Chaffey Aged Care

Performance Report

2 Main Avenue North   
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Phone number: 03 5025 1200

**Commission ID:** 3782

**Provider name:** Chaffey Aged Care Inc

**Site Audit date:** 30 March 2022 to 1 April 2022

**Date of Performance Report:** 20 June 2022

# Performance report prepared by

Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Non-compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this 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 Site Audit report received 6 June 2022
* other information and intelligence held by the Commission in relation to the service

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

Consumers considered they were treated with respect and dignity and that staff valued their individual identities. Staff spoke of consumers in a respectful manner and demonstrated a shared understanding of consumer’s identity, culture, and diversity. Care planning documentation included information on the consumer’s life history, cultural identity, and cultural practices.

Staff demonstrated familiarity with consumer’s identities and described the various ways they supported individual needs, which included different communication strategies for those consumers with communication difficulties.

Consumers were satisfied that they were supported to exercise choice and independence, had the ability to make their own decisions and maintain personal relationships that were important to them.

Care planning documentation evidenced consultation with allied health professionals and consumers. Consumers confirmed the service supported them to live the life they chose and engage in activities that were important to them. Staff demonstrated an awareness of activities that included an element of risk to consumers, which included smoking, gardening and trips outside of the service and could describe the strategies in place to mitigate these risks.

Consumers advised they were provided with sufficient information to assist them in making choices about their care and lifestyle preferences, which included meal selections, daily activities, and access to health professionals.

Most consumers stated that the service consistently respected their privacy and described ways that staff managed this, including knocking before entering, not disturbing them when they are with visitors and ensuring privacy when providing care. The Assessment Team observed the online portal where all confidential records were kept and the shredding bin where private information was disposed of. Physical care documents were kept secure in locked work areas and computers used by staff were password protected.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

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

The service demonstrated it effectively identified and addressed the current needs, goals and preferences of consumers, including advance care planning and end of life planning. Staff were able to describe how the assessment and care planning process identified and captured consumers’ goals, needs and preferences and how that information informed the care plan development and delivery of care.

Care planning documentation evidenced an ongoing partnership with the consumer and others that the consumer wished to be involved in their care. Consumers and representatives confirmed they were involved in the assessment and care planning process on an ongoing basis. Allied health professionals described the process for assessment, care planning and review of consumers under care and alternate interventions for pain.

While some consumers and representatives reported being infrequently involved in formal assessment and planning on an ongoing basis, they felt that they had access to both management and staff should they require any information about the care of consumers. Management advised care plan evaluation processes involved discussions with consumers and their representatives and staff confirmed that care plans were reviewed every three months.

Staff demonstrated knowledge of the incident reporting process and described how and when these incidents prompted a review of consumer care needs.

Staff had a shared understanding of the service’s process for referrals to allied health professionals and communication planning processes which were completed on entry to the service and reviewed regularly. Care staff confirmed clinical staff ensured they were updated when changes in consumers’ care needs occurred.

However, the Assessment Team found that the service did not demonstrate effective assessment and planning or appropriate consideration to individual risks, this has been explored under the specific Requirement below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*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.*

#### The Site Audit report identified that some consumer care plans were not consistently updated or reviewed when changes to consumer’s condition occurred, or that the service had considered individual risk in relation to restraint management. Relevant (summarised) evidence included:

* One named consumer with multiple health diagnoses and an indwelling catheter. The Assessment team identified that this consumer was administered a prescribed ‘as needed’ medication in March 2022, however no non-nonpharmacological interventions were documented prior to the administration of the medication as per the consumer’s care plan. The Assessment Team also identified out-of-date assessments or plans for this consumer.
* One named consumer with a leg wound that was being appropriately managed, but who had not had an updated skin integrity assessment since May 2020. The Assessment Team further identified that this consumer’s nutrition and hydration plan was last reviewed in June of 2020, despite changes to their weight.
* One named consumer with a dementia diagnosis who was administered psychotropic medications to manage behaviours in March of 2022. There was no evidence that nonpharmacological strategies were attempted prior to the use of the medication, nor that representatives were contacted prior to use
* One named consumer who suffered a fall from bed in March 2022, resulting in injuries. A Falls Risk Assessment had not been undertaken for this consumer until two days post fall.
* The Assessment Team brought forward evidence in relation to 78 consumers with beds positioned against the walls of their rooms and identified this practice as physical restraint. The Site Audit report identified a lack of risk assessment and authorisation for these consumers.
* The Assessment team spoke with care staff who acknowledged they didn’t always complete the tasks or notes in the clinical management system as there wasn’t always time, rather information regarding consumers was shared during handovers.

