plan is developed for each consumer when they move into the service. The care plan covers areas such as transfers and mobility, dietary details, continence requirements, communication, pain management, and oral health.

The service also demonstrated that it identifies and addresses each consumer's current needs, goals, and preferences, including advance care planning and end-of-life wishes. Staff described, and documentation reviewed confirmed the service asks consumers about their end-of-life wishes during the admission process. Management were able to describe how they discuss consumer goals and preferences, including completion of end-of-life paperwork.

The care plans and documentation of the consumers reviewed showed the service includes other organisations and/or individuals when they are involved in the care of the consumer, such as Residential Care Line, Speech Pathologist, Physiotherapist, and General Practitioner. Overall, consumers and their representatives expressed satisfaction with their input during the care planning process, and clinical staff were able to describe how consumers and their representatives participate and make contributions to their assessments and care planning on admission and on an ongoing basis.

All consumer files reviewed showed evidence of assessment by the Physiotherapist, and mobility plans were completed and available. The service demonstrated that outcomes of assessment and planning are communicated to consumers, representatives, and staff, and they are aware of the existence of care plans and can ask for or discuss care plans with staff. Staff confirmed they use desktop computers and mobile devices to access consumer care plans, assessments, and when documenting progress notes.

The service regularly reviews and updates care plans to ensure they address the consumer's current needs and goals. Documentation reviewed by the Assessment Team evidenced regular communication and ongoing reviews by the clinical and allied health team. Staff confirmed care plans are reviewed and updated after an incident or if there have been changes in a consumer's health status. Clinical staff advised that when a change in a consumer's health status is identified, they will assess the consumer, document any changes required in the care plan and communicate to staff at handover. Changes to the care plan are discussed with the consumer where applicable and communicated to their representative.

# 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. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | 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 is assessed as non-compliant as one of the seven specific Requirements has been assessed as non-compliant. The Assessment Team recommended Requirement 3(3)(b) Not Met.

**Requirement 3(3)(b)**

Whilst the Assessment Team found the service was able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer in relation to falls, pain, pressure injuries and diabetes, it was not able to demonstrate effective management of risks associated with psychotropic medications used to alter consumers’ behaviours.

The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* Three consumers identified by the Assessment Team as a subject to chemical restraint to influence their behaviours were administered medications with no evidence documented to show non-pharmacological strategies were trialled prior to the use of chemical restraint. In addition, there was no documented evidence of regular monitoring of the identified consumers to ensure the medication is being used in accordance with the requirements and responsibilities outlined in the Quality of Care Principles 2014 in relation to use of restrictive practices.
* The Assessment Team observed all three consumers were drowsy when observed on multiple occasions during the Site Audit and staff confirmed the consumers can be drowsy on some days.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan which is being implemented to address the deficits with planned completion in September 2023.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 3(3)(b) Non-compliant.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report with continuous improvement actions commenced during the Site Audit. However, I find the service does not ensure risks associated with chemical restraint are effectively managed.

I have considered evidence in the Assessment Team’s report showing the service did not recognise three consumers were chemically restrained and were unable to demonstrate best practice alternatives to restraint were trialled before administration of chemical restraint and was used as a last resort.

For the reasons detailed above, I find Requirement 3(3)(b) Non-compliant.

In relation to Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g), the Assessment Team found the service provides safe and effective personal and clinical care that is tailored to each consumer’s needs and aligns with best practice where evidence is available. Consumers and representatives said the service knows the consumers and what their needs and preferences are.

Staff advised they follow consumers’ care plans when delivering care and services to consumers to ensure they address the consumers’ current needs and goals. Consumers and representatives interviewed were satisfied with the clinical and personal care consumers receive, and staff were able to describe the support they provide consumers during end of life, including being pain-free and having their ‘loved ones’ with them. The service has policies and procedures to guide staff on how to recognise and provide care to consumers during end of life.

