Performance

Report

1800 951 822

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| Name of service: | Performance report date: |
| Churches of Christ Golden Age Aged Care Service | 15 August 2022 |
| Commission ID: | Activity type: |
| 5060 | Site audit |
| Approved provider: | Activity date: |
| Churches of Christ in Queensland | 31 May 2022 to 2 June 2022 |

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 Churches of Christ Golden Age Aged Care Service (**the service**) was considered by James Howard, delegate of the Aged Care Quality and Safety Commissioner (the Commissioner)[[1]](#footnote-2).

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.

# Services included in this assessment

Churches of Christ Golden Age Aged Care Service (Commission ID: 5060)

**Material relied on**

The following information was considered in preparing the performance report:

* the Assessment Team’s report for the site audit, conducted from 31 May 2022 to 2 June 2022; 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 6 July 2022.
* 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 | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

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

**Standard 1** Consumer dignity and choice

**Standard 2** Ongoing assessment and planning with consumers

**Standard 3** Personal care and clinical care

**Standard 4** Services and supports for daily living

**Standard 6** Feedback and complaints

**Standard 7** Human resources

**Standard 8** Organisational governance

# Standard 1

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

I find this Quality Standard as non-compliant as I am satisfied the service is non-compliant with Requirement 1(3)(a).

*Requirement 1(3)(a):*

Consumers and representatives provided mixed feedback regarding staff consistently treating them with respect and dignity and provided examples of consumers not being treated with care and respect including:

waiting on the toilet for assistance

not having their hair washed in a timely manner

not being showered regularly

not having bed linen changed regularly

rough manual handling

staff not being aware of deterioration in consumer conditions and subsequently not understanding the needs of consumers

staff behaviour towards consumers, including shouting and/or swearing

care documentation not being updated to reflect preferences or additional needs

Staff said low staffing levels resulted in compromises in the care provided and reported mandatory training did not cover getting to know consumers and this aspect of care was left to them. Some staff gave examples of other care staff not always showing respect and dignity and advised they escalated these matters to management.

The Assessment Team reviewed care plans and identified gaps between the content of care plans and the care provided to consumers. The Assessment Team observed behaviours and care given to consumers that were not in keeping with the Requirement.

Management was advised of the issues during the site audit and responded it would develop an action plan in response to the negative feedback provided by the Assessment Team on behalf of the consumers and representatives interviewed.

In its response, the Approved Provider acknowledged the issues mentioned in the site audit report and outlined actions it was taking to find solutions to the issues. While I acknowledge the service has taken appropriate actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate that each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

*The remaining Requirements:*

I am satisfied the Service is compliant with other Requirements within Standard 1 at the time of the site audit.

Consumers advised staff were aware of and respected their cultural preferences; for example, by supporting them to attend religious services. Consumers said they were supported to maintain their independence and were able to engage in activities and maintain relationships on their own as they wanted. Consumers said they felt they would be supported to engage in risk activities should they want to and were confident this would be achieved safely. Consumers and representatives interviewed said they were provided with information which assisted them with care and lifestyle choices, including meal selections and daily activities. Consumers said staff respected their privacy.

Staff said they used a variety of resources to understand and accommodate consumers’ cultural preferences. Staff described the various ways they provided choice to consumers on a daily basis, for example by inviting them to social activities and asking if they would like their personal care to be delivered differently to their care preferences in care planning documents. Staff said that assessments of risk-taking activity occurred in consultation with the consumer, representative and relevant health professionals. Staff said they always knocked and showed discretion with personal care and opening and closing doors.

The service demonstrated it had various policies and procedures which assisted and guided staff in providing care and services to consumers in a culturally safe way and all members of the care team had appropriate training, knowledge, and skills in relation to recognising diversity and providing inclusive care.

The service demonstrated consumers communicated their decisions as to which care and services they wished to access, who their nominated representatives or points of contact were and how they wanted to maintain relationships. The service demonstrated it supported consumers in making choices and engaging in risk-taking activities.

# Standard 2

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

## Findings

I find this Quality Standard is non-compliant as I am satisfied the service is non-compliant with Requirement 2(3)(a) of the Standard.

*Requirement 2(3)(a):*

In relation to Requirement 2(3)(a), I find the service did not demonstrate assessment and care planning processes were implemented to inform the delivery of safe and effective care and services. Care planning documents showed assessments are completed for consumers upon entry to the service; however, not all assessments were fully completed and did not always include risk assessments.

Consumers expressed dissatisfaction with the assessment and care planning at the service, as they felt they did not have input into the process, and they did not have copies of their care planning documentation.

