Performance

Report

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| Name: | Cooee Lodge |
| Commission ID: | 0216 |
| Address: | Townsend Drive, GILGANDRA, New South Wales, 2827 |
| Activity type: | Site Audit |
| Activity date: | 19 September 2023 to 21 September 2023 |
| Performance report date: | 13 November 2023 |
| Service included in this assessment: | Service: 232 Cooee Lodge |

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 Cooee Lodge (**the service**) has been prepared by G-M. Cain, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit 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 24 October 2023 and additional information received form the approved provider on 10 November 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* Requirement 8(3)(e) – Where clinical care is provided – a clinical governance framework, including but not limited to the following:

(i) antimicrobial stewardship

(ii) minimising the use of restraint

(iii) open disclosure.

# Standard 1

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

Findings

Consumers and representatives spoke of consumers feeling respected and valued as individuals’, for example, one consumer who identified as an Indigenous Australian said staff were aware of her cultural background and were respectful, always treating her with dignity. Care documentation reflected consumers diversity and included individualised information about their cultural, sexual and religious beliefs and preferences. The service had a cultural diversity plan that outlined what it means to treat consumers with dignity and respect, and observations showed staff interacting with consumers respectfully. Workforce education on cultural diversity is provided during orientation and ongoing.

Consumers and representatives said the service recognises and supports their cultural backgrounds, customs and preferences and considers these in consumers' care and services. Staff demonstrated understanding of consumers' diverse backgrounds and described how these are considered in the delivery of care and services.

Consumers confirmed they were supported to maintain the relationships they wished, decide who was involved in their care and are given a choice about when care is provided, which is respected. The service demonstrated support for consumers to remain connected during periods of isolation due to COVID-19 lockdowns through the purchasing of additional devices to allow consumers to engage in videoconferencing calls.

Consumers are supported to make choices and take risks that enable them to live their best lives. Staff demonstrated an awareness of the risks taken by consumers and how supporting these risks can enable consumers to live the way they choose. Care documentation included risk assessments, acknowledgement of risk, mitigation strategies and signed dignity of risk forms. Dignity of risk is included in workforce orientation education and ongoing training.

Information related to consumer care and services is provided to consumers and representatives in a way that is clear and easy to understand, allowing them to make informed decisions. Consumers and representatives confirmed they are kept informed through printed information sources, verbal reminders, emails and information on noticeboards.

Consumers said staff were respectful when providing care and maintained their privacy. Staff advised that they knocked on doors before entering rooms, announced themselves, and sort consent from consumers before discussing consumer care with others. Care staff confirmed that consumer information is secured appropriately, and the electronic care management system is accessed within the staff workstation, not visible to others. Observations showed staff knocking and announcing themselves before entering consumers' rooms and an awareness of consumer privacy and confidentiality. Feedback to management at the time of the Site Audit in relation to the management of photography of consumers’ wounds was actioned immediately, and I am satisfied that the service maintains and stores consumers' personal information appropriately.

# Standard 2

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

Findings

The service demonstrated consumer assessment, which included consideration of risk; staff described how these are considered and informed consumer care planning and the service maintains a clinical risk register. However, the Site audit report contained information that the service did not have an RN rostered on-site and on-duty 24/7 and did not have processes to guide staff in escalating concerns to the on-call RN, and as a result, appropriate assessment of consumers post-incident may not occur. I have considered the 24/7 RN coverage under Standard 7 and on-call processes under Standard 8. In relation to assessments not occurring for consumers, the Site Audit report referred to 2 named consumers:

* The first named consumer was assessed as having a high risk of pressure injury and decreased mobility, however, care plan interventions related to these were general in nature and the consumer was observed to be sitting in a chair in the same position. Care documentation identified the assessment of a Stage 1 pressure injury on the consumer's sacrum. I have considered this information alongside the Approved Provider's response, which provided clarifying information that confirmed the implementation of individualised strategies to minimise identified risks, including regular repositioning of the consumer. The identified pressure injury was assessed, a wound management plan was implemented, and evidence was provided that the pressure injury has now resolved.
* A second-name consumer was assessed as a high risk for falling, having experienced 12 reported falls in the previous 6 months. Care documentation identified that the consumer experienced most falls when mobilising without their mobility aid, as this could not fit through some doorways. I have considered this information alongside the Approved Provider's response, which provided clarifying information and evidence of actions taken by the service, including the review and assessment of the consumer by the physiotherapist for a suitable mobility aid and the supply of a personal alarm.