The service responds to deterioration or change in consumers’ health in a timely manner. Staff were able to describe the signs and symptoms of clinical deterioration and how they respond to it, and a review of consumer files reflected the identification and response to deterioration is being done in a timely manner. The service has processes in place for consumers to be referred to other organisations, individuals and care providers.

The service has processes in place to minimise the risk of infection to consumers, including using standard precautions to prevent and control infection and appropriate antibiotic prescribing to reduce the risk of antibiotic resistance. Consumers and representatives interviewed were satisfied with the current measures in place to minimise the spread of COVID-19 and other infections. The service has an Infection Prevention and Control Lead (IPC) who is onsite Monday to Friday, and policies and procedures which guide staff with all infection control related issues.

Staff was observed adhering to the service’s infection prevention and control measures, including washing their hands, using hand gel and putting on surgical masks. The service has an outbreak management plan in place to be used in the event of an outbreak. Management advised the service is planning to introduce Medication Advisory Committee (MAC) meetings to focus on the safe prescription of antibiotics.

The service has policies and procedures to guide staff on provision of best practice personal and clinical care, including clinical deterioration, referrals and infection control-related issues.

For the reasons detailed above, I find Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) Compliant.

# 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. | 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. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

**Requirement 4(3)(a)**

The Assessment Team recommended Requirement 4(3)(a) Not Met. The Assessment Team found two consumers who are living with a diagnosis of dementia, with one of them from linguistically and culturally diverse backgrounds, were observed through the Site Audit not being engaged in conversations, activities of their interests and not being provided any supports in line with their assessed needs, goals and preferences documented in their care plans. The Assessment Team found the following in relation to these two consumers:

* One consumer was observed seated at the table with other consumers, either asleep at the table, or when awake were unengaged. Activity participation records showed no evidence of activities recommended by an external service provider to whom the consumer was referred to get support on management of changed behaviours. In addition, the consumer was not being provided with one-on-one support in line with their assessed needs and their care plan.
* The representative of the second consumer expressed their dissatisfaction with the lack of meaningful activities and supports resulting in the consumer’s frustration, agitation and impacting their mental and physical well-being. Activity participation records showed the consumer was not provided with activities and supports recommended by an external service provider, including supporting the consumer to participate in familiar and meaningful tasks, such as washing, setting and clearing tables, washing dishes, sweeping and dusting. Lastly, the consumer was placed on a diet which was not in line with the consumer’s goals, needs and preferences.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan which is being implemented to address the deficits with planned completion in September 2023.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 4(3)(a) Non-compliant.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report with continuous improvement actions commenced during the Site Audit. However, I find the service does not ensure 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.

I have considered evidence in the Assessment Team’s report demonstrating two consumers were not provided activities tailored to their needs, goals and preferences to optimise the consumers’ well-being and support management of changed behaviours. Whilst these activities were documented in the consumers’ care documentation, these were not implemented or were reported by staff as no longer suitable.

I have also considered one consumer was provided a restricted diet which was not based on the assessed consumer’s goals and preferences and was rather initiated by the service to reduce consumption of snacks by the consumer.

For the reasons detailed above, I find Requirement 4(3)(a) Non-compliant.

In relation to Requirements 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g), the Assessment Team found the service has effective measures in place to promote emotional, spiritual, and psychological well-being of its consumers. Staff are aware of individual needs and provides support when consumers feel low. The service has a lifestyle and allied health team that monitors consumers' well-being by reviewing their care plans, progress notes, attendance at activities, assessments, incidents and surveys.

The service provides appropriate supports that help consumers participate in the community within and outside the service, have personal relationships, and do things of their interest. Staff were able to describe how they provide necessary assistance as per the individual's interests identified through assessments. Consumers were observed participating in activities of their choice and going into the community with friends.