In its written response of 6 June 2022, the Approved Provider addressed the evidence brought forward by the Assessment Team and provided the following response;

* In relation to the named consumer the Assessment Team identified had been administered medication without trailing alternate strategies. The Approved Provided submitted evidence to demonstrate that alternative strategies had been trialled, noting that the nature of strategies could have been better documented. The Approved Provider also brought forward evidence that the service’s policy was to review assessment and plans every six months and that the assessments identified by the Assessment Team had not exceeded this timeframe.
* In relation to the named consumer with a leg wound who’s care and assessment plans were identified by the Assessment Team as being out of date. The Approved Provider acknowledged that in some instances the plans were out of date and provided evidence that these plans had now been completed
* In relation to the named consumer with a diagnosis of dementia who the Assessment Team stated was administered psychotropic medication with no documented alternate strategies. The Approved Provider acknowledged that documentation could be improved and provided evidence that some progress notes had been recorded by staff along with additional evidence of consent and authorisation processes in place to notify next of kin prior to use
* In relation to the named consumer who had suffered a fall who the Assessment Team identified had not had a fall risk assessment undertaken until two days later, the Approved Provider explained that after a hospital admission the consumer returned to the service and an assessment was undertaken within 24 hours of return
* In relation to the consumers with beds against walls identified by the Assessment Team as a type of physical restraint. The Approved Provider disagreed with the Assessment Team’s categorisation of restraint and provided further clarification around the purpose of the placement of the beds – confirming that no consumers had beds placed against walls for the purposes of restraint.
* In response to these issues raised the Approved Provider advised it had engaged two staff members for the specific purposes of supporting the review and documentation relating to restrictive practices

I acknowledge the evidence brought forward by the Assessment Team and the response and explanation provided by the Approved Provider however, based on the totality of evidence, I am of the view that at the time of the Site Audit the service could not consistently demonstrate that assessment and care planning, including risks to individual consumer’s health and wellbeing, informed the delivery of safe and effective care and services.

I therefore find the service Non-compliant with this Requirement.

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

The service had processes in place to ensure consumers were receiving individualised care that was tailored to their specific needs and preferences. Staff described how they were guided by organisational policies and procedures to direct personal and clinical care that was best practice and confirmed they were supported by management, including after hours, for information and advice as required.

Staff confirmed that copies of Advance Care Planning (ACP) and end of life wishes were documented and retained on file if consumers or their representative had chosen to complete them. Representatives were confident the service would support consumer needs and preferences through end-of-life care. Staff were guided by the service’s policies and procedures and demonstrated a shared understanding of their roles and responsibilities in recognising and addressing consumers nearing the end of their life.

Consumers and representatives felt that deterioration or changes in consumer’s health was recognised and responded to in a timely manner, and staff were able to describe how information was shared and documented when changes occurred.

Care planning documentation evidenced that timely referrals were made to medical officers, allied health therapist and hospitals, and input sought to inform the delivery of safe and effective care for consumers. Representatives confirmed that consumers had appropriate access to individuals, organisations and external providers of care and services. The Assessment Team noted that information and recommendations arising from external referrals were consistently recorded within the consumer’s care planning documents.

The service had documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. Staff indicated they had received training on infection minimisation strategies, including hand hygiene, the use of appropriate Personal Protective Equipment (PPE) usage and outbreak management processes.

The Assessment Team found the service did not meet Requirement 3(3)(b) regarding the effective management of risks for consumers. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Compliant under Requirement 3(3)(b). I have provided reasons for my findings in the relevant Requirement below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team identified that the service managed the risk associated with skin integrity and pain effectively, however brought forward evidence in relation to consumers whose beds were positioned against the wall of their room, limiting freedom of movement, the Assessment Team generally categorised this positioning as a form of restraint. The Assessment Team also identified five consumers in receipt of psychotropic medication without behavioural support plans in place, relevant (summarised) evidence included.

