Performance

Report

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| Name of service: | Christophorus House Hostel |
| Service address: | 396 Peats Ferry Road HORNSBY NSW 2077 |
| Commission ID: | 0200 |
| Approved provider: | Christophorus House Retirement Village |
| Activity type: | Site Audit |
| Activity date: | 31 October 2022 to 2 November 2022 |
| Performance report date: | 10 January 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 Christophorus House Hostel (**the service**) has been prepared by K. Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 4 January 2023
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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.

* **Requirement 2(3)(a) –** The Approved Provider ensures assessment and planning, including consideration or risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* **Requirement 2(3)(b) –** The Approved Provider ensures assessment and planning identifies and address the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.
* **Requirement 2(3)(d) –** The Approved Provider ensures the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.
* **Requirement 3(3)(a) –** The Approved Provider ensures each consumer gets safe and effective personal care, clinical care, or both personal and clinical care that is best practice, tailored to their needs, and optimises their health and well-being.
* **Requirement 3(3)(b) –** The Approved Provider ensures effective management of high impact or high prevalence risks associated with the care of each consumer.
* **Requirement 3(3)(c) –** The Approved Provider ensures 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) –** The Approved Provider ensures 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 7(3)(d) –** The Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* **Requirement 8(3)(c) –** The Approved Provider ensures effective organisation wide governance systems relating to:

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.

* **Requirement 8(3)(d) –** The Approved Provider ensures effective 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.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives stated they were treated with respect and dignity and their culture and identity was valued. Staff confirmed they have received training in delivering care with respect to dignity, choice, and inclusion. Staff interactions with consumers were observed to be respectful.

Staff described strategies used to support consumers, including the use of cue cards, to communicate with a consumer who is culturally and linguistically diverse. The service demonstrated accommodating a consumer’s preference related to the gender of care staff to assist them. Brochures for various services were made available in multiple languages.

Consumers and representatives stated they were supported to exercise choice about the way in which care and services were delivered, who should be involved, how care decisions are communicated, and to make and maintain relationships of choice. Staff confirmed consumers could exercise choice over all aspects of their life. Documentation demonstrated consumer choice related to the delivery of personal cares, mealtimes, and food likes and dislikes.

Consumers said they could take risks which enabled them to live life as they choose. Staff described risk taking activities of certain consumers which optimised independence. Care planning documentation described the preferences of consumers who take risks, however not all risk assessments were current or complete.

Consumers and representatives said they received timely and accurate information which enabled them to make choices about their care and services. Staff confirmed they discussed pertinent information with consumers and representatives. Various communications, including letters demonstrated the provision of accurate and timely information to consumers and representatives.

Consumers and representatives said their privacy is respected and their personal information is kept safe. Staff described practical ways they respected consumers’ privacy, including knocking on doors and requesting permission to enter before entering rooms and closing doors and curtains when providing cares. The Assessment Team observed staff computers and a cupboard containing confidential information were locked when not in use.

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

Findings

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

* Assessment and planning, including a consideration of risks to the consumer’s health and well-being informed the delivery of safe and effective care and services.
* 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.
* 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.

The Assessment Team found despite the services’ policy of attending to assessment, care planning and case conference on a three-monthly basis, some consumer care plans were not current and did not reflect changes in care needs. Assessment and planning for pain, falls, and diabetic management and end-of-life care were not consistently reflective of consumers’ needs of risks to the consumer’s safety, health, and well-being. Staff were unable to describe how assessment and planning informed the delivery of care and services and said they did not have easy access to care planning documentation. The care planning documentation for one named consumer who self-managed their diabetes, and independently engaged with the outside community, did not include a risk assessment for medical events such as hypoglycaemia when out of the service. The diabetic assessment did not contain strategies to manage the consumer’s conditions or minimise the risk and the named consumer’s ongoing pain was not identified, resulting in ineffective pain management.

A further named consumer was identified by the Assessment Team has having a high falls risk, especially overnight when independently toileting with no assessment or interventions in place to support mobilisation, despite care documents showing an increased number of falls.

The Approved Providers response, received on 4 January 2023 provided further explanation of the issues raised by the Assessment Team. In relation to the consumer with a high risk of falls, the Approved Provider submitted care documentation, unavailable during the Site Audit that detailed the service had engaged with the consumer in relation to overnight assistance preferences. In response to the Site Audit the service has completed a risk assessment with this consumer, engaged the services of an external physiotherapist to provide services and provided evidence that case conference reviews have been completed for all consumers following the Site Audit.