The Assessment Team examined care planning documentation and noted several instances where care plans were incomplete, Advanced Care Planning had not been discussed, and risk documentation was not complete or was not up-to-date. In one case, a consumer’s Falls Risk Assessment Tool noted they were a high falls risk and had fallen four times in the past four weeks; however, the risk documentation in the care plan stated “No” in response to the prompt for identified risks and the fields for risk benefits and consequences had not been completed.

In its response, the Approved Provider acknowledged the issues mentioned in the site audit report and outlined actions put in place to resolve these issues. While I acknowledge the service will take appropriate actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate assessment and planning, including consideration of risks to consumers’ health and wellbeing, informed the delivery of safe and effective care and services.

*Requirement 2(3)(b):*

In relation to Requirement 2(3)(b), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team noted consumers’ current needs, goals and preferences were identified; however, the evidence showed advanced care planning and end-of-life planning information was not discussed with consumers and representatives upon entry to the service and as consumers’ care needs changed. The Assessment Team drew upon several examples to support their finding of Not Met: these included no advanced care planning (ACP) documents in place, no discussions with consumers or representatives regarding ACPs, no ACP policy in place, and care not aligned with ACPs.

In its response, the Approved Provider gave details of examples mentioned by the assessment Team and explained actions taken and plans put in place to address the issues identified. The Approved Provider gave information to support a finding the service is now meeting the Requirement. This information included details of the AP’s policy of ACP, staff conferring with consumers and representatives to ensure ACP has been discussed when needed, and plans made for other consumers, including the scheduling of family conferences where necessary, so ACP can occur.

Therefore, given the above information, I decided the service was compliant with Requirement 2(3)(b).

*Requirement 2(3)(c):*

In relation to Requirement 2(3)(c), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team found most care plan evaluations and review did not show evidence of consultation with consumers and representatives in the care planning process and did not provide details of ongoing partnerships, nor any information about who was involved in the assessment and planning process including the consumer, the representative, staff and other providers. This was in contravention of the service’s policies.

In its response, the Approved Provider gave details of how it held case conferences with family members and involved them in the process of care planning. The Approved Provider gave details of the involvement of other health professionals in the care planning process for consumers, such as general practitioners. It also surveyed staff about their understanding of restrictive practices and advised it will provide remedial training for staff

Therefore, given the above information, I decided the service was compliant with Requirement 2(3)(c).

*Requirement 2(3)(d):*

In relation to Requirement 2(3)(d), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team found for the consumers sampled, care documentation did not detail ongoing partnership between the service, the consumer and others the consumer wished to be involved in the assessment, planning and review of the consumer’s care and services, including providers of other services. The Assessment Team provided examples of representatives not being consulted in the care planning process, nor having access to care plans.

In its response, the Approved Provider acknowledged the service was behind in conducting case conferences with family at the time of the site audit; however, it has now rescheduled and completed outstanding conferences. Registered staff said the service would communicate outcomes of all assessments and planning, as well as care plans, through care plan conferences on a three-monthly basis or more often as necessary. Further information in the response showed involvement of consumers and representatives in the care planning process.

Therefore, given the above information, I decided the service was compliant with Requirement 2(3)(d)

*Requirement 2(3)(e):*

In relation to Requirement 2(3)(e), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team found the service did not regularly review the care and services it provided to consumers and that care and service plans were not up to date and so it was unclear if care plans met consumers’ current needs.

The care plan review schedule showed the service was behind on planned monthly reviews and this was supported through evidence obtained in interviews with consumers, representatives and staff. Consumers and representatives (and people important to consumers) were not always engaged in reviews which impacted on the needs, goals, or preferences of the consumer.

In its response, the Approved Provider gave details of care planning reviews completed since the time of the site audit and of how other care details have been updated as required. The Approved Provider gave details of education and training provided to staff where any gaps were identified regarding care planning updates and/or reviews.

Therefore, given the above information, I decided the service was compliant with Requirement 2(3)(e).

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | 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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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

This Quality Standard is non-compliant as I am satisfied the service is non-compliant with five of the seven Requirements in this Standard, specifically Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e), and 3(3)(f).

*Requirement 3(3)(a):*

In relation to Requirement 3(3)(a), I based my finding of non-compliance on the following information.

The site audit report highlighted various examples of how consumers and their representatives were not confident or satisfied with the care provided to consumers. Specific examples concerned skin integrity, personal care, showering, and hygiene. Consumers and representatives said personal care and or clinical care provided did not support consumers’ health and wellbeing. Restrictive practice documentation, authorisation and assessments were not aligned with best practice.