I am satisfied that the service ensures consumer assessment and care planning processes, including the identification of individual consumer risks and the implementation of strategies to monitor and mitigate these risks.

In relation to the remaining requirements, consumers spoke of staff knowing what was important to them regarding how their care was delivered and what consumers' preferences were. Consumers and representatives said they were offered the opportunity to discuss advance care directives and care documentation documents containing information about consumers end of life wishes.

Consumers and representatives were observed to be involved in discussions about consumer care and services. Care documentation evidenced that consumers, representatives, and other providers were involved in ongoing assessment, planning and review of consumers' care and services, including case conferences and referrals to other health professionals.

Consumers and representatives spoke of being informed, and the service is open to feedback about consumer care and services. They confirmed they were consulted during care plan reviews and provided the opportunity to read the consumers' care plans. Staff said, and documentation confirmed that the outcomes of assessment and planning were communicated with consumers, representatives, and others through electronic records management accessible via a mobile application and case conferences.

Consumers and representatives explained that the service communicated that consumers' circumstances had changed or incidents occurred, warranting an updated care plan review. Staff described the assessment and planning processes in place to review consumers' care and services for effectiveness on a six-monthly basis or at other times as required. Care planning documents contained information about consumers' goals, preferences, and needs and were reviewed every 6 months consistent with staff feedback. For example, a review by the physiotherapist after consumers experience a fall.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Site Audit Report contained information about deficiencies in consumers' clinical care relating to pain management, medication management and inconsistent documentation of consumers' condition, needs and preferences.

*In relation to Requirement 3(3)(a)*

Consumers and representatives spoke of consumers' personal and clinical care being individualised and understood by staff, and consumers' care documentation reflected detailed information to guide staff in clinical and personal care delivery including restrictive practices, wound care, continence care, and management of nutrition and hydration.

However, the Site audit report contained information relating to the clinical care of 2 named consumers:

* A review of care documentation for one named consumer identified as required medication was not consistently evaluated; staff did not consistently implement non-pharmacological strategies as documented in the consumers' care plan. On several occasions, the consumer was observed to be loudly verbalising without evidence of any action by staff. I have considered this information alongside the approved provider's response, which provided clarifying information, including (but not limited to) copies of medication charting, progress notes, pain assessments and clinical incidents. The evidence provided as part of the response submission identified the service:
  + On most occasions, the evaluation of the effectiveness of the medication was recorded as 'content', and charting identifies that non-pharmacological strategies, including repositioning, were implemented.
  + I have placed weight on the information that a referral was made to an external dementia specialist service in July 2023, as the service identified changes in the named consumers' behaviour. A copy of the consumer's behaviours support plan includes directives made by the specialist dementia service and identifies the consumer will at times verbalise and staff are to leave the consumer to calm down and reapproach at a later time.
* For a second-name consumer, the Site Audit Report contained information that identified:
  + Care documentation identified the second name consumer was reviewed by the medical officer in August 2023, who prescribed an increase in oxygen flow administration. However, the consumer’s care plan did not record this change in oxygen prescribing.
  + The administration of as required medication on 4 occasions in 2 months; however:
    - On 1 of the 4 occasions, staff did not follow the service's processes for the administration of as required medication, including the approval by an RN before administration.
    - On 1 of the 4 occasions, the Site Audit report identified that the medication management process, including the counting of Schedule 8 medications, was not followed.

I have considered this information alongside the approved provider response, which provided clarifying information, and the evidence provided as part of the response submission identified:

* In relation to the prescribing of oxygen, the response submission contained information that whilst the medical officer had prescribed an increase, the consumer had subsequently required admission to the hospital. The discharge summary directive included oxygen administration between 1 to 2 litres/minute.
* In relation to the administration of as required medication, the occasion where an as required medication was administered to the consumer without the RN approval was recorded by the service as a medication incident, and the medical officer was subsequently informed. For the 1 occasion where the processes of counting Schedule 8 medications after administration were not followed, the response submission identified this incident was not related to the consumer as named in the Site Audit Report. Information was provided that evidenced action was taken in response to this incident.

The site audit report contained information that the service did not consistently have a RN rostered on-site and on-duty at the service; however, RN staff are on-call overnight and on weekends. Responsibilities associated with the on-call RN role, including escalation processes to guide staff were not evidenced. I have considered this information under Requirement 7(3)(a) and Requirement 8(3)(e). This Requirement requires that each consumer gets safe and effective personal care and/or clinical care that is best practice tailored to their needs and optimises their health and well-being. Following a review of the information contained in the Site Audit report alongside the Approved provider's response, I have decided that Requirement 3(3)(a) is Compliant. This was based on feedback from the 27 consumers and representatives who were interviewed and overall provided positive feedback about personal and clinical care and service.