* The Assessment Team observed 78 beds against the wall and could not find any information documented regarding informed consent authority or risk assessment for these consumers
* Staff who advised they did not always have time to document or read consumer care plans, preferring to learn updates from daily handovers
* Five consumers in receipt of prescribed psychotropic medications. The Assessment Team inspected care documentation for these consumers and identified consent authorisations were not in place and non-pharmacological strategies were not trialled and documented prior to use. The Assessment team generally categorised all these consumers as being subject to chemical restraint and noted there were no behavioural support plans in place for these consumers.

In its written response of 6 June 2022, the Approved Provider addressed the findings of the Assessment Team, relevant (summarised) evidence included:

* In response to the consumers with beds placed against the walls, the Approved Provider has undertaken to conduct a review audit of these consumers to ensure appropriate assessment and management of risk, this has been explored further under Requirement 2(3)(a)
* In response to the consumers in receipt of psychotropic medication, the Approved Provider advised that not all consumers were prescribed medications to treat behaviours, nor used as chemical restraint and as such were not required to have behaviour support plan in place. While noting that the Assessment Team did not identify specific consumers to enable further response, the Approved Provider advised it had undertaken an audit to ensure appropriate behaviour support plans are in place for those who need it and has taken steps to improve the restrictive practices authorisations documentation used by the service
* A revised policy regarding restrictive practices had been implemented across the service
* Amendments to reporting templates and avenues to report clinical governance matters to the Board
* Additional education and reference materials provided to staff in relation to the management of restrictive practices

I have considered the evidence brought forward by the Assessment Team and the additional evidence tendered by the Approved Provider. On the balance of all evidence brought forward, I am of the view that the Approved Provider has demonstrated appropriate management of risk under this Requirement.

I therefore find the service Compliant with this Requirement

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

Consumers and representatives felt that consumers received safe and effective services and supports for daily living that met their needs, goals and preferences and optimised their independence, health, well-being, and quality of life. Care planning documentation outlined the services and supports consumers required to help assist them in participating in activities of interest to them. The Assessment Team observed consumers engaging in a variety of group and independent activities throughout the service.

Consumers and representatives felt supported by the service to do the things of interest to them, which included participating in activities as part of the service’s lifestyle program or spending time on independent activities of choice. The Assessment Team observed the weekly activity calendar that demonstrated a variety of activities were offered to meet the different needs and preferences of consumers and staff described how they sought feedback to ensure the activity program met individual preferences. Consumers described their emotional, spiritual and psychological wellbeing needs, goals and preferences as being well supported within and outside of the service.

Care planning documentation included information about the interests of consumers and detailed the supports that assisted consumers participate in their community, within and outside of the organisation's service environment

Consumers and representatives considered that information about their daily living choices and preferences was effectively communicated throughout the service, and staff understood their needs and preferences. Care planning documentation included information to support the delivery of effective supports for daily living. Staff described how the needs and preferences were documented, updated and communicated throughout the service to ensure consistency of care. The Assessment Team observed a shift handover and staff communicating relevant updates and changes in consumer conditions.

Consumers and representatives were satisfied that consumers receive timely and appropriate referrals to external organisations and other providers of care and services. Care planning documents evidenced the involvement of external providers of care in the provision of lifestyle supports for consumers. The Assessment Team observed a variety of brochures available to support referral to external organisations as required. The service was guided by organisational procedures regarding referral processes to services outside the service

Consumers and representatives expressed positive feedback regarding the quality and quantity of the meals provided by the service. Care planning documentation showed that information regarding consumer dietary requirements and preferences were captured, and kitchen staff demonstrated a shared understanding of individual dietary requirements and meal preferences.

The Assessment Team observed that where equipment was provided, it was safe, suitable, clean, and well maintained. Consumers indicated they had access to equipment such as mobility aids and considered the equipment safe and clean. Staff expressed they had access to required equipment, could describe the process to document and report when equipment was faulty and stated that equipment issues were resolved in a timely manner by maintenance staff.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

Consumers felt they belonged within the service and stated they felt safe and comfortable in the service environment. Consumers considered the service environment was welcoming, safe, clean, and well maintained and described how they access activities in different areas of the service, including outdoors.