Whilst I acknowledge the information provided by the Approved Provider and the actions taken in response to the Site Audit, I consider the service failed to demonstrate assessment and planning included a consideration of risks to the consumer’s health and well-being and informed the delivery of safe and effective care and services. Therefore, I find Requirement 2(3)(a) non-compliant.

The Assessment Team found assessment and planning did not identify and address consumers’ current needs, goals, and preferences in relation to pain and diabetic management and end of life cares. For example, the care planning documentation for a named consumer contained conflicting information and directions for the management of their diabetes. The Assessment Team reviewed a folder of advance care directives which contained unsigned and dated directives with conflicting directions for some consumers, when compared to the electronic forms. A named consumer who received end of life cares at the time of the site audit had an advance care directive made around the time of entry to the service, in which the information regarding resuscitation was faded and not legible and another directive which was unsigned and undated. Staff said the named consumer did not have a palliative care plan and could not identify the consumer’s end of life wishes.

The Approved Providers response, received on 4 January 2023 advised that all consumers had since been offered the option of completing and advanced care directive and provided examples of recently updated plans, the service has also scheduled formal palliative care training for staff, due for February 2023 and engaged with the medical officer to offer further education and support throughout 2023.

Whilst I acknowledge the information provided by the Approved Provider, I consider, some of these changes will take to measure for effect, such as staff training. I am of the view that the service failed to demonstrate assessment and planning identified and addressed consumers’ needs goals and preferences relating to pain and diabetes management and end-of-life planning at the time of the site audit. Therefore, I find Requirement 2(3)(b) non-compliant.

Most consumers and representatives reported they were not informed of outcomes of assessment and planning and said they had not been offered a copy of their care plan. Care planning documentation for some consumers did not reflect effective communication with consumers and representatives. Staff said they could not readily access consumer care planning documents as there are only two computer terminals throughout the service, and these are slow, often in use, and not always operational. Management said they identified these gaps and were working to provide training to staff and provide more effective tools for staff to utilise. Issues related to the communication or outcomes and assessment planning were added to the service’s continuous improvement plan.

The Approved Providers response, received on 4 January 2023 provided further explanation of the actions taken since the site audit, including plans to replace the care management system to better support staff access, the service has also brought care conferences up to date for all consumers since the site audit and planned future conferences through to April 2023.

Whilst I acknowledge the planned action of the Approved Provider, I consider, at the time of the Site Audit, the service failed to demonstrate effective communication of outcomes and assessments and the availability of consumer care planning documentation. Therefore, I find Requirement 2(3)(d) non-compliant.

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

Most consumers and representatives said they, and the people important to them, are involved in assessment and planning on an ongoing basis. Care planning and case conferences occurred every three months and progress notes demonstrated input from consumers and representatives, medical officers, and allied health specialists in consumer care assessment and planning. Staff and management described the involvement of others in assessment and planning on entry to the service and an ongoing basis.

Most consumers and representatives said they were regularly informed of consumer care changes and when incidents occurred. Care planning documentation evidenced regular reviews and reviews in response to incidents or changes in care needs. Staff and management confirmed care planning documentation is reviewed every three months or when health or care needs change.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Non-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. | Non-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

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

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

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

* Effective management of high impact or high prevalence risks associated with the care of each consumer.
* The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.
* 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.

Consumers and representatives reported they did not receive safe and effective personal and clinical care related to continence, pain, and diabetes management. Care planning documentation for two named consumers indicated their need for assistance to manage continence, however, the service did not demonstrate these needs being met. For example, one of these named consumers was required to use a bed pain, against their wishes, as the service did not have mobility equipment which was suitable for the shower and toilet. Care documentation for a consumer with a diagnosis of diabetes contained conflicting directives for the management of their diabetes and documented cares did not reflect management of the consumer’s diabetes in accordance with the medical officer’s directive.

Consumers did not have pain managed in accordance with best practice. For example, the care documentation for a named consumer who suffered from ongoing pain demonstrated ineffective pain relief being administered despite alternatives contained within the medical officer’s direction. Staff did not display an understanding of restrictive practices which resulted in three consumers being potentially subject to a restrictive practice without appropriate assessments and authorisations.

The Approved Providers response, received on 4 January 2023 provided additional evidence in response to the Site Audit. The Approved Provider submitted care documents for the named consumers requiring pain, continence and diabetes management that was not available at the time of the Site Audit due to information technology issues. The additional evidence demonstrated that directives and assessments were in place prior to the Site Audit or have since been updated for the management of diabetes and storage of medication, management of pain and continence support.

The service further advised that staff training has delivered throughout December 2022 in relation to continence management and further formal training planned for 2023.