Staff advised consumers' preferences and choices are incorporated into their care plan which is easily accessible through the electronic management system (EMS). They reported communication between staff and consumers, and between different organisations, is effective. Staff are informed of consumers' needs, conditions, goals, and preferences through care plan reviews, handover meetings, and documentation. The chef and cook are informed of any changes in consumers' diet by the clinical nurse manager, which is then communicated to the kitchen staff and updated accordingly.

There is a referral process in place to refer consumers to other care providers and services in a timely manner. Staff described how they refer consumers to internal and external services where appropriate. The service has a rotating menu that is changed every 6 months which offers a variety of meals. Most consumers and their representatives said consumers enjoy the food.

The equipment used to support consumers was observed to be clean, well-maintained, and stored appropriately. Various equipment, including wheelchairs, shower commodes, hoists, tilted shower chairs, beds, and modified cutlery, is available in good working order. Staff report any unsafe equipment in the maintenance request book and ensure that the equipment has an “out of service” tag placed on it. Repair requests are promptly addressed, and this was evidenced by feedback from consumers and staff, and observations of the reactive maintenance request book. Staff were observed using sanitising wipes and clean shared equipment between consumer use.

For the reasons detailed above, I find Requirements 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g) Compliant.

# Standard 5

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

Findings

This Quality Standard is Compliant as three of the three Requirements have been assessed as Compliant.

Consumers and representatives found the service welcoming and easy to navigate, and the service encouraged them to personalise their rooms. Staff were observed to be friendly and approachable, and consumers' rooms were decorated to reflect their past, present, and character. The service has well-lit corridors with mobility rails, various indoor and outdoor spaces for interaction and quiet reflection, and appropriate wayfinding signage and colours for easy navigation.

Management described how they walk around each day and have a conversation with consumers and their families to ensure they feel welcome. The service environment was observed to be well maintained and comfortable, and consumers were able to move freely both indoors and outdoors. Consumers and representatives reported their rooms and the service environment are clean, well maintained, and safe. Staff were observed cleaning consumer rooms and communal areas throughout the Site Audit.

A regular preventative maintenance schedule pertaining to the fire systems is in place and conducted by an approved contractor. The furniture, fixtures, and fittings are safe, clean, and well maintained. Staff advised they ensure all equipment is safe for consumers to use and described how they report maintenance concerns. The service has a preventative maintenance program conducted by approved contractors and a reactive maintenance program managed by the onsite maintenance officer. A maintenance request book is in each wing of the service where requests are lodged and checked daily to address any maintenance issues, liaise with external contractors as needed, in addition to completing the routine preventative maintenance schedule.

# Standard 6

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

Findings

This Quality Standard is Compliant as four of the four Requirements have been assessed as Compliant.

Consumers and representatives confirmed they feel comfortable raising concerns with management and staff and are aware of the mechanisms in place to provide feedback. Management advised they obtain feedback through various systems, including the complaint and feedback policy, feedback forms, consumer surveys, and observations. All consumers and representatives interviewed confirmed they are comfortable raising concerns with staff or management.

Consumers have access to advocates, language services, and different methods for raising and resolving complaints. Consumers and representatives interviewed said they would try to resolve complaints with staff and management directly. Some staff interviewed were not aware of advocacy services but were able to describe the process of escalation to management if a consumer or representative wanted to pursue this avenue. Information about advocacy services, language services, and complaint handling at the Commission was observed available in communal areas of the service.

Most consumers and representatives reported when they provide feedback, they feel the issue is addressed at the time, and management and staff inform them when things have gone wrong. Staff were able to describe open disclosure principles and policies that guide staff in following an appropriate complaint resolution and open disclosure process when adverse events occur. The service has a complaint and feedback policy that describes the process, roles and responsibilities, escalation of complex complaints to the organisation, and principles of open disclosure and the process to be followed when things go wrong.

Management advised, and documentation showed feedback and complaints is entered on a centralised system to ensure organisational oversight, and opportunities for continuous improvement are identified and actioned. Feedback and complaints are trended and analysed monthly and used to drive continuous improvement. The therapy team has made changes to the lifestyle program following feedback from consumers and representatives, and the service has commenced development of a café to provide a place for consumers and families to meet.

