Churches of Christ Gracehaven Aged Care Service

Performance Report

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**Commission ID:** 5245

**Provider name:** Churches of Christ in Queensland

**Site Audit date:** 29 March 2022 to 31 March 2022

**Date of Performance Report:** 06 May 2022

# Performance report prepared by

Kimberley Reed, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 29 April 2022
* other information and intelligence held by the Commission in relation to the service.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

To understand the consumer’s experience and if the organisation understood and applied the requirements within this Standard, the Assessment Team sampled the experience of consumers, asked them about the requirements, reviewed their care documentation (for alignment with the feedback from consumers) and tested staff understanding and application of the requirements under this Standard. The Assessment Team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Consumers were not treated with dignity and respect, consumers and representatives described certain staff practices, such as rushing consumers’ care delivery, failing to deliver cares and services in a timely manner or in accordance with their preferences, and how staff interacted with them, negatively impacted their dignity and made them feel disrespected.

While consumers were not treated with dignity and respect, other aspects of this Standard were compliant including consumers were supported to exercise choice regarding the way their care and services were delivered and in taking risks to enable them to live the life they chose. Consumers and representatives confirmed the information provided to them was accurate and timely and enabled them to make informed decisions about the consumer’s care and services. Consumers were encouraged to do things for themselves and maintain their independence. Consumers provided feedback their privacy was respected.

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

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

Consumers were not treated with dignity and respect. Consumers experienced embarrassment, disrespect and fear relating to their care delivery. Consumers stated staff rushed their cares, failed to deliver care and services in accordance with their preferences which impacted their dignity.

Consumers and representatives provided examples of incidents involving staff practices which negatively impacted consumers’ dignity. These incidents included staff providing care procedures without gaining consent, switching off call bells without attending to the consumer, telling a consumer to be quiet, delays in response to call bells causing incontinence, delays in meal services and not providing a consumer with their preferred toileting method. Consumers and representatives provided feedback the cause of these staff practices was staff insufficiency.

Staff confirmed that due to insufficiency of staffing, they did not have the capacity to attend to consumers’ preferences for care in a timely manner. Staff provided examples relating to consumer care delivery impacted by insufficiency of staffing which included rushing consumers through their care delivery, inability to spend time with consumers, consumers missing out on lifestyle activities and incontinence of consumers. This feedback from staff was confirmed by consumer feedback.

While the organisation documented their commitment to a culture of inclusion and respect for consumers, including through policies such as the Care Service and Delivery policy, Quality Management policy, Open Disclosure policy and plan for continuous improvement, consumer and staff feedback identified occasions where consumers have not been treated with dignity and respect.

The Approved provider in its written response to the Site audit report has voiced its disappointment that some consumers felt they weren’t respected, felt valued or treated in a dignified manner. Further education was provided to staff regarding treating consumers with dignity and respect including seeking consent prior to care delivery. Care conferences were held with the individual named consumers or representatives noted to have provided negative feedback regarding staff conduct. Apologies were provided to the named consumers and representatives using an open disclosure process, and case conferences were arranged as required. Where necessary care plans have been amended and staff notified of these changes. While I acknowledge actions the Approved provider has taken or is planning to take to address the deficiencies in this Requirement, I also note plans to evaluate the effectiveness of these actions will not be completed until a consumer survey is completed in June 2022. As there is no current evidence to support the rectification actions taken or planned by the service have been effective, it is my decision this Requirement is Non-compliant.

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

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

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

# STANDARD 2 COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

To understand the consumer’s experience and if the organisation understood and applied the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewed their care documentation in detail, asked consumers about how they were involved in care planning, and interviewed staff about how they used care documents and reviewed them on an ongoing basis.

Consumers felt like partners in the ongoing assessment and planning of their care and services. Consumers were included in the ongoing assessment and planning of their care and services, and other persons the consumer wished to be involved were also included in assessment and planning processes. Consumers and representatives were informed about the outcomes of assessment and planning, and consumers had access to their care documentation if they required it.