Whilst I acknowledge the information provided by the Approved Provider in the written response. I have also placed weight on the consumer and representative feedback and consider the future training planned for staff will take time to measure for effect. I consider, at the time of the site audit, the service failed to demonstrate consumers received care which was best practice, tailored and optimised their health and well-being. Therefore, I find Requirement 3(3)(a) non-compliant.

Most consumers’ clinical documentation, including incident reports, progress notes, assessments and care plans demonstrated the service did not consistently or accurately assess consumers’ high impact risks such as pain, falls, and diabetic management following incidents or changes. When strategies contained in care planning documentation were not effective, revised strategies to manage the risks were not always implemented. Despite the service’s policy which provided all falls must be logged and reviewed, the physiotherapist did not have knowledge of frequent fallers and had not implemented any strategies to manage this risk.

The Approved Providers response, received on 4 January 2023 provided further information regarding the general changes planned and actioned by the service to address the deficiencies in information sharing and access to care plans and policies throughout the service. The Approved Provider did not provide further information on the strategies it intends to implement to address and manage risk at an individual level. Whilst I acknowledge the information provided by the Approved Provider and the general changes the service has made and intends to make to address the deficiencies identified by the Assessment Team. I consider, at the time of the site audit, the service failed to demonstrate effective management of high impact or high prevalence risks associated with the risks associated with the care of each consumer. Therefore, I find Requirement 3(3)(b) non-compliant.

Some staff were unable to advise which consumers were receiving palliative care, how they were monitored for pain and whether consumers had their comfort maximised. Staff, management, and documentation demonstrated palliative consumers were not correctly identified, their end of life was not individualised or tailored to their needs and preferences. In relation to a named consumer who was palliating at the time of the site audit, the Assessment Team identified a failure to identify a pressure injury, delays in administering analgesia and staff were unaware of the named consumer’s end of life wishes, including the prescription of oxygen for comfort cares. Staff reported being unable to attend to hourly checks of the palliating consumer because they were too busy.

The Approved Providers response, received on 4 January 2023, acknowledged the deficiencies identified by the Assessment Team and advised that palliative care training will be delivered to all staff by the end of January 2023. The service has implemented a system for staff to identify which consumers in which rooms are receiving palliative care and directives sent to staff to ensure they are up to date on the individual wishes of consumers who are receiving palliative care. Additional pain management training has been rolled out by the service for all staff and is due for completion by January 2023.

Whilst I acknowledge the information provided by the Approved Provider, I have also considered the evidence brought forward by the Assessment team an impact to consumers. I consider that at the time of the site audit, the service failed to demonstrate the needs, goals, and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. Therefore, I find Requirement 3(3)(c) is non-compliant.

Whilst some consumers and representatives felt a change in their condition would be recognised, this was not reflected in care documentation. Staff described the process for identifying and reporting changes and deterioration of consumers’ condition, however, this did not translate into practice. The care documentation for a named consumer who was palliating at the time of the site audit demonstrated the identification of swallowing difficulties but did not demonstrate this change was measured or managed in a timely manner. Similarly, the care documentation for another named consumer who suffered from ongoing pain demonstrated their pain was not identified, monitored, or managed in a timely manner.

The Approved Providers response, received on 4 January 2023 acknowledged the deficiencies identified by the Assessment Team and advised it felt confident that the further education and training that is due to be rolled out in January 2023 would address the deficiencies. The Approved Provider did not submit any further explanation to address the issues raised by the Assessment Team in relation to specific consumers. I acknowledge the information provided by the Approved Provider in the response dated, however, I consider, the service failed to demonstrate timely recognition and response to changes to consumer’s health or condition. Therefore, I find Requirement 3(3)(d) non-compliant.

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

Consumers and representatives said consumers’ care needs and preferences were effectively communicated between staff and they received the care they need. Information relating to consumers’ condition, needs and preferences was documented in the electronic case management system and communicated to others where the responsibility of care was shared. Consumers’ files demonstrated notification of consumers’ medical officers and representatives following clinical incidents, hospital transfers or medication changes.

Consumers and representatives reported timely and appropriate referrals were made and consumers had access to supports and services such as medical officers, physiotherapists, occupational therapists, dieticians and speech pathologists. Care planning documentation evidenced a referral process to other care providers as needed. Staff described the process for referring consumers to other health professionals and how this informed the care and services provided to consumers.

The service had implemented policies and procedures which guided staff in relation to antimicrobial stewardship, infection control and management of a COVID-19 outbreak. Staff demonstrated an understanding of precautions to prevent and control infections and strategies to minimise the need for antibiotics. Consumers and representatives said staff performed standard and transmission-based precautions to prevent and control infections.