Examples included the following:

a consumer continuing to sustain injuries, despite interventions, due to ineffective falls management.

incomplete care planning documents, including charts in relation to wound management and pressure injuries and incomplete pain assessment and pain management plans.

issues with medication not being delivered to consumers, or delays in delivery.

feedback from consumers of rough manual handling, which a consumer reported resulted in them being in pain.

feedback from consumers and representatives indicated consumers did not receive personal care in line with their preferences and, in some instances, did not receive personal care, such as showers, at all.

feedback from one consumer who said their bed was against the wall and the service did not discuss why this was the case or what their preferences was.

restrictive practice plans and authorisation forms were lacking in detail and were not properly completed.

restrictive practice plans were not always signed by consumers or representatives.

Staff spoke of a lack of equipment, such as having to use paper towels for personal care of consumers due to a lack of wash cloths. When raised with management, it was not aware of this issue and said it would order more wipes. Care staff said they had not received any training on the legislative changes related to restrictive practices and could only identify mechanical restraint.

The service had policies and procedures in place concerning skin integrity, pain management, and restraint; however, in several cases, it was apparent the policies were not being followed in practice. This was evidenced by issues with registers for risks such as falls (see Requirement 3(3)(b) below for further information) and with self-medicating consumers.

In its response, the Approved Provider acknowledged deficits in staff knowledge and advised it will undertake assessments to determine the level of staff knowledge and then provide education. It also acknowledged deficits in documentation, particularly in relation to wound management, and advised it undertook surveys of staff to assess their knowledge and has planned education for clinical staff.

The Approved Provider’s response demonstrated it has taken, or will take, action to address the identified deficits, including:

Conducting an assessment to determine the need to have a consumer’s bed against the wall and, when it was determined there was no care requirement, moving the bed.

Conducting a full audit which identified there were a total of two consumers with restrictive practice assessments and authorisations that were not signed following consultation and verbal informed consent; these forms have now been signed.

The Approved Provider thanked the Assessment Team for highlighting the opportunity to improve staff knowledge on restrictive practices.

While I acknowledge the service is taking appropriate actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider that, at the time of the site audit, the service did not demonstrate that each consumer gets safe and effective personal and clinical care.

Therefore, given the above information, I decided the service was non-compliant with Requirement 3(3)(a) at the time of the site audit.

*Requirement 3(3)(b):*

In relation to Requirement 3(3)(b), I based my finding of non-compliance on the following information.

The Assessment Team found most consumers sampled did not have risk assessments in place. Some representatives advised they were unhappy with how the service managed risks and gave examples of how consumers continued to sustain injuries and risks were evident and, on occasion, unaddressed.

The Assessment Team considered the information in the service’s register of high impact and high prevalence risks was inaccurate. However, in its response, the Approved Provider included clarifying information that demonstrated the information in the register was accurate.

In its response, the Approved Provider acknowledged the issues raised and provided details of remedial actions being taken to address the issues raised in the site audit report.

The Approved Provider gave explanations for specific consumers identified in the report and deficiencies in documentation and confirmed it would address these deficiencies in its continuous improvement plan.

While I acknowledge the service is taking appropriate action to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider that, at the time of the site audit, the service did not properly manage high impact and high prevalence risks and that this failure affected consumers’ care.

Therefore, given the above information, I decided the service was non-compliant with Requirement 3(3)(b) at the time of the site audit.

*Requirement 3(3)(d):*

In relation to Requirement 3(3)(d), I based my finding of non-compliance on the following information.

The Assessment Team found staff at the service did not always recognise and respond to changes in consumers’ care needs in a timely manner. Several representatives spoke of instances where their loved one’s condition had deteriorated.

Staff said they were aware of what to do when a consumer’s condition deteriorated; however, clinical staff said they were unable to make referrals as this was the responsibility of the medical officer.

In its response of, the Approved Provider included details of actions and interventions made after the site audit and clarified staff roles and responsibilities.

The response provided evidence of consumers being reviewed for mobility on a regular basis to monitor any deterioration in mobility.

The response also provided evidence that referrals to external health providers are now being arranged. Although staff previously considered this option, at the time of the site audit, referrals were not being arranged.

The Approved Provider confirmed staff will receive training so they are aware of the process for referring consumers to external health providers.

While I acknowledge the service is taking appropriate actions to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider, at the time of the site audit, the service did not demonstrate staff at the service always recognised and responded to changes in consumers’ care needs in a timely manner.

Therefore, given the above information, I decided the service was non-compliant with Requirement 3(3)(d) at the time of the site audit.

*Requirement 3(3)(e):*

In relation to Requirement 3(3)(e), I based my finding of non-compliance on the following information.

Most consumers and representatives felt consumers’ care preferences, and needs were not consistently communicated to assist the provision of quality personal and clinical care. Care documentation records, including progress notes, consistently lacked enough detail to facilitate care which aligned with consumers’ needs, preferences, and goals.

Consumers spoke of having to repeat themselves multiple times with staff in communicating their care needs. However, consumers advised they felt their needs and preferences were effectively communicated between staff.