Initial assessments were completed to identify consumers’ needs, goals and preferences, including advance care planning and end of life planning. Risks were identified as part of the assessment and care planning process. Care plans were reviewed on a regular basis or as consumer care needs changed. The service accessed external services and allied health professionals as required to support consumer care.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

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

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

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

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

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

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

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

To understand the consumer’s experience and if the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensured the delivery of safe and effective care for consumers. The Assessment Team also examined relevant documents.

Most consumers received personal care and clinical care that was safe and right for them. Consumers had access to a Medical officer or other health professionals as required. Consumers and representatives were included in decisions about consumers’ care and care was tailored to meet their needs, goals and preferences. Consumers nearing their end of life received safe and appropriate care which maintained their comfort and dignity.

Restrictive practice assessments and authorisations were not completed in line with legislative requirements and staff did not demonstrate a shared understanding of the legislative requirements and organisational procedure related to restrictive practices. For one named consumer, their unplanned weight loss was not effectively managed to optimise their health and well-being.

Information regarding consumers’ needs and preferences was communicated and documented within the service and with others as required. Most consumers were appropriately referred to specialist services including allied health services in a timely manner. Care documentation demonstrated deterioration or changes in the consumer’s health care needs were generally responded to in a timely manner. The service had processes in place to minimise infection-related risks, including monitoring of required staff vaccinations and effective processes to manage a potential COVID-19 outbreak.

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

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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.*

While most consumers received safe and effective clinical and personal care, the management of restrictive practices at the service were not effective. Assessments and authorisations were not completed in line with legislative requirements and staff did not demonstrate a shared understanding of the legislative requirements and organisational procedure related to restrictive practices. For one consumer, their unplanned weight loss was not effectively managed to optimise their health and well-being.

The management of restrictive practices were not effective. A restrictive practices register was used to monitor the use of restrictive practices at the service and to ensure assessment, authorisation and consent documentation is up to date, however, a review of the register identified consumer restraint authorisations were not current. Review of care documentation for five consumers demonstrated current restraint assessment and authorisations were not in place for those consumers. Consumer representatives were not provided with information to support informed consent was gained prior to the use of chemical restraint. Management confirmed there were no processes in place to ensure the accuracy of the register.

The Approved provider in its response to the findings of the Site audit confirmed restrictive practice authorisations contained in the restraint register were not current. Restrictive practice education has been completed by all staff including the completion of a survey. Each consumers’ medication chart has been reviewed by clinical management staff and where required restrictive practice documentation has been completed. The Approved provider has stated all consumers with restrictive practices in place have current and accurate documentation, however, I also note the Approved provider has set 31 May 2022 as the date when 100% compliance will be achieved for restrictive practice documentation to meet legislative and organisational requirements.

For one named consumer, following an extended hospital admission of 18 days, the consumer had a weight loss of 9.6kgs. The consumer was commenced on food and fluid monitoring charts and despite directives to reweigh this consumer following their return from hospital, this did not occur. Food and fluid charting were not consistently recorded, which did not allow for the accurate assessment of the consumer’s intake. Management were not aware of the consumer’s rapid weight loss and referral processes were not activated until after feedback by the Assessment Team.

The Approved provider in its written response to the Site audit report confirmed the named consumer was referred to a dietitian following feedback provided by the Assessment Team during the Site audit. Documentation sent by the Approved provider confirmed the named consumer was reviewed by the Dietitian and strategies implemented to address the consumer’s weight loss. However, I note the consumer’s weight loss was recorded 11 days prior to feedback provided by the Assessment Team, and referral processes were not instigated when the weight loss was identified. A case conference was held with the consumer and an apology provided. The Approved provider undertook a weight audit to identify consumers who were underweight which identified 32 consumers (106 consumers were onsite during the site audit) were under the benchmark of body mass index for their age bracket. While the Approved provider indicated consumers with identified weight loss are being referred to the Dietitian or Medical officer, there was no evidence in the Approved provider’s response to support any of the 32 consumers who were noted to be underweight were referred to the appropriate specialist.

While the processes relating to restrictive practices and the management of one consumer’s weigh loss was not managed effectively, skin integrity and pain management processes were effective at the service.

While I acknowledge the actions planned or taken by the Approved provider to address deficiencies in this Requirement, some of these actions have not been completed or tested for their effectiveness. Therefore, it is my decision this Requirement is Non-compliant.