# Standard 4

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

Findings

Consumers and representatives said they were supported to do things they enjoyed, and which provided them with a good quality of life and sustained health and well-being. Staff described the individual preferences of consumers. Care planning documentation captured information related to consumers’ interests and preferences for activities of daily living.

Consumers felt supported emotionally and to be independent. Staff described a range of supports available to consumers which supported their emotional, spiritual, and psychological well-being. Consumers were observed to be involved in one-on-one activities and leaving the service to pursue their own activities in the community or with family and friends.

Consumers and representatives confirmed they were supported to participate within and outside the service, to have social and personal relationships and do things of interest to them. Staff described the ways individual consumers participated in activities of interest, both inside and outside the service. The Assessment Team observed consumers participating within the service, having, and continuing social and personal relationships and doing things of interest to them.

Consumers and representatives confirmed their needs and preferences were communicated within the service and with others where responsibility is shared. Lifestyle staff confirmed they notified registered staff and the consumers’ families, and updated care planning documentation, when they noticed changes in a consumer’s condition, needs, or preferences. Care planning documentation confirmed changes were recorded and shared with other’s who provided care for individual consumers.

Care planning documentation demonstrated the service collaborated with external providers to support the diverse needs of consumers. The service had documented policies to support the referral of consumers to other providers. Consumers reported they received services and supports from other providers of care and services.

Consumers reported satisfaction with the quantity and quality of the meals provided. The Chef demonstrated knowledge of individual consumers’ dietary needs and preferences and meals were cooked fresh at the service and prepared to meet the needs of consumers.

Consumers said the activities areas and other equipment provided were clean and safe. The Assessment Team observed equipment used to support activities for daily living and lifestyle activities to be clean and suitable for their purpose.

# Standard 5

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

Findings

Consumers felt at home at the service and reported the service environment to be spacious and light filled. The Assessment Team observed the service to be easy to navigate and welcoming with extensive garden beds and lawns, terrace areas, paintings, and decorations. Staff described how consumers were able to freely access all areas of the service.

Consumers provided positive feedback related to cleanliness at the service. Staff described how cleaning was undertaken according to cleaning schedules and produced these schedules for the Assessment Team. The Assessment Team observed consumers moving freely both indoors and outdoors.

Consumers considered furniture, fittings and equipment were safe, suitable, clean, and well-maintained. The service’s preventative maintenance schedule confirmed all scheduled maintenance was up to date. Maintenance staff described how reactive maintenance requests are logged through the electronic case management system by staff, and in the maintenance, logbook kept in reception by consumers and representatives.

# 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

Consumers and representatives were familiar with the feedback and complaints process and said they provided feedback to staff in person, during consumer and representative meetings, and through the locked suggestion box at reception. Staff and management described processes which encouraged and supported feedback and complaints. The Assessment Team observed a suggestion box and feedback forms displayed in reception.

Consumers and representatives knew they could raise concerns externally and were made aware of advocates, language services, and other methods for raising complaints. The Assessment Team observed information relating to advocacy services displayed throughout the service and the consumer handbook contained information relating to internal and external complaint mechanisms.

Consumers and representatives reported appropriate and timey response to their concerns. Staff and management demonstrated an understanding of open disclosure and described when they have applied open disclosure following an incident. The service had documented policies related to open disclosure.

Consumers and representatives stated feedback and complaints were used to improve care and service. Management and staff described how feedback and complaints have resulted in improvements to service delivery and improvement actions were evaluated through consumer and representative meetings and surveys. The services’ continuous improvement plan reflected improvement actions in response to feedback and complaints.

# Standard 7

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

Findings

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

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

The Assessment Team identified staff were not effectively supported with relevant training to build on their current knowledge and skills to deliver quality care and services. Staff demonstrated a deficiency in the understanding and delivery of palliative care, restrictive practices and pain and wound management. Staff reported policies and procedures were not accessible and demonstrated a lack of knowledge and application of policies related to high impact and high prevalence risks. The service’s continuous improvement plan reflected planned improvements regarding training related to documentation, high risk clinical care and pain assessments.

The Approved Provider’s response, received on 4 January 2023 acknowledged the Assessment Team’s findings and provided evidenced of actions taken in response to the Site Audit, which included an upgrade to the staff education system to include policies and procedures, informal staff education sessions regarding palliative care, additional formal training sessions for staff to be undertaken throughout 2023 and additional communication avenues for staff to ensure advanced notice of training sessions.