In its response, the Approved Provider acknowledged the concerns of consumers and representatives and advised it has implemented a program to focus on sharing of information between staff.

Other information in the response included:

A misunderstanding in the service’s processes, where consumer was captured through the service’s organisational risk assessment system, rather than electronic care planning system.

In relation to specific examples raised in the site audit report, the Approved Provider advised of remedial actions being undertaken by the service, such as case conferences and one-on-one discussions between staff and consumers and rectification/competition of relevant documentation.

While I acknowledge the service is now taking appropriate action to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider, at the time of the site audit, the service did not demonstrate consumers’ care preferences and needs were consistently shared to assist the provision of quality personal and clinical care.

Therefore, given the above information, I decided the service was non-compliant with Requirement 3(3)(e) at the time of the site audit/

*Requirement 3(3)(f):*

In relation to Requirement 3(3)(f), I based my finding of non-compliance on the following information.

Some consumers and representatives advised they were not satisfied timely and appropriate referrals occurred and that, in some cases, they had spoken with staff to request a referral “10 times or more” without any action being taken. Examples included requests by consumers or representatives for referrals to a podiatrist, physiotherapist, dentist, optometrist and geriatrician.

During the site audit, the Assessment Team spoke with a registered nurse and with management about the evidence from consumers. Management said they would review consumers’ needs and arrange appropriate referrals so consumers could receive the required services.

The Approved Provider’s response acknowledged the issues identified in the site audit report and advised it was acting on the areas of concern. However, there has not been sufficient time to demonstrate the sustainability and effectiveness of any actions taken by the Approved Provider. I consider, at the time of the site audit, the service did not demonstrate each consumer received safe and effective personal and clinical care.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in this Standard, Requirements 3(3)(c) and 3(3)(g).

Most consumers now have Advanced Care Plans in place and these included consumers’ preferences. Management and registered staff said copies of Advanced Care Plans and end-of-life wishes were retained on file if consumers or their representatives chose to complete them, but they would still call the representative to ensure current needs and preferences were followed. The service maintained a palliative care framework and had an end-of-life policy which guided and informed staff.

The service had systems in place which minimised the risk of an infection outbreak at the service. As part of the service’s induction program, staff at the service completed mandatory online infection control training and were educated in the steps to take should there be an outbreak at the facility.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-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

This Quality Standard is non-compliant as I am satisfied the service is non-compliant with Requirement 4(3)(d).

*Requirement 4(3)(d):*

In relation to Requirement 4(3)(d), I based my finding of non-compliance on the following information.

Consumers’ conditions, needs and preferences were not consistently communicated within the organisation, and with others where responsibility for care was shared. Consumers gave examples of needs and preferences not being communicated amongst staff, and of needing to remind staff of these things on different occasions. Examples included a consumer whose dietary care plan indicated they did not like certain foods, but who continued to be served those foods, and a consumer with a vision impairment who frequently needed to remind staff not to move things around in their room.

Staff indicated that communication within the service was not effective, stating that updates to consumers’ conditions were not well communicated during the handover process and updates, such as provision of personal care, were not adequately documented.

In its response, the Approved Provider acknowledged the gaps identified by the Assessment Team and outlined actions taken to address some of those gaps. However, the Approved Provider’s response did not acknowledge or address feedback from staff regarding ineffective communication processes. While I acknowledge the service has taken appropriate actions to address some of the deficits identified by the Assessment Team, at the time of the site audit I consider the service did not demonstrate information about consumers’ conditions, needs and preferences were communicated effectively within the organisation.

*Requirement 4(3)(g):*

In relation to Requirement 4(3)(g), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team observed the following:

One wheelchair with a faulty footplate.

A four-wheel walker had broken cables and could not be used.

Remnants of food left on a tub chair.

Cleaners attending to their scheduled cleaning of consumer rooms, corridors, and communal areas.

A wide range of lifestyle activity products such as books, magazines, music, TV, board games and sensory and reminiscing resources, well maintained and clean.

Staff interviewed said that in the event of identifying an issue with equipment, they informed maintenance staff by lodging a work request, or if possible, spoke directly to maintenance staff.

Other comments from consumers were that equipment was well maintained and kept clean.

In its response, the Approved Provider gave further contextual information about the issues raised in the site audit report. The Approved Provider showed it had remedied the issues raised and attempted to speak with representatives to explain and clarify what occurred.

The Approved Provider implemented improvement plans in relation to the cleaning and I consider these plans will be effective in preventing the occurrence of similar incidents.

Therefore, given the above information, I decided the service was compliant with Requirement 4(3)(g).

*The remaining Requirements:*

I am satisfied the service is compliant with the other Requirements in Standard 4.