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

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

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

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

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANTServices and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

To understand the consumer’s experience and if the organisation understood and applied the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they liked to do and how these things were enabled or supported by the service and staff were asked about their understanding and application of the requirements. The Assessment Team also examined relevant documents.

Consumers received the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they wanted to do. Consumers and representatives were generally satisfied with the activities the service has available to the consumers. Consumers who attend group activities provided positive feedback in relation to these activities.

While staff expressed difficulty in providing emotional support, consumers and representatives advised they received some emotional, spiritual and psychological support from lifestyle and chaplaincy staff and volunteers.

Consumers were supported to keep in touch with people who were important to them by means of receiving visitors at the service, going out on social leave and through contact by voice and video telecommunications. Consumers liked the food and there was sufficient choice, quality and quantity. Consumers’ needs and preferences were documented in care documentation and available to all staff. Consumers had timely and appropriate referrals to other organisations and providers of other care and services. Equipment to support lifestyle processes were safe, suitable, clean and well-maintained.

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

## Assessment of Standard 4 Requirements

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

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

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

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

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

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

To understand the consumer’s experience and if how the organisation understood and applied the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The Assessment Team also examined relevant documents.

Consumers felt they belonged in the service and felt safe and comfortable in the service environment. Consumers had access to call bells to alert staff if they need assistance. Consumers confirmed the service environment was clean, tidy and well maintained, and equipment and furniture provided was both safe, clean and suitable for their needs. Consumers could move freely inside and outside the service if they chose to do so.

Staff had an awareness of how to report items requiring maintenance. Documentation identified reactive maintenance was attended in a timely manner and preventative maintenance was undertaken as scheduled.

The indoor and outdoor environment was observed to be welcoming, clean, well-maintained and easy to access. Equipment was observed to be clean, well maintained and appropriate to consumer needs.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

To understand the consumer’s experience and if the organisation understood and applied the requirements within this Standard, the Assessment Team sampled the experience of consumers – asked them about how they raised complaints and the organisation’s response. The Assessment Team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

While consumers were encouraged and supported to give feedback and make complaints and demonstrated an awareness of avenues to make complaints and provide feedback, consumers and representatives did not consider the service provided timely and appropriate action in response to feedback or complaints. Consumers and representatives were not satisfied the service had used their feedback and complaints to improve the quality of care and services.

Consumers and representatives who had recently made a complaint or provided feedback, expressed dissatisfaction with the significant delay in the resolution of their complaints and the lack of communication from management regarding actions taken by the service. Consumers and representatives could not provide examples of improvements or changes that have been made at the service as a result of feedback or complaints provided to management.

Although management and staff demonstrated a shared understanding of the principles of open disclosure, review of relevant documentation and interviews with consumers and representatives did not demonstrate an open disclosure process was applied where required.

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

## Assessment of Standard 6 Requirements

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

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

### Requirement 6(3)(b) Compliant

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

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

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

Appropriate and timely action was not taken in response to consumer feedback or complaints. Open disclosure processes were not consistently applied following the receipt of a complaint. Consumers and representatives were dissatisfied with the management of their complaints and stated the service did not endeavour to address or resolve their concerns in a timely manner. Consumers and representatives provided feedback management and staff did not always provide an apology or provide communication relating to the resolution process.

Three named consumer representatives provided feedback regarding their dissatisfaction with the management of complaints raised. Feedback included apologies were not provided, acknowledgement of their complaint had not occurred or that information was not provided in relation to an investigation into their complaint. Feedback was provided from other consumers and representatives who stated they no longer raise complaints due to a lack of response.

A review of the complaints register, action plans and plan for continuous improvement identified the service did not consistently document complaints and feedback, implement actions in a timely manner, or engage in ongoing communication or follow up with the complainant to ensure their satisfaction.

While management and staff demonstrated a shared understanding of the principles of open disclosure, in circumstances where the service was not consistently documenting complaints or details of discussions had with complainants, the service was not able to demonstrate an open disclosure process is appropriately applied.