Whilst I acknowledge the proposed actions of the Approved Provider, I consider some of the proposed actions are yet to have taken place, such as staff training and will need time to be delivered and have effect, at the time of the site audit, the service failed to demonstrate the workforce is trained and equipped to deliver the outcomes required by the Quality Standards relating to palliative care and pain management and were unable to access policies to support their roles. I find Requirement 7(3)(d) is non-compliant.

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

Some consumers and representatives described having personal care attended to efficiently and in line with their preferences. Management described how the workforce was planned and the number and mix of staff were adequate to provide safe and quality care. The roster for the week preceding the site audit confirmed all shifts were filled.

Consumers and representatives said they were treated with respect and dignity and their identities and backgrounds were understood by staff. Staff were observed to engage with consumers in a respectful and genuinely caring manner. The service had relevant policies and procedures and provided training for cultural diversity and safety.

Consumers and representatives said most staff were effective in their roles and reported satisfaction with the care provided. Management described how they ensured staff met the minimum qualification and registration requirements for their respective roles. Training documentation confirmed staff received orientation and annual mandatory training and competencies in line with their roles and responsibilities.

Management described the performance review processes and provided examples of reviews conducted with staff. Staff confirmed they participated in regular reviews which included a self-assessment which was reviewed by management and discussion with management.

# 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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

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

* Effective organisation wide governance systems relating to:

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

* 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 found that the service had effective systems in relation to continuous improvement, management had identified and documented areas for improvements in the service’s continuous improvement plan and regularly monitored progress through monthly meetings. The service had an effective feedback and complaints system that supported consumers and representatives in providing feedback and demonstrated actions taken in response. The workforce governance systems were efficient in performance management and the service demonstrated effective and appropriate financial governance with organisational oversight and support.

However, the service’s information systems did not include an effective electronic case management system through which staff could access policies and procedures. Staff reported access is limited to two computers located in the service environment and did not have access to consumer care and services plans or clinical documentation. Management confirmed enhancements to information systems were planned and reflected in the service’s continuous improvement plan. The Assessment team also found that there was no central clinical governance or quality team to guide regulatory compliance, with the management and the leadership team being responsible for providing updates related to legislative changes However, the Assessment Team found policies and procedures related to clinical governance and restrictive practices did not reflect updated restrictive practices legislative updates.

The Approved Providers response, received on 4 January 2023 included updated care plans for all consumer and an explanation of updates the service has undertaken to the information management systems, including back up hard copy, care documents for each consumer. The Approved Provider has made hard copy policies in relation to restrictive practices available at the nurse’s station for staff and planned ongoing education for staff in relation to the application of these policies.

Whilst I acknowledge the planned actions of the Approved Provider, I consider, at the time of the site audit, the service demonstrated ineffective information systems and were unable to demonstrate up to date regulatory compliance policies. Therefore, I find requirement 8(3)(c) non-compliant.

The service failed to demonstrate implementation of effective risk management systems. Whilst the service had policies and procedures to guide staff in the management and response to high impact or high prevalence risks, the Assessment Team found staff lacked knowledge related to the availability, application and content of the organisation’s policies and procedures. The service did not demonstrate regular monitoring to ensure policies and procedures were adhered to in the management of high risk and high prevalence risks, such as falls, pain management and diabetic management.

The Approved Providers response, received on 4 January 2023 provided further evidence of actions taken and planned to address the deficiencies identified by the Assessment team including additional staff training through staff meetings, toolboxmeetings, and a formal education plan to ensure staff have the knowledge to apply risk management policies. The service has also undertaken risk assessment revies for all consumers and has further case conferences planned for early 2023 to be led by service management to ensure care plans reflect the needs and preferences of all consumers.

While I acknowledge the actions, planned and undertaken by the service in response to the Site Audit, I consider, at the time of the site audit, the service failed to demonstrate the implementation of effective risk management systems and practices relating to managing high impact or high prevalence risks associated with the care of consumers. Therefore, I find requirement 8(3)(d) non-compliant.

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

Consumers and representatives felt they could partner in improving the delivery of care and services. Management demonstrated effective organisational systems which engaged and supported consumers to be involved in decision making. Staff confirmed consumers and representatives are kept informed of changes in care to ensure effective communication and engagement.

Management described how the organisation’s governing body promoted a culture of safe, inclusive and quality care and services through the organisational structure which allowed for direct communication from service management to the organisation management team. Staff described discussions of clinical indicators, quality indicators, and incidents at relevant meetings.

The service had a clinical governance framework which included policies and procedures related to antimicrobial stewardship, minimising the use of restraints, and open disclosure. Education and training was provided to staff in relation to antimicrobial stewardship and infection prevention and control. Management advised an independent auditor is utilised to review and monitor consumers subject to restrictive practices and the psychotropic register.

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