The Assessment Team observed the service was easy to navigate and optimised each consumer’s sense of belonging, independence, interaction, and function. Consumers and representatives expressed positive feedback regarding the service environment and indicated that the service was an enjoyable place to live. Staff described the layout of the service, with courtyards and common areas for consumers to socialise and relax throughout the day.

The Assessment Team found the service environment to be safe, clean, well maintained, and comfortable, allowing consumers to move freely throughout the facility, both indoors and outdoors. The Assessment Team reviewed maintenance requests that showed maintenance issues were addressed in a timely manner and maintenance staff described how they oversaw corrective maintenance and advised on-site maintenance was scheduled throughout the year via a formal maintenance schedule.

The Assessment Team observed the furniture, fittings, and equipment at the service to be safe, clean, well maintained and suitable for consumers. Consumers confirmed they felt safe when staff were providing care using mobility or transfer equipment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as one of the four specific requirements have been assessed as Non-compliant.

Consumers and representatives felt encouraged and supported to provide feedback and make complaints. Staff were aware of the avenues available to consumers and representatives to provide feedback and could describe the ways they supported consumers to lodge complaints. The service was guided by a complaints management policy that specified the process around the management of lodging a compliment, complaint, or feedback.

Representatives expressed that the service took appropriate action in response to complaints. Management demonstrated their understanding of open disclosure principles in relation to complaints and said they apologise to consumers when they express any dissatisfaction with care and services.

The Assessment Team found the service did not meet Requirements 6(3)(b), 6(3)(c) and 6(3)(d). I have considered the evidence brought forward in the Site Audit Report and the Approved Provider’s response and found the service Non-complaint under Requirement 6(3)(b) and Compliant under Requirements 6(3)(c) and 6(3)(d). I have provided reasons for my findings in the relevant Requirements below.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Non-compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

The Assessment Team identified that consumers and their representatives were not made aware of, nor had access to advocates, language services and other methods for raising and resolving complaints. Relevant (summarised) evidence included:

* Four consumers and/or representatives who were not aware of external complaint reporting pathways or advocacy services
* Staff were aware of internal complaints and feedback avenues but were unfamiliar with external complaints pathways, advocacy and translation services available for consumers and their representatives
* Management acknowledged information regarding advocacy and language services was not readily available to consumers
* Aged Care Quality and Safety (ACQSC) posters and brochures highlighting different ways a complaint could be raised with the organisation were displayed and available in English, without representation of other languages.
* Older Persons Advocacy Network (OPAN), Translator and Interpreting Services (TIS) and National Relay Services for hearing and speech impaired consumers were not represented within the service.

In its written response of 6 June 2022, the Approved Provider, provided the following response.

* In relation to the four consumers who were not aware of external reporting or advocacy services the Approved Provider stated the resident handbook has been updated to include contact details
* In relation to the lack of translation or language services being readily available for consumers, the Approved Provider advised that while no consumers who currently reside within the service require these services, it had revised the resident handbook and admission information to include these contact details

While I acknowledge the actions taken by the Approved Provider, I am of the view that at the time of the Site Audit the Approved Provider did not ensure that all consumers had access to advocates, language services and other methods for raising and resolving complaints. I find this Requirement Non-compliant.

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team identified that the service was unable to demonstrate appropriate and timely action was taken in response to some complaints, or that an open disclosure process was adopted when things go wrong. Relevant (summarised) evidence included:

* One representative who advised they had complained about clothing being discoloured during laundering, dating back to December 2021
* Two named representatives who advised they had been refused entry to the service due to miscommunication and mismanagement of COVID entry requirements
* A further representative who referred to a previous complaint in relation to missing belongings and concerns around personal care. This representative described the process undertaken by the service to resolve their complaint
* One named consumer who described providing feedback to management of disturbed sleep and confirmed the service had satisfactorily resolved their issues
* The Assessment Team observed the service’s feedback policy and process which included logging the complaint, acknowledgement and action planning with the parties, investigation and resolution and formal registration of the outcome

In its written response, of 6 June 2022 the Approved Provider gave further context and explanation of the issues raised, which included.