The Approved provider in its written response to the Site audit report notes that it is dissatisfying to note the service was unable to manage complaints appropriately with timely actions. Education was provided to staff on the feedback and complaints processes, which included a survey completed by staff to evaluate staff knowledge of the complaints process to ensure further training can be provided appropriately. While the Approved provider noted 100% of staff who completed the survey were aware of acknowledgement, escalation and identification processes relating to complaints, I also noted through a review of the survey results some staff members scored as low as 45% in the survey results. This suggests that additional education and training is required for staff to have sound knowledge of complaints processes and I am unable to determine from the Approved provider’s response what actions were taken to address these knowledge deficits. While the Approved provider has documented a feedback and complaints audit has been developed and utilised in April 2022, results of this audit provided demonstrated not all feedback and complaints received were acknowledged within two working days.

In relation to Open-disclosure processes which were identified to be deficient at the Site audit, the Approved provider developed a survey for all staff to complete by May 2022. I have not been able to determine what rectification actions the service has put into place following the completion of the survey by staff, which identified some staff had survey results as low as 50%. Named representatives who provided negative feedback recorded in the Site audit report, open disclosure processes were undertaken, and an apology provided for any distress experienced.

Based on the information contained above, it is my decision this Requirement is Non-compliant and improvement actions have not been established or tested for their effectiveness.

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

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

Feedback and complaints provided by consumers and representatives were not consistently reviewed or used to improve the quality of care and services. Consumers and representatives reported they did believe feedback and complaints were used to improve the quality of care and services provided to consumers.

Three consumer representatives provided feedback they were concerned issues raised in their complaints would occur again as no changes had occurred at the service following their complaints.

Management did not demonstrate effective actions have been taken to resolve concerns raised by consumers or to implement suggestions to improve the quality of care and services. Staff said they were unaware of any particular improvements made by management as a result of complaints.

The complaints register, action plan and plan for continuous improvement did not include information evidencing how feedback and complaints were used to improve the quality of care and services, or that improvement actions were evaluated for effectiveness.

Ongoing concerns raised by consumers and representatives during meetings and through individual complaints, feedback and suggestions particularly with regard to call bell response times and poor staff behaviour were not accurately collated or recorded to reflect any improvements made by the service in response to those complaints.

The Approved provider in its written response has recorded refresher training was provided to the management team on 22 April 2022, and the Service manager and Clinical manager are now fully aware that gaps identified during the investigation process are required to be entered into the service’s plan for continuous improvement. A survey was developed to test staff knowledge of the complaints processes. As noted in Requirement 6 3) c), there is a lack of information to address what actions have been taken for staff who scored as low as 45% in the survey results. Individual representatives who provided negative feedback in relation to the handling of their complaints and the lack of action taken following their complaints, case conferencing and apologies have been provided.

Based on the information contained above, it is my opinion rectification actions relating to complaints are in their infancy and will require time to be implemented and evaluated for their effectiveness, therefore it is my decision this Requirement is Non-compliant.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

To understand the consumer’s experience and if the organisation understood and applied the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Consumers and representatives considered they received care and services from staff who had the qualifications, knowledge and skills to effectively perform their roles. However, most consumers and representatives reported there was insufficient staff to deliver timely care and services that aligned with consumers’ preferences and care and services plans.

Interviews with consumers, representatives and staff identified, review of documentation including the complaints register, incident reports and meeting minutes confirmed, consumers were not consistently treated with kindness and respect.

Processes to monitor and ensure the completion of mandatory training were ineffective. Several staff members were overdue in completing training and competency assessments deemed mandatory by the organisation. In addition, training to address deficiencies in staff performance had not been delivered in a timely or effective manner. Staff performance was not regularly being assessed, monitored or reviewed, including following recent reported incidents of elder abuse.

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

## Assessment of Standard 7 Requirements

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

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

The service’s workforce was not planned or adequate in number to enable the delivery and management of safe and quality care. Consumers and representatives reported there was insufficient staff to provide cares in accordance with their preferences, in a timely manner, and to afford them with dignity. Negative feedback received from consumers and representatives was corroborated by staff interviews and documentation reviews.