# 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. | 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. | Non-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 Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant.

**Requirement 7(3)(b)**

The Assessment Team recommended Requirement 7(3)(b) as Not Met. The Assessment Team found whilst some consumers and consumers representatives advised staff are kind and caring and respectful in their interactions, observations during the Site Audit and feedback from one representative showed that staff are not always interacting in such a way. The Assessment Team provided the following information and evidence to support their recommendation of Not Met in this Requirement:

* The Assessment Team observed a staff member holding one consumer’s hand so they could not take the spoon from the staff member assisting with their meal restricting the consumer from independently eating.
* Staff were observed standing whilst assisting a seated consumer to eat and assisting two consumers to eat at the same time and some staff were not engaging with consumers when assisting them with their meal.
* A consumer’s representative advised the consumer is routinely put to bed when the consumer is not ready despite complaining multiple times to staff and management.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan which is being implemented to address the deficits with planned completion in July 2023.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report with continuous improvement actions commenced during the Site Audit. However, I find the service does not demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

I have considered observations of a staff member holding one consumer’s hand so they could not take the spoon from the staff member assisting with their meal. I consider this staff member’s non-verbal interaction with the consumer was not kind nor caring and it is not a respectful way to assist a consumer with their meal. I have also considered observations of staff standing while assisting a consumer to eat, assisting two consumers to eat at the same time and some staff not engaging with consumers when assisting them with their meal are not respectful interactions.

For the reasons detailed above, I find Requirement 7(3)(b) Non-compliant.

**Requirement 7(3)(c)**

The Assessment Team recommended Requirement 7(3)(c) as Not Met. The Assessment Team found the service has policies and processes to ensure they attract and recruit staff that have appropriate qualifications, and provide ongoing support, education and training to make sure staff are up to date and act within the scope of their role requirements. However, the Assessment Team found staff do not have knowledge around restrictive practices to enable them to effectively perform their roles. The Assessment Team provided the following information and evidence to support their recommendation of Not Met in this Requirement:

* Whilst staff and key personnel interviewed throughout the Site Audit said there were no consumers who were subject to chemical restraint with some staff not being able to explain what a restrictive practice was, the Assessment Team identified at least three consumers for whom psychotropic medication was used to influence their behaviours, hence falling under the category of chemical restraint.
* Staff advised they do not document the actions they implemented or record the effectiveness of the medication when a medication to influence consumers’ behaviour is administered.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan which is being implemented to address the deficits with planned completion in October 2023.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report. However, I find the service does not ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles.

I have considered staff were not able to identify chemical restraint which was used to manage changed behaviours of some consumers at the service. I have also considered information under Requirement 3(3)(b) demonstrating lack of documentation and monitoring around chemical restraint. Therefore, staff do not have knowledge to effectively perform their roles specifically in relation to chemical restraint use and the provider’s obligations in relation to documentation and monitoring of its use.

For the reasons detailed above, I find Requirement 7(3)(c) Non-compliant.

In relation to Requirements 7(3)(a), 7(3)(d) and 7(3)(e), the Assessment Team found the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Consumers and representatives interviewed confirmed that there are enough staff available to meet their needs, and they don’t have to wait long for assistance. New staff members complete an orientation and induction program that guides them on completing a checklist, mandatory training, and employee handbook that outlines the service’s expectations and processes. They are also paired with experienced staff for support and mentoring during their early shifts.

The service has a scheduled training program that starts with orientation and induction and continues to deliver outcomes required by standards. The education and training provided are a mix of face-to-face and online training, with further education provided as required in small groups or with the individual based on their needs.