* In relation to the representative who raised concerns about the laundry process, the Approved Provider highlighted that this example dated back to December of 2021 and provided explanation of the steps taken at the time to resolve the issue. The Approved Provider further detailed actions taken by the service to avoid further issues occurring
* In relation to the two named representatives who advised they had been refused entry to the service. The Approved Provider gave additional explanation of the steps taken to resolve the complaint at the time, which included an apology and the use of open disclosure. The Approved Provider further advised that additional staff training and communication had occurred as a result.
* In relation to the representative who described issues with missing belongings and concerns around personal care, the Approved Provider advised that the issues relating to personal care were resolved in May of 2022 and provided additional evidence to support this.

While I acknowledge the evidence brought forward by the Assessment Team, I am not of the view that the examples provided are a demonstration of Non- Compliance under this Requirement. Further, the Approved Provider’s response has demonstrated effective actions and responses to issues raised and a culture of open disclosure. I therefore find the service Compliant with this Requirement.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team brought forward evidence in the Site Audit report that while actions were taken by the service to resolve complaints, response to feedback did not always lead to an improvement to the care and services. The Assessment Team concluded the feedback and complaint process was not used to improve the quality of care and services for consumers.

Relevant (summarised) evidence included:

* A representative who stated that despite complaints in relation to the laundry service, no identifiable improvements had occurred
* Management advised that the service trends and analyses feedback and complaints from consumers and representatives and used this information to inform continuous improvement activities across the service.
* A review of the service’s quality improvement documentation demonstrated that complaints, feedback and suggestions had been documented, along with planned improvement actions, dedicated timeframes and evaluation notes.

In its written response, of 6 June 2022 the Approved Provider gave further context and explanation of the issues raised, which included.

* In relation to the issue raised by the representative, the Approved Provider provided explanation of the steps taken to address these issues on an individual level and where possible, the changes made on an organisational level
* Reference to the continuous improvement plan and reiteration that changes and improvements to the service are reported and discussed monthly at resident meetings
* Explanation of the escalation points for feedback, including Board notification of complaints and involvement in complaint resolution where appropriate

While I acknowledge the evidence brought forward by the Assessment Team, I am not of the view that the examples provided are a demonstration of Non- Compliance under this Requirement. On the balance of evidence brought forward by the Assessment Team and the Approved Provider I am of the view the service has demonstrated effective review and improvement processes are in place and that feedback is used to improve the quality of care and services. I therefore find the service Compliant with this Requirement.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as three of the five specific requirements have been assessed as Non-compliant.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful manner. Consumers confirmed staff were kind and respectful when providing care services.

Staff demonstrated an understanding of consumers backgrounds, care needs and preferences which aligned with care documentation and feedback provided by consumers and representatives.

The Assessment Team found the service did not meet Requirement 7(3)(a), 7(3)(c), 7(3)(d), 7(3)(e), regarding the workforce being planned, recruited, trained, equipped, monitored and assessed to deliver the outcomes required by these standards.

I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Complaint under Requirement 7(3)(c), and Non-Compliant under Requirement 7(3)(a), 7(3)(d) and 7(3)(e). I have provided reasons for my findings in the relevant Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team spoke with consumers and representatives who stated there had been some temporary staff shortages and while they did not directly link this to an impact on the quality of care provided, consumers and representatives felt the service would benefit from additional staff. Further relevant evidence brought forward by the Assessment Team included.

* One representative who stated they felt it took a long time for the staff to respond to the call bell
* One consumer who estimated it usually took around ‘five minutes’ for staff to respond to the bell. The consumer acknowledged that COVID may have had an impact on the workforce
* Two named representatives who stated that there was generally about a ten-minute wait for call bell response but there had been up to a thirty-minute wait time. They also identified issues with sufficiency of staff overnight.
* Management advised that the recruitment of staff is ongoing, and shifts were extended for rostered staff where possible to ensure coverage
* Clinical staff reported staff shortages but felt that these have largely not impacted on consumers’ needs and preferences. Staff acknowledged that documentation is the lesser priority as consumer care always takes precedence.
* Call bell data for February 2022 was reviewed and showed the average call bell response was 4 minutes and 3 seconds.