Feedback received from consumers and representatives relating to how the insufficiency of staff affected consumer care delivery included lengthy wait times for call bell assistance resulting in incontinence, and subsequent anger and feeling upset. Consumers stated their preferences are not supported due to insufficiency of staff including preferences for using the toilet or commode in a timely manner. Three consumers provided feedback staff turn off their call bell prior to attending to their needs, provide assurance they will return to attend to the consumer, however, fail to return.

Staff expressed concerns regarding staffing levels at the service and stated they did not consistently have sufficient time to undertake their allocated roles and responsibilities. Care staff provided feedback they are not able to consistently deliver safe and quality care that meets the needs and preferences of individual consumers, including hygiene cares, assistance with feeding and provision of emotional support. Care staff confirmed while they endeavour to answer call bells in a timely manner, this cannot consistently occur and there are often delays.

Registered staff said the service is often not able to fill vacant registered staff shifts, and whilst at least one registered nurse is always required to be rostered, this does not consistently occur. On these occasions, an enrolled nurse is rostered instead of a registered nurse and seeks clinical support from the clinical management team.

Management and staff confirmed there had been a significant decrease in staff in 2022. In February 2022 alone, 19 staff were terminated or resigned from the service. Whilst staff acknowledged the service is in the process of recruiting staff to fill vacant shifts, they said this has added additional pressure on them as they are required to assist in the orientation and mentoring of new staff.

Rosters and allocation documentation was reviewed during the site audit which evidenced in the 14 days prior to the Site audit in excess of 1000 hours of registered, care, lifestyle, hospitality and maintenance staff hours were not filled.

During the Site Audit, the Assessment Team observed a named consumer wait for 32 minutes for their call bell to be answered. The consumer was seeking assistance to the toilet. The same named consumer was observed to mobilise unsupervised on the second day of the audit as there was no staff available to assist the consumer, the consumer is assessed as being at high risk of falls. For a second named consumer who requires assistance with meals, the Assessment Team observed a delay of over 30 minutes for staff to assist the consumer with their meal.

Management advised the service was endeavouring to recruit additional staff for the purpose of ensuring safe and effective care delivery for the consumer cohort, to fill unplanned leave and vacant shifts, and to support the workforce. The service had an ongoing recruitment drive in place with the intention of hiring staff across various roles.

Management at the service reported until such time that additional staff have been recruited, the service will utilise the clinical management team to assist with care delivery when required, increase monitoring and trending of call bell response times, and continue to monitor clinical indicators, consumer and representative feedback and complaints.

The Approved provider in its written response confirmed the service experienced a decrease in staffing levels for the proceeding two months to the site audit, a total of 25 left the service during that time. While the service has active recruitment processes, a total of 14 staff have been recruited, which included four personal care workers, however, the service had 20 personal care workers leave the service in February 2022. The Approved provider also noted five additional personal care workers will be commencing at the service shortly, I am concerned this leaves a deficit of 11 personal care workers.

While I acknowledge the actions the Approved provider has taken or is taking to ensure there are sufficiently skilled staff to deliver care and services to consumers, the feedback from consumers, representatives and staff at the time of the site audit provides me with sufficient evidence to rate this Requirement as Non-compliant.

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

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

Interactions between staff and consumers were not consistently kind, caring or respectful. Some consumers felt threatened and mistreated by staff. Some consumers reported staff had made threatening or upsetting comments which resulted in consumers feeling mistreated.

Examples of concerns raised by consumers of staff conduct included staff swearing, using disparaging language, being forceful during cares, being told to be quiet and refusal of assistance to go to the toilet.

The service’s reportable incidents register, and complaints register included recorded incidents whereby staff had not been kind, caring or respectful, including assault, swearing, refusal of care and rude and threatening treatment. Registered staff meeting minutes dated 19 January 2022 identified staff were notified of complaints regarding staff being ‘short and almost aggressive’ with consumers. The meeting minutes did not identify further discussions with staff on this matter or actions taken to address this issue.