Consumers and representatives said the activities provided by the service supported their needs, goals, and preferences and staff assisted them to engage in activities of interest that promoted their health, wellbeing, and independence. Consumers advised their emotional, spiritual, and psychological well-being, along with their needs and preferences, were well supported. Consumers reported they were able to participate in activities, both within and outside the service, and staff assisted them to maintain relationships with people important to them. Consumers advised they were referred to outside people and organisations as required and this occurred quickly and effectively. Consumers and representatives said they were content with the variety and quality of food provided at the service.

Staff demonstrated how they evaluated and identified consumers’ needs, goals, and preferences with a view to providing activities that promoted their health and wellbeing and met their needs and interests. Staff said all consumers and representatives were invited to provide input into the calendar through the annual survey and at bi-monthly resident meetings. After every activity, the lifestyle staff always requested feedback. Staff described ways they adapted care and services to provide for the emotional, psychological, and spiritual needs of each consumer, including religious activities and visits from people in the community. Staff gave examples of how they supported and encouraged consumers to maintain relationships, both inside and outside the service, and to participate in the wider community. Lifestyle staff described how the service worked with external organisations to help supplement lifestyle activities and kitchen staff were able to describe how they are kept informed of consumers’ dietary needs and preferences.

The service demonstrated it had policies and processes in place which supported consumers to engage in activities that were of interest to them and matched their capabilities. The Assessment Team observed activities underway during the site visit and noted that care plans listed consumers’ emotional and spiritual needs. The service maintained a care and service delivery policy which stated where care and services could not be met through internally employed staff, the service will arrange referral to an appropriately skilled and qualified service provider or organisation.

# Standard 5

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| Organisation’s service environment | | Compliant |
| 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 said they felt at home in the service and the environment was welcoming and enhanced their feelings of belonging and independence. Consumers reported they were able to easily navigate the service and particularly enjoyed areas such as the internal courtyard. Representatives echoed comments made by the consumers and confirmed the service made them feel at home. Both consumers and representatives said the service was clean and well maintained, they could raise any issues with equipment or the environment with staff and they were quickly resolved. Furniture, fittings, and equipment were described as clean and in good working order.

Staff confirmed their understanding and awareness of the importance of ensuring consumers felt at home and were comfortable in the service. Staff described environmental features and processes, such as orientation to support consumers settle into the service. Staff showed how they monitored and managed maintenance and repairs, this included rostering for cleaning as well as maintenance scheduling and dealing with issues as they arise. Staff from all areas of the service reported they have enough supplies and were able to identify methods for escalation for reporting faults or need for repairs.

The service environment was welcoming and designed to be homely and accommodating for consumers. The service was undergoing a major renovation of consumers’ rooms, bathrooms, staff, and common areas. The service showed it had processes in place which ensured the service environment was safe, clean, well maintained, and comfortable. The Assessment Team observed maintenance actions were monitored and actions taken were recorded against each item and were completed in a timely manner. Regular cleaning audits were completed each month across all areas of the service. **Standard 6**

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| --- | --- | --- |
| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Non-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. | Non-compliant |

## Findings

I decided this Quality Standard is non-compliant as I am satisfied the service is non-compliant with Requirements 6(3)(a) and Requirement 6(3)(d).

*Requirement 6(3)(a):*

In relation to Requirement 6(3)(a), I based my finding of non-compliance on the following information.

The Assessment Team found consumers and representatives were not consistently aware of how to provide feedback and/or lodge complaints; whilst some consumers advised they understood the process, others did not. Some consumers said they did not always feel comfortable making a complaint and representatives expressed concern over how consumers would be treated if they complained or raised issues on their behalf.

The Assessment Team noted the following:

A lack of posters/materials guiding consumers/representatives on how to make complaints

No pamphlets available in languages other than English.

A pamphlet stand in the corner near the entrance of the hall and was not easily accessible to all consumers.

Locked boxes were provided for feedback; however, there were few or no feedback forms available.

In its response, the Approved Provider outlined actions taken to address the deficiencies identified in the site audit report.

Examples of actions taken by the Approved Provider in response to the site audit report included:

An attempt to contact a representative who stated not all complaints were actioned.

The service spoke with consumers who were not aware of the complaint process and explained the process to the consumers.

The service met with a representative who was concerned about how a consumer would be treated if they complained and the service provided reassurance that all complaints were treated fairly and transparently.

The service spoke with a consumer who said they did not feel comfortable raising a complaint and the consumer subsequently advised they had no concerns raising a complaint.

While I acknowledge the service took appropriate action to address some of the deficits, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate consumers, their family, friends, carers and others were encouraged and supported to provide feedback and make complaints.

Therefore, given the above information, I decided the service was non-compliant with Requirement 6(3)(a) at the time of the site audit.