There is a performance management process that is held at 6 months following the probationary period and then ongoing bi-annually. Specific performance issues are dealt with as they occur, and staff performance is monitored via various methods such as direct observations, feedback, complaints, and incidents. Staff members receive documentation outlining the service’s expectations of performance during induction, and their job description and the employee handbook further document the expectations.

Staff advised they attend regular training sessions and feel confident in their knowledge and skills. The majority of staff interviewed advised they have had a performance review, where they received feedback and discussed their future development.

For the reasons detailed above, I find Requirements 7(3)(a), 7(3)(d) and 7(3)(e) Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

**Requirement 8(3)(e)**

The Assessment Team recommended Requirement 8(3)(e) as Not Met. The Assessment Team found while the organisation has a clinical governance framework that is supported by policies and procedures including for open disclosure and antimicrobial stewardship, they were unable to demonstrate they effectively minimise the use of restrictive practices. The Assessment Team provided the following information and evidence to support their recommendation of Not Met in this Requirement:

* Four sampled consumers on psychotropic medication used with the intention of modifying changed behaviours, were not identified as subject to chemical restraint, the appropriate legislative requirements were not in place for the consumers sampled, and the service could not demonstrate an effective system to monitor and review these restraints.
* In relation to environmental restraint and mechanical restraint, evidence of informed consent was not provided and there was no effective system to monitor and review these restraints.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a Remediation Action Plan with actions specific to this Requirement which is being implemented to address the deficits with planned completion in July 2023.

I acknowledge the provider’s commitment to rectify deficiencies identified in the Assessment Team’s report. However, I find the service does not have an effective clinical governance framework to minimise restrictive practices.

I have considered the service did not identify where chemical restraint and mechanical restraint was used with some instances of not identifying environmental restraint. I consider this shows the service does not have an effective system in place to identify and monitor the use of restraint at the service. Furthermore, the service did not have documented evidence to show they were following minimisation principles which shows the service does not have effective systems to minimise the use of restraint.

For the reasons detailed above, I find Requirement 8(3)(e) Non-compliant.

In relation to Requirements 8(3)(a), 8(3)(b), 8(3)(c) and 8(3)(d), the service has demonstrated that it has a workforce plan in place, and there is an appropriate mix of staff to provide safe and quality care to the consumers. Consumers and their representatives have reported that there are sufficient staff, and they are not kept waiting for assistance, nor do they feel rushed when receiving care. New staff are given orientation and induction, mandatory training, and an employee handbook that outlines expectations and processes. Experienced staff members are available to mentor and support new staff.

The service has a scheduled training program that is delivered to provide outcomes required by the Quality Standards. Staff members have job descriptions that detail the expectations and requirements of their roles. The service has a performance management process in place, and staff performance is monitored through various methods such as direct observations, feedback and complaints, and incidents. Management has policies and procedures in place to guide monitoring and managing each staff member's performance. Staff members have received feedback on their performance and discussed future development in performance review meetings.

The service engages consumers in the development, delivery, and evaluation of care and services. Consumers and representatives can provide input about care and services, and consumer engagement occurs through different channels, such as family care conferences, feedback and complaint mechanisms, and consumer satisfaction surveys. Consumers and representatives can engage directly with staff and management, and their engagement is welcomed. Consumers have reported feeling safe and included in the service.

The organisation has governance wide systems, including a governance framework, monitoring systems, assigned delegations and accountabilities and policies and procedures. Information systems and processes are in place to ensure staff and management have ready access to relevant and up-to-date information to perform their role. Management described the annual financial planning process and financial delegation systems for out of budget expenditure, with examples, including refurbishment of the memory support area.

The service has systems in place to ensure a culture of safe, inclusive, and quality care and services. These include committees, regular service, organisation, and leadership meetings, reporting mechanisms, and policies and procedures. The service has an effective system for risk management, including the collection and analysis of clinical incident data, improvements identified, and reporting mechanisms.

For the reasons detailed above, I find Requirements 8(3)(a), 8(3)(b), 8(3)(c) and 8(3)(d) Compliant.

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