As part of the Approved provider’s response to the deficits identified in this Requirement, consumers or representatives who expressed concerns regarding staff conduct have had their concerns acknowledged, apologies provided, and reassurance provided regarding actions the service has taken to prevent reoccurrence of poor staff practices. Consumers and representatives were provided with information encouraging them to raise any concerns with management and this will be a standing agenda item at consumer meetings, and a discussion regarding the Serious incident reporting scheme is planned. Staff training will be reviewed in relation to orientation heightening staff knowledge around the Serious incident response scheme, elder abuse and dignity of risk.

While I acknowledge the actions the service has taken in relation to deficits in this Requirement, including disciplinary action, based on the information recorded above workplace interactions were not kind, caring and respectful and there has been insufficient actions taken to date to ensure these poor staff practices do not reoccur. Therefore, my decision is this Requirement is Non-compliant.

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

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

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

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

The members of the workforce have not received training and support to deliver the outcomes required by the Quality Standards. Mandatory training has not been delivered and competency-based assessments were overdue and not completed by all relevant staff. Training has not been provided to staff following major incidents to decrease the risk of reoccurrence.

While most consumers and representatives expressed confidence in the abilities of the staff delivering their care and services, some consumers and representatives, specifically those who have been impacted by staff mistreatment of consumers, said staff should receive training in relation to respectful treatment of consumers and customer service.

Staff confirmed they had not completed mandatory training modules and/or competency assessments as they did not have time to do so during work hours. Whilst staff acknowledged they will be paid to complete mandatory training modules outside of work hours, they had not felt compelled to do so as there were no adverse consequences to them not completing the training within specified timeframes.

Monitoring processes were ineffective in identifying staff who had not completed mandatory training or competency-based assessments. Management described the various sources of information to identify staff training needs, including following incidents. However, when a training need was identified, actions were not taken, or are not taken in a timely manner, to rectify this need. For example, despite management being aware of staff choosing not to escalate incidents of elder abuse and repeated incidents of elder abuse during mid to late 2021, staff did not receive training on incident management/escalation, dignity and respect, elder abuse, nor other training of a similar nature.

The Approved provider in its written response to the Site audit findings has stated it is disappointing that staff have not followed the mandatory training process. The Approved provider has indicated it was difficult to recruit new staff and allocating staff to complete their mandatory training at the same time as ensuring adequate staffing on the floor to ensure consumers’ safety and care needs were met. A training schedule has been developed with targeted completion dates to ensure staff complete mandatory training requirements. An audit tool was developed relating to rostering and mandatory training, the Approved provider submitted the audit results for 30 March 2022, which indicated deficiencies were identified in relation to orientation of new staff, monitoring of new staff completing online learning modules and the currency of mandatory training completion. There were no subsequent audit results submitted as part of the response to indicate an improvement has occurred in the compliance of this Requirement.

Based on the information contained above it is my decision this Requirement is Non-compliant, and processes are yet to be established to ensure the workforce was trained and equipped and supported to deliver the outcomes required by these standards.

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

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

Staff performance has not been assessed or monitored including following an incident or an episode of poor staff performance. Monitoring processes were ineffective in identifying poor staff performance, which caused negative outcomes for consumers.

While staff have been recently terminated by the service, the monitoring of these staff members performance was ineffective in identifying poor performance prior to their termination. While poor staff performance was identified and resulted in staff being terminated from the service, the service did not conduct a service-wide investigation or review of staff performance to determine whether there were similar deficiencies in the practices of remaining staff. The Approved provider in its written response has committed to the commencement of the investigation of current staff performance in May 2022, this is despite 11 incidents of elder abuse reported by the service to the Serious incident response scheme in February 2022. It is my opinion this is not a timely response to determine if any remaining staff require performance management or monitoring.

The Approved provider in its written response to the Site audit report has reported disappointment the service was unable to demonstrate the assessment and monitoring of staff performance. The Approved provider has stated the orientation program is currently under review and this will include training and education relating to the Serious incident response scheme and incident management.

Based on the information contained above, it is my decision this Requirement is Non-compliant, staff performance was not assessed, monitored or reviewed, and actions taken by the service since the Site audit have not been tested or evaluated for their effectiveness.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Consumers and representatives consider that the organisation was run well, and they could partner in improving the care and services the consumers receive. Consumers and representatives confirmed they could choose to be involved in the development and evaluation of the care and services the consumers received, such as through their participation in meetings, consumer experience surveys, and by utilising complaints and feedback mechanisms.