*Requirement 6(3)(c):*

In relation to Requirement 6(3)(c), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

The Assessment Team interviewed a consumer’s representative who stated they unsuccessfully attempted to contact the service 17 times to enquire about their loved one’s health during a COVID-19 outbreak and lockdown. As they could not get through by telephone, they sent an e-mail to the service.

The Assessment Team considered the service could not demonstrate it took timely and appropriate action in response to complaints; however, it considered the service applied an open disclosure process when things went wrong. A consumer provided an example of staff practising open disclosure and staff demonstrated they were trained in and familiar with the open disclosure process.

In its response, the Approved Provider provided an explanation of the situation at the time of the COVID-19 outbreak and lockdown. It explained daily communications were sent via email to the families which notified them of consumers’ overall conditions. Additionally, the service faced a staffing shortage during the outbreak which contributed to it being unable to answer the representative’s calls in this case. The Approved Provider attached evidence it responded to the representative’s email the following day and sent a letter of apology to the representative.

The site audit report contained a single example of negative consumer feedback about complaints and the Approved Provider outlined the actions it took to resolve the complaint at the earliest time possible after experiencing a COVID-19 outbreak. The evidence presented under this Requirement is insufficient to support a finding that the service does not take appropriate action in response to complaints.

Therefore, given the above information, I decided the service was compliant with Requirement 6(3)(c).

*Requirement 6(3)(d):*

In relation to Requirement 6(3)(d), I based my finding of non-compliance on the following information.

Due to a lack of documentation of verbal feedback and complaints, the Assessment Team could not determine how the service recorded, analysed, and acted on feedback and complaints to improve the quality of care and services.

The Service Manager said she did not document the minutes of team leader meetings, or verbal complaints when raised by consumers, but instead acted on any issues raised. The Service Manager acknowledged this process did not allow the service to accurately analyse complaints and establish trends and that it would review this practice.

In its response of 6 July 2022, the Approved Provider outlined actions it took to address the deficiencies identified in the site audit report.

Provided education to management on feedback and complaint management

Conducted a staff survey that showed of the 71 staff who completed the survey, 100% were aware that they needed to record feedback and complaints

Scheduled further education for staff on feedback and complaints

In relation to the representative who said clothes were not hung up, an agenda item on this issue was added to the staff meeting agenda and management will follow up and perform spot checks

In relation to the consumer who said items of clothing are missing, management provided an apology and laundry staff are working with management to find missing clothes

While I acknowledge the service has taken appropriate actions to address some of the deficits, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

Therefore, given the above information, I decided the service was non-compliant with Requirement 6(3)(d) at the time of the site audit.

*The remaining Requirements:*

In relation to Requirement 6(3)(b), consumers were aware of and had access to advocates, language services and other methods for raising and resolving complaints and I am satisfied the service had policies and processes in place to support a finding of compliant for this Requirement.

**Standard 7**

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

## Findings

I decided this Quality Standard is non-compliant as I am satisfied the service is non-compliant with Requirements 7(3)(a), 7(3)(b), 7(3)(d) and 7(3)(e).

*Requirement 7(3)(a):*

In relation to Requirement 7(3)(a), I based my finding of non-compliance on the following information.

Consumers and representatives experienced delays to their care and services, which left them feeling anxious, frustrated, and angry. Consumers said, at times, the delays meant they spent extended periods of time in soiled continence aids, did not receive personal care in line with their preferences and had to wait for meals and pain medication.

Multiple staff across the service said they did not receive sufficient support and as a result, were unable to complete their tasks or deliver care and services adequately. Staff gave examples of not being able to bathe consumers adequately and not being able to consistently provide quality care.

The Assessment Team presented feedback to management, and it acknowledged issues had been faced in filling shifts; however, management advised it had put strategies in place to remedy the situation.

Strategies mentioned by management included:

Ongoing recruitment efforts were in place

Staff were offered additional shifts as they arise, with some staff opting to work double shifts

The service manager stated they filled nursing shifts themselves when the service was short staffed

Agreements were formalised with additional staffing agencies to increase likelihood of sourcing staff when needed

In its response, the Approved Provider also outlined actions taken to address staffing shortages.

While I acknowledge the service is taking action to address staffing shortage, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate the workforce is planned to enable the delivery and management of safe and quality care and services in line with consumers’ needs and preferences.

Therefore, given the above information, I decided the service was non-compliant with Requirement 7(3)(a) at the time of the site audit.

*Requirement 7(3)(b):*

In relation to Requirement 7(3)(b), I based my finding of non-compliance on the following information.

One consumer reported that staff spoke to them in an unkind, uncaring, and disrespectful manner. Other consumers reported staff treated them roughly, left them unattended when they required assistance with toileting or other personal care, or refused to assist with personal care at times, and this resulted in some emotional distress to consumers. Observations made by the Assessment Team supported consumers’ evidence, as staff were not always kind and respectful to consumers through their interactions and delivery of care.