In its written response of 6 June 2022, the Approved Provider gave further context to the evidence brought forward by the Assessment Team, relevant (summarised) evidence included;

* Context around call bell response times and further reference to the data gathered by the Assessment Team in the Site Audit report that evidenced average response times of less than five minutes for February 2022.
* Further explanation around increases to call bell response times being due to COVID-19 outbreaks and the impacts of donning and doffing Personal Protective Equipment (PPE)
* Explanation of roster planning and how the service ensures sufficiency of staff based on skills and experience to ensure the delivery of care, the service also utilised a causal workforce to fill shifts

I acknowledge the evidence brought forward in the Site Audit report and the additional written response provided by Approved Provider, however I have also given weight to the feedback and the comments from consumers and staff in relation to staff shortages and the impacts that has had on other areas of care and services, such as documentation. I therefore find the service Non-Complaint with this Requirement.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

Most consumers found staff competent, and felt staff possessed the skills required to meet their needs, provide care and perform their duties effectively,

The Assessment Team brought forward evidence of effective recruitment and screening processes with relevant qualifications and checks in place for staff. The service demonstrated effective organisational governance with clear expectations of roles and responsibilities and an established annual training program.

However, the Assessment Team brought forward the following evidence as a demonstration of Non-compliance.

* Outdated position descriptions for two roles, with one due for review in April 2016 and the other due for review in June 2021
* Training records that demonstrated not all staff had completed two modules of the annual mandatory training matrix
* The Assessment Team referred to the Service’s management of risk, as indication of Non-compliance with this Requirement, this has been discussed further in Requirement 2(3)(b)

In its written response of 6 June 2022, the Approved Provider provided additional evidence in relation to this Requirement.

* The Approved Provided stated only qualified staff or those working towards formal qualifications are recruited into care roles,
* The recruitment process includes screening to ensure staff have the relevant qualifications and registration requirements for their respective roles
* Position descriptions were provided to staff on their commencement at the service and set out the expectations for their respective roles.
* Care and registered staff complete buddy shifts on commencement during which any individual additional training needs were identified. Staff also completed an orientation and on-boarding process, site orientation, mandatory training and core competency checks.
* Staff complete annual mandatory training and competency assessments which includes manual handling, medication competencies, workplace health and safety, fire and emergency training, hand hygiene and infection control principles among others.
* Training completion records and an electronic training program with annual training that runs from February to November

While I acknowledge the evidence brough forward by the Assessment Team, I am of the view that on balance of the evidence, at the time of the Site Audit, the Approved Provider demonstrated that the workforce had the qualifications and knowledge to effectively perform their roles. I therefore find this Requirement Compliant

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found the service did demonstrate an appropriately trained and equipped workforce. Relevant (summarised) evidence included:

* Staff and management described the training modules, available online and confirmed staff must complete mandatory training as per the annual mandatory training matrix.
* Some staff confirmed that they received training in relation in the Serious Incident Response Scheme (SIRS), incident management and reporting, which was mandatory for all staff and described how they would respond if an incident arose.
* Staff training records in relation to SIRS did not clarify what elements of the scheme it covered, and management acknowledged the training may need to be reviewed and evaluated further.
* Training records that showed not all staff had completed the mandatory training and an outdated employee handbook that did not align with the online training matrix.

In its written response of 6 June 2022, the Approved Provided further commentary around the recruitment, training and support provided by the organisation to staff to ensure staff are appropriately trained and equipped to perform their roles. The response did include acknowledgement of some of the issues raised by the Assessment Team which included.

* Additional SIRS training extended to Board and executive members, with evidence of completion
* Updates to the employee handbook to align with current online training matrix
* While the Approved Provider stated that management comments in relation to the SIRS training on the day could have been taken out of context, it confirmed that the SIRS training had not been commenced within the service until May 2021.

I acknowledge the evidence brought forward by the Assessment team, the additional response provided by the Approved Provider, and the actions commenced and proposed by the Approved Provider in relation to this Requirement.

However, I am of the view that at the time of the Site Audit the service did not demonstrate that all staff were trained and supported to deliver the outcomes required by these standards. I therefore find the service Non-compliant with this Requirement.