While consumer and representatives provided positive feedback regarding the organisation, the organisation was not able to demonstrate there were effective governance systems in place relating to continuous improvement, workforce governance, regulatory compliance, and feedback and complaints. The organisation had implemented risk and incident management systems and practices to support the service in identifying, reporting, preventing and managing risks to the health, safety and well-being of consumers and to enable consumers to live a life of their choosing. However, these systems and practices were not effective in identifying and responding to abuse of consumers, nor managing and preventing incidents.

The organisation had not ensured that effective and consistent clinical oversight at a service level was occurring in accordance with the organisation’s clinical governance framework, specifically in relation to minimising the use of restrictive practices.

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

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

There were ineffective organisation wide governance systems as deficiencies were identified in relation to continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

Complaints and feedback made by consumers and representatives were not consistently used to inform continuous improvement actions and were not reflected in the service’s Plan for continuous improvement. There were deficiencies in staff practices relating to their treatment of consumers, escalating incidents, and the use and management of restrictive practices which had not been identified by the service’s quality monitoring mechanisms and subsequently did inform continuous improvement actions.

Incidents, including those reported in accordance with the SIRS, had not been used to inform service-wide continuous improvement actions. For example, following 11 serious incidents reported in 4 February 2022, the continuous improvement actions taken were limited to terminating relevant staff, and providing staff education on elder abuse in March 2022. These actions had not been evaluated for their effectiveness at the time of the Site audit.

The governing body received various information and consolidated reports from the service and governance committees on a monthly basis which outlined information relating to the service’s internal and external audit results, consumer, representative and staff feedback and complaints, continuous improvement activities and human resource matters, and clinical and incident data analysis. The governing body used this information to identify the service’s compliance with the Quality Standards and to initiate improvement actions to enhance performance. However, in circumstances where the monitoring processes applied by the service have failed to identify deficiencies identified in the Site audit report and resulted in Non-compliance in four of the Quality Standards had not been reported to the governing body, the governing body could not be assured of the accuracy of the information received from the service and the service’s compliance with the Quality Standards.

Whilst the organisation had various documented policies and procedures relating to Human resource management, these were not effectively being applied or monitored at a service and organisational level. The workforce was not sufficient to ensure the care needs of consumers were met in a timely manner and in accordance with their preferences. Workforce interactions with consumers and representatives were not consistently kind, caring and respectful. Staff were not consistently being trained nor supported to deliver the outcomes required by the Quality Standards. Specifically, the completion of mandatory training and competency assessments was not consistently or effectively being monitored, and staff did not receive timely or effective training following identified deficiencies in staff performance. Staff performance was not regularly monitored or reviewed, specifically following an incident or identified deficiency in staff practice or conduct.

While the organisation has organisational processes to comply with regulatory compliance, management did not demonstrate a sound understanding of the Serious incident response scheme, specifically the distinction between priority one and priority two incidents. The service’s reportable incidents register identified some incidents were incorrectly categorised, incidents were reported outside legislative timeframes and one incident was not identified as a serious incident until feedback was provided at the Site audit. The service did not consistently taking investigative and remedial actions in response to reported incidents, nor did they act to prevent recurrence and ensure the ongoing safety of consumers as required by the legislation.

Consumers’ care documentation and documentation to monitor the use of restrictive practices at the service identified several consumers who were subject to chemical restrictive practices did not have current assessment, consent and authorisation documentation in place to comply with legislative requirements. Management and staff did not demonstrate a shared understanding of the legislative definitions of physical and mechanical restrictive practices.

Systems and processes were not in place to ensure appropriate and timely action was consistently taken, an open disclosure process was applied, and improvements were initiated at the service as a result of consumer/representative feedback and complaints.

The Approved provider in its response to the findings in the Site audit report has implemented a number of surveys including feedback and complaints, incident management, serious incident reporting, restrictive practices to evaluate staff knowledge on the deficiencies identified in the site audit report to develop training modules to improve staff knowledge in areas of deficiencies. In relation to workforce governance, the Approved provider has reviewed the orientation process for new staff and a draft program has been developed and is under review.