The Assessment Team provided feedback to management, which developed an action plan in response. The action plans listed strategies such as providing staff with education relating to dignity and respect and conducting elder abuse training modules with all staff.

In its response, the Approved Provider outlined actions taken to address the deficiencies identified in the site audit report.

Actions included:

The service investigated and followed up with each of the identified consumers who raised concerns and the Approved Provider reported that consumers and/or representatives expressed satisfaction with the outcomes

The Approved Provider stated it was not able to substantiate the observations made by the Assessment Team in relation to staff not being kind and respectful to consumers; however, it advised staff are required to sign a Code of Conduct which acknowledges they understand their responsibilities and that 92% of staff have signed the Code of Conduct

While I acknowledge the service is taking action to address the deficiencies identified in the site audit report, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider at the time of the site audit the service did not demonstrate workforce interactions with consumers were kind, caring and respectful.

Therefore, given the above information, I decided the service was non-compliant with Requirement 7(3)(b) at the time of the site audit.

*Requirement 7(3)(d):*

In relation to Requirement 7(3)(d), I based my finding of non-compliance on the following information.

Consumers identified areas where they felt staff could benefit from more training, these included:

manual handling techniques

understanding the impacts of deterioration in senses, such as eyesight

Management confirmed the organisation had a system in place which supported recruitment needs and personnel. Procedures guided the recruitment, orientation and qualifying periods of staff and outlined the need for a fair and transparent process, while ensuring adequate selection criteria and quality checks occurred.

However, although the service had policies and processes in place for staff training, records showed numerous staff had not completed the required training at the time of the site audit. The Assessment Team raised this issue with management who acknowledged not all staff had completed the expected training sessions and it confirmed it would implement an action plan to address this.

In its response, the Approved Provider outlined actions taken to address the deficiencies identified in the site audit report.

The response included:

An explanation of the difficulties faced by the service during COVID-19 outbreaks, which affected the ability of staff to complete training

As of 4 July 2022, the percentage of staff who completed mandatory training had increased; however, the response did not contain documentary evidence to corroborate this

In relation to specific consumer feedback, staff were notified of the care needs of these consumers and relevant training was arranged

While I acknowledge the service is taking action to address the deficiencies, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes and if the additional training delivered to staff has improved the care and services delivered to consumers. I consider, at the time of the site audit, the service did not demonstrate the workforce was trained to deliver care and services in line with consumers’ needs and preferences.

Therefore, given the above information, I decided the service was non-compliant with Requirement 7(3)(d) at the time of the site audit.

*Requirement 7(3)(e):*

In relation to Requirement 7(3)(e), I based my finding of non-compliance on the following information.

Staff recalled having performance appraisals at some point; however, they could not recall how long ago, nor what the outcomes were from their appraisals. A review of the service’s performance appraisal schedule showed annual appraisals were significantly behind schedule. The service’s performance appraisal schedule had a total of 89 listed staff. The appraisal schedule demonstrated that 42 staff (47%) were overdue for their annual appraisals. Fifteen staff (16%) were overdue for their probationary appraisals, and 27 staff (30%) were overdue for their annual appraisals.

The Assessment Team raised this issue with management and, in response, the service’s manager acknowledged the service needed to improve in this area.

In its response of 6 July 2022, the service outlined reasons why the annual performance appraisal of staff was behind schedule and its commitment to completing the outstanding staff appraisals. While I acknowledge the service’s reasons and commitment to improving the situation I consider that, at the time of the site audit, the service did not demonstrate that it carried out regular assessment, monitoring, and review of staff.

Therefore, given the above information, I decided the service was non-compliant with Requirement 7(3)(e) at the time of the site audit.

*The remaining Requirements:*

In relation to Requirement 7(3)(c), I decided this Requirement is met as the service demonstrated the workforce was competent and possessed the qualifications and relevant clearances to effectively perform their roles. Consumers reported staff were effective in their roles and were happy with the care provided, with the exception of issues such as delays in receiving care as discussed above. Management was able to describe how the service determined whether staff were competent and capable in their roles; for example, through the recruitment process and annual mandatory training and competency assessments. **Standard 8**

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| Organisational governance | | Non-compliant |
| 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. | 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

This Quality Standard is non-compliant as I am satisfied the service is non-compliant with Requirement 8(3)(c).

*Requirement 8(3)(c):*

In relation to Requirement 8(3)(c), I based my finding of non-compliance on the following information.

The service had organisation-wide governance systems which guided practice in:

information management

continuous improvement

financial governance

the workforce, regulatory and legislative compliance

feedback and complaints

However, the Assessment Team could not see evidence of these systems and processes working effectively at the service level.