### Requirement 7(3)(e) Non-compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The Assessment Team found the service was not able to demonstrate that the performance of the workforce was regularly assessed, monitored, and reviewed. Relevant (summarised) evidence included.

* Staff who reported they had not participated in or been evaluated formally utilising an annual performance review process, however, were all aware there was an expectation to undergo an annual performance review, as per their position descriptions.
* Management acknowledged that performance reviews had not been completed for staff and advised a new performance appraisal tool had been developed and trialled on the senior management team with plans to implement this across the broader staffing group commencing in April 2022.
* Management and staff confirmed, the service had probationary and ongoing performance review systems in place. Performance reviews were conducted at the end of the probationary period for staff on probation

In its written response dated 6 June 2022, the Approved Provider provided additional evidence and clarification in response to the Site Audit Report, which included:

* A new, recently implement, formalised review process, which incorporates personal development plans and key performance indicators
* Competence assessed through ongoing informal supervision and assessment, with concurrent training and competency checks
* A revised performance appraisal tool was implemented and circulated to staff in May 2022

While I acknowledge the additional information the service provided in relation to the new and implemented monitoring and review processes, these processes were not in place at the time of the Site Audit and will take time to be fully implemented and demonstrate effectiveness.

I am of the view that the service did not demonstrate regular assessment, monitoring and review of staff performance was occurring at the time of the Site Audit. I find this Requirement Non-compliant.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

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

Consumers considered the service well run and described ways they were involved with the delivery and evaluation of services such as involvement with consumer groups and forums written feedback channels and informal discussions, consumers noted they could freely discuss ideas for service improvement.

The Assessment Team found the service had organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Staff reported they can access relevant information when they need it and the service demonstrated how it identified and implemented opportunities for continuous improvement.

The service had a clinical governance framework in place; staff were able to demonstrate an understanding of the identification and response to abuse and neglect and clinical staff demonstrated an understanding of appropriate management of incidents.

Staff had been educated about risk management policies and were able to provide examples of their relevance to their work

The Assessment Team found the service did not meet Requirements 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e), regarding the service’s clinical governance framework, delivery of care and management of risks. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Complaint with Requirements 8(3)(b), 8(3)(c), 8(3)(d), and Non-compliant with Requirement 8(3)(e). I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The Assessment Team brought forward evidence that while the organisation promoted a culture of safe, inclusive, and quality care and services and demonstrated accountability for its delivery, it did not demonstrate how it assessed the services and measured organisational governance. Relevant (summarised) evidence brought forward included.

* High risk practices such as consumers beds positioned against the wall without assessment and evaluations suggested the organisation does not have overarching reporting and identification mechanisms in place
* Staff vaccination records reflective of government directive timeframes was not included in monthly reporting information that is provided to the Board for review, therefore indicators for regulatory compliance were not apparent.

Additional evidence brough forward by the Assessment Team included.

* Evidence that the service recorded incident data to identify ways to reduce or minimise events from occurring again and included opportunities for improvements.
* Examples of recent changes driven and implemented by the Board which included the introduction of an intergenerational program

In its written response of 6 June 2022, the Approved Provider submitted additional evidence in relation to this Requirement. Relevant summarised evidence included;

* Evidence to demonstrate quality processes, captured through the audit and quality plan that tracks and monitors service quality within the service
* Recent quality and data audits undertaken by the organisation between October and December 2021 to evaluate care and services within the service

The Approved Provider reiterated observations made by the Assessment Team within the Site Audit report that highlighted involvement by the governing body in delivering care and services in line with the Quality Standards.

I have considered the evidence brought forward by the Assessment Team and the additional evidence provided by the Approved Provider and on the totality of evidence I am satisfied the Approved Provider demonstrated a governing body that promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. I therefore find the service Complaint with the Requirement.

### Requirement 8(3)(c) Compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The Assessment Team brought forward evidence of effective, organisation wide systems, which included.