*In relation to Requirement 3(3)(b)*

The Site Audit report contained evidence that high-impact and high-prevalence risks are not consistently being managed by the service in relation to pain management, falls management and the management of as required mediation management for 3 named consumers.

For the first named consumer, observations during the Site Audit showed the consumer loudly verbalising, and staff reported this as usual behaviour for the named consumer. Care documentation identified that whilst pain assessments were completed before administering as required pain medication, the effectiveness of these was not consistently documented. I have considered the information relating to this named consumer under my decision for Requirement 3(3)(a).

For the second named consumer, who experienced 12 reported falls in the previous 6 months. The Site Audit Report contained information that care documentation did not consistently record all incidents of the consumer falling. I have considered this information alongside the Approved Provider's response, which provided clarifying information and evidence of actions taken by the service, including the review and assessment of the consumer by the physiotherapist for a suitable mobility aid and the supply of a personal alarm. Evidence was provided as part of the response submission, which identified the recording of all incidents of falls.

For the third named consumer, the Site Audit report contained information relating to administering as required medication. I have considered this information under Requirement 3(3)(a).

The service maintains a clinical risk register and undertakes weekly risk meetings to discuss consumers' clinical risks. This Requirement requires services to effectively manage high-impact or high-prevalence risks associated with the care of each consumer. From the evidence before me, I have decided that Requirement 3(3)(b) is compliant; I have placed weight on the evidence provided in the Site Audit report, including care and clinical staff describing the risks for individual consumers and the strategies implemented to mitigate risk. The service demonstrates the effective management of risks for consumers associated with nutrition and hydration, including the risk of choking and minimising restrictive practices.

*In relation to Requirement 3(3)(e)*

The Site Audit report contained evidence that some information, such as daily documentation and recording of clinical observations was incomplete or not reported by care staff to the RN relating to the clinical care of 4 named consumers:

* Wound care documentation for one named consumer with an ischemic toe, showed inconsistent recording of wound measurements and wound photography, and directives for care staff to review the toe daily during personal care.
* For the second named consumer, care documentation did not evidence consistent recording of the evaluation and effectiveness of pain medication. I have considered medication management including as required medication and medication evaluation under Requirement 3(3)(a) and 3(3)(b).
* For the third name consumer, a blood pressure measurement recorded on 19 September 2023 was identified as being outside of normal parameters.
* Care documentation for the fourth named consumer, who has been identified as having unstable blood oxygen saturations shows across an 18 day period, oxygen saturation charting records measurements out of range.

The Approved Providers response submission refuted the findings, and provided clarifying information and evidence of actions taken by the service, including:

* For the first name consumer, wound photography (date stamped 10 September 2023) was provided which shows the ischemic toe and a ruler measurement illustrating the size of the wound. Whilst the response submission asserts the wound is not for active treatment, directives in the consumers care documentation requires daily observation of the wound during personal cares. I would expect regular documentation should be made of the appearance of the toe to inform care staff who would be observing the wound daily and alert them to any changes.
* For the third name consumer, the response submission provided clarifying information including progress notes with evidenced the documentation and communication of information relating to the consumers low blood pressure, including to the medical officer for review on 22 September 2023.
* For the fourth named consumer, the Approved Provider asserted that the directive for staff to alert the RN when the consumers oxygen level was not a directive documented in the consumer care documentation. The response submission provided evidence of the consumers oxygen saturation recording between the 12 October 2023 to 26 October 2023 with documented parameters between 71% to 95% oxygen saturations and provided explanation the consumer receives continues oxygen therapy and stated the consumer often removes the nasal prongs. Care documentation provide for the period 3 August 2023 to 23 October 2023 identified recording of oxygen levels and escalation to the medical officer on several occasions.

This Requirement requires services to have information about the consumer’s condition, needs and preferences documented and communicated within the organisation, and with others where responsibility for care is shared. I have decided, from the evidence before me, that the service is Complaint with Requirement 3(3)(e).

In relation to the remaining requirements, care documentation showed that consumers nearing end-of-life had their dignity preserved and care provided in accordance with their needs and preferences. Advanced care plans outline consumers' needs, goals and preferences and are available to staff in the electronic care documentation system. Staff are provided education in palliative care for consumers, and the service is supported by external palliative care specialist and services.