The Assessment team found:

Information management systems were not effective as care staff reported that handover processes were poor and they were unaware of updates to consumers’ conditions and needs.

The continuous improvement system was not effective as the service’s continuous improvement system did not effectively capture, monitor and action service improvements.

The workforce compliance system was not effective as staff were not up-to-date with mandatory training requirements or annual appraisals.

The feedback and complaints system was not effective as the service’s feedback and complaint management processes did not feed into an effective governance system, as the it did not effectively capture or document feedback and complaints.

In its response, the Approved Provider outlined actions taken to address the deficiencies identified in the site audit report.

The Approved Provider’s response stated:

Management is completing spot checks at handover times and asking staff about information received, to check staff are paying attention to details of consumer’s conditions

The service is reviewing the process of capturing, documenting, actioning and reviewing continuous improvement items

Challenges faced due to COVID-19 outbreaks resulted in staff falling behind on training and annual performance appraisals

* The service acknowledged not all feedback is documented and it understands the importance of doing this

While I acknowledge the service is taking action to address the deficiencies outlined in the site audit report, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider that, at the time of the site audit, the service did not demonstrate it had effective, organisation-wide governance systems.

Therefore, given the above information, I decided the service was non-compliant with Requirement 8(3)(c) at the time of the site audit.

*Requirement 8(3)(d):*

In relation to Requirement 8(3)(d), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

In the site audit report, the Assessment Team considered the information in the service’s register of high impact and high prevalence risks was inaccurate. However, in its response, the Approved Provider included clarifying information that demonstrated its records were accurate.

The service had a risk management system in place and the management team demonstrated it continued to work with staff at the service to implement all components of the risk management system.

The Approved Provider’s response included a documented risk management framework, including policies which described:

How high impact or high prevalence risks associated with the care of consumers were managed

How the abuse and neglect of consumers was identified and responded to

How consumers were supported to live the best lives they could

How incidents were managed and prevented

The response explained how incident trending and incident analysis was used to identify service improvements, detailed how all falls were recorded, and how the clinical team conducted reviews to identify causative factors and determine appropriate strategies. The service’s risk management strategy included identifying all consumers who experienced an increase in falls in the past month and referring them to a program which included twice-weekly balance and co-ordination classes and a virtual falls clinic.

Therefore, given the above information, I decided the service had an effective risk management system and was compliant with Requirement 8(3)(d).

*Requirement 8(3)(e):*

In relation to Requirement 8(3)(e), the Assessment Team considered the Requirement was Not Met. However, after reviewing the information in the site audit report and the Approved Provider’s response, I found the service is compliant with the Requirement.

In the site audit report, the Assessment Team noted the service demonstrated it had a clinical governance framework and policies which supported antimicrobial stewardship, minimisation of restrictive practices and open disclosure.

The organisation provided:

a documented clinical governance framework

a policy relating to antimicrobial stewardship

a policy relating to minimising the use of restraint

an open disclosure policy

information on antimicrobial stewardship, restrictive practices, and open disclosure

However, the Assessment Team considered overall clinical governance was not consistently effective, concerning the assessment, planning and provision of personal and clinical care to consumers and it therefore found this Requirement was Not Met.

Under Standard 3, the Assessment Team provided evidence relating to incomplete assessments and care planning and gave examples of the unsatisfactory provision of personal and clinical care to consumers. This included examples of staff being rude to a consumer, handling a consumer roughly when changing positions, and consumers waiting for assistance at times.

However, while some consumers were dissatisfied with care, other consumers provided positive comments about the conduct of the staff, the care they received and the availability of care plans and other information.

As noted above, at the time of the site audit, the service had a clinical government framework and systems in place. Although the material in the site audit indicated the systems were not always consistently implemented by staff all the time, the evidence does not indicate there were systemic flaws or failings in the service’s clinical governance and the planning and delivery of personal and clinical care to consumers.

Therefore, given the above information, I decided the service was compliant with Requirement 8(3)(e).

*The remaining Requirements:*

I decided the service was compliant with the remaining Requirements in this Standard, Requirements 8(3)(a) and 8(3)(b).

Consumers said the organisation was well run, and they partnered in improving the delivery of care and services. Management provided examples of ways the service engaged consumers, such as through surveys and consumer meetings. The organisation had governance systems and structures in place for the service to implement at a site level.

The service demonstrated the Board promoted a culture of safe, inclusive, and quality care and services and the development, delivery, and evaluation of care was made in consultation with consumers. Management reported the board satisfied itself that the Quality Standards were being met across the service through several checks including a monthly report detailing service specific updates, achievements and challenges, high risks within the service and recent ‘good news’ stories.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)