While I note the Approved provider has plans to address the deficiencies identified in this Standard, these actions have not been completed or commenced in some areas, therefore have not been tested or evaluated for their effectiveness. It is my decision this Requirement is Non-compliant.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

Risk management systems and processes were not effective, specifically in relation to the management and prevention of incidents.

Whilst staff and management demonstrated a shared understanding of the processes for identifying, escalating, managing and recording incidents, including incidents of elder abuse and neglect, most staff said they did not feel supported to escalate incidents to management as they do not feel as though their concerns will remain confidential.

The Approved provider in its response acknowledged management at the service were aware of staff feeling reluctant to inform others when they had witnessed poor staff practice including incidents of elder abuse. Staff were re-enrolled in an elder abuse training module to emphasise the importance of timely identification and escalation of incidents of abuse. Management and registered staff were provided with Leadership essentials training to reinforce best practice reporting and to empower staff in following organisational processes for identifying and escalating incidents. The work instruction relating to the reporting of serious incidents was developed to provide detailed guidance on how to identify and correctly report serious incidents. To incorporate changes made to the serious incident work instruction and the Harm, abuse and neglect policy, the organisation’s Consumer incident management procedure was updated.

While I acknowledge policies and workflow instructions have been updated and training and education has been provided, there is a lack of evaluation of these changes contained in the Approved provider’s response. Therefore, I am not convinced these changes are effective in addressing the deficiencies identified in this Requirement. My decision is this Requirement is Non-compliant.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The service did not have effective clinical governance systems and processes in place that were aligned with the organisation’s clinical governance framework, policies and procedures, clinical oversight was not effectively occurring at the service. Deficiencies in staff and management knowledge were identified in relation to restrictive practices, open disclosure and clinical oversight relating to weight loss. Clinical monitoring processes and systems were not effective as they have failed to identify the clinical deficiencies brought forward specifically in relation to restrictive practices and the monitoring of significant changes in a consumer’s clinical status.

The Approved provider in its response to deficiencies identified in the Site audit report has recorded an open disclosure survey was created to evaluate staff understanding about open disclosure to guide staff training. There is no evidence to support an analysis of these survey results has occurred to ensure appropriate training has been provided. As results as low as 50% were recorded in the survey.

The organisational Restrictive practices work instruction was updated and this was communicated to staff in a newsletter. To address deficits in registered staff knowledge relating to the type of restraints in use at the service, a survey was developed and completed by registered staff, and results demonstrated 100% of registered staff can distinguish between physical and mechanical restraint. While staff may be able to distinguish the types of restraint, a review of the survey results indicated scores as low as 31% in relation to registered staff knowledge of restraint management. Furthermore, there is no evidence to support these results have been analysed to direct further education and training opportunities.

To address the deficiencies in clinical monitoring, particularly relating to weight loss, the service conducted a weight audit which identified 32 consumers were classified as underweight in accordance with their body mass index. While the Approved provider stated this audit was to identify consumer requiring referral or additional review of their weight, documentation was not supplied to support this process occurred after the completion of the weight audit.

While surveys have occurred, and work instructions updated, I am not convinced there was an effective clinical governance framework at the time of the site audit and rectification actions have not been completed and are not sufficient to address the deficiencies in this Requirement. Therefore, it is my decision this Requirement is Non-compliant.

# Areas for improvement

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

* Consumers are to be treated with dignity and respect
* Clinical care provided is to safe and effective
* Appropriate action is to be taken following complaints using an open disclosure process
* Complaints and feedback are to be reviewed to improve the quality of care and services
* The workforce needs to be sufficient to deliver safe and quality care and services.
* Workforce interactions with consumers need to be kind, caring and respectful
* The workforce needs to be trained, equipped and supported to deliver the outcomes required by these standards
* Regular assessment, monitoring and review of the performance of each member of the workforce must occur
* Effective organisational governance systems relating to continuous improvement, workforce governance, regulatory compliance and feedback and complaints are required to be in place
* An effective risk management system is required to identify and respond to abuse of consumers, and to manage and prevent incidents
* An effective clinical governance framework is required, particularly in relation to the changes in consumers’ condition.