* Effective, electronic care management systems, appropriate information access for staff in relation to policy information, education training and reference materials.
* Appropriate engagement and guidance from the board to guide and drive continuous improvement, supported by consumer satisfaction survey data
* Effective financial governance delegations and expenditure monitoring
* Effective workforce governance systems and assignment of duties and roles
* Appropriate and effective mechanism for raising and resolving complaints

While the Assessment Team identified that the service had appropriate communication, guidance, training, and application of legislative requirements from leadership roles down within the service, the Site Audit report identified some deficiencies in staff understanding of the SIRS reporting requirements and associated gaps in mandatory training associated with regulatory compliance.

In its written response of 6 June 2022, the Approved Provider reiterated the processes in place to ensure regulatory compliance, specifically highlighting ways the organisation obtains information, engages with regulatory bodies, and then disseminates this to staff to apply in their roles.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider and am satisfied the Service has demonstrated effective organisation wide systems in accordance with this Requirement. I there for find the service Compliant with the Requirement.

### Requirement 8(3)(d) Compliant

*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.*

The Assessment Team brought forward the following summarised evidence in relation to this Requirement.

* Staff and management demonstrated that the service had effective systems and practices in place to identify and respond to abuse and neglect of consumers, to support consumers live their best life, and to manage and prevent incidents through the use of an incident management system.
* Staff had been educated about risk and reporting policies and were able to provide examples of their relevance to their work.
* Clinical staff were able to demonstrate an understanding of the management of incidents of high impact or high prevalence risks.
* The service was unable to demonstrate SIRS reporting parameters had been incorporated into their incident management system

The Assessment Team highlighted gaps in physical restraint training and education, due to the high number of beds that are located against consumer’s walls without an evaluation process or education made available to staff as a demonstration of Non-compliance with this Requirement, this has been discussed further in Requirement 3(3)(b).

In its written response of 6 June 2022, the Approved Provider reiterated the systems in place to appropriately manage risk and report incidents, some of which were also acknowledged by the Assessment Team in the Site Audit report. The Approved Provider referred to the clinical and governance frameworks in place to guide staff and support the identification and reporting of incidents.

While I acknowledge the evidence brought forward by the Assessment Team in relation to the individual assessment and planning of care and management of risk on an individual level, I am of the view that the Approved Provider has demonstrated management and risk frameworks on an organisation level that meet its obligations under this Requirement. I therefore, find the service Compliant with this Requirement.

### Requirement 8(3)(e) Non-compliant

*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.*

The Assessment Team found that the service had an established clinical governance framework in place guiding antimicrobial stewardship and open disclosure. The Assessment Team noted that inadequate governance was provided over the use of restraint

The Site Audit report identified that the organisation maintains:

* a clinical governance framework
* an antimicrobial stewardship policy
* an open disclosure policy.

However, at the time of the Site Audit the organisation was unable to provide a policy relating to minimising the use of restraint

Further (summarised) evidence brought forward by the Assessment Team included.

* Staff were unable to demonstrate knowledge of policies and were not always able to provide examples of their relevance to their work.
* Gaps in the internal training matrix relating to open disclosure and management of restraint

The Assessment Team also relied on evidence in relation to the understanding and use of restraint, I have discussed this further in Requirement 2(3)(a).

In its written response of 6 June 2022, the Approved Provider brought forward the following (summarised) evidence.

* The Service reviewed its restrictive practices policy, executed in June of 2022
* Additional open disclosure education for all staff, commencing from June 2022

While I acknowledge the service has implemented additional training and policies to support staff and strengthen its framework, the changes being implemented will take time to demonstrate effectiveness.

I am of the view that at the time of the Site Audit, the service did not demonstrate an effective clinical governance framework in relation to minimising the use of restraint. I therefore find this Requirement, Non-compliant.

# Areas for improvement

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

### Requirement 2(3)(a) – The service ensures that assessment and planning, including consideration of risks to consumer health and well-being, informs the delivery of safe and effective care and services.

### Requirement 6(3)(b) - The service ensures consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

### Requirement 7(3)(a) – The service ensures the workforce is planned with the number and mix of members of the workforce deployed to enable, the delivery and management of safe and quality care and services.

### Requirement 7(3)(d) – The service ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

### Requirement 7(3)(e) – The service ensures regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

### Requirement 8(3)(e) – The service ensures a clinical governance framework, in relation to minimising the use of restraint.