Consumers and representatives expressed satisfaction about the responsiveness of the service when there is a deterioration in the condition, health, or ability of the consumer. Care documentation evidenced timely identification and response to deterioration or changes in consumers' health and condition. Staff demonstrated understanding of signs which may indicate a deterioration in a consumer’s condition, including changes in mobility, cognition, mood and behaviour.

Consumers spoke of referrals being timely, and staff keeping them informed of appointments. Staff described the referral process, and care documentation confirmed the referral to and input of others in consumers' care and services.

Consumer representatives expressed satisfaction with how the service had managed the minimisation of infection related risks including during outbreaks. The service had policies and procedures to guide staff on antimicrobial stewardship, infection control management and managing an outbreak. Staff demonstrated an understanding of precautions to prevent and control infections and the steps they could take to minimise the need for antibiotics. The service had 2 appointed an Infection Prevention Control Lead to oversee infection control and staff have received training in infection control management.

# Standard 4

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

Findings

Consumers and representatives spoke of being satisfied with the services and supports for daily living that meet consumers’ needs, goals, and preferences and supported independence and quality of life. However, the Site Audit report contained information that activities staff had not completed lifestyle qualifications, activities were not provided over the weekend for consumers and the activities officer was on emergent leave during the Site Audit and these shifts were not covered. In addition, observations in the secure living environment showed consumers sitting watching television for long periods. I have considered this information alongside the Approved Provider's response, which provided clarifying information and evidence including a copy of the service’s activities calendar for the period 18 September 2023 to 24 September 2023 which evidenced a schedule of activities, and whilst the activities officer was on leave, a consumer who enjoys running activities was observed to be delivering some activities. I have place weight on the positive consumer and representative feedback about lifestyle supports, and there was a lack of feedback from consumers relating specifically to the activities program, and positive feedback under other Requirements where consumers spoke of feeling connected and engaged in meaningful activities. In addition, observations in the Site Audit Report under Requirement 5(3)(a) showed consumers socialising in communal areas and engaged in activities. Therefore, it is my decision Requirement 4(3)(a) is Compliant.

Consumers spoke of feeling connected and engaged in meaningful activities and described how the service promoted their emotional, psychological, and spiritual well-being through services and supports, for example pastoral, religious and spiritual services. Staff described individualised support provided to consumers, including prioritising one to one visits for those consumers who choose not to participate in activities and prefer spending time alone. Care documentation contained information to guide staff in supporting consumers' psychological, spiritual, and emotional needs.

Consumers spoke of being supported to participate in activities, engage in social interactions, and do things of interest to them. Care documentation included information regarding each consumer's hobbies, social relations and areas of interest. The service supported connections for consumers during COVID-19 lockdowns by utilising video-calls for consumers to enable them to remain connected to family and friends.

Staff described various ways they communicate information regarding the consumer's condition, needs and preferences, including via shift handover and documented in the electronic care management system. Consumers and representatives confirmed information relating to consumers supports for daily living wre communication, one consumer spoke of ‘being very confident’ that staff communicate and advise of any changes.

Consumer representatives said other organisations, support services and external providers of care and services supported consumers. Staff described how the service worked with external organisations to provide individual consumer support. Care documentation evidenced the service works with other specialist services and community supports in the provision of consumers’ supports for daily living.

Consumers expressed satisfaction with the variety, quality and quantity of meals, and said there are choices of hot meals, sandwiches, soups and salads. The service supports consumers to be involved in the development of the menu including through food focus meetings, and meals are available to consumers if they choose across 24 hours of the day. Care and catering staff demonstrated knowledge of consumers' dietary preferences and assessed needs, and how these are accommodated in the menu provided.

Consumers and representatives said they had access to clean, safe, well-maintained equipment to assist with mobility and maintain their independence. Consumers spoke of feeling comfortable in raising issues if equipment needed repair, and confirmed they knew the process for reporting an issues. There was sufficient equipment available to support lifestyle activities, and equipment was observed to be safe, suitable, clean and well maintained.

# Standard 5

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

Findings

Observations showed the service was welcoming, with consumers socialising in communal areas and engaged in activities. Consumers rooms were observed to be personalised and outdoor areas were accessible for consumers, one consumer spoke of liking being in the garden and enjoying the flowers. Signage throughout the service supported consumers to navigate, and artwork and furnishing provided a home like environment.

Consumers and representatives said the service is clean, and consumers rooms and the service environment were observed to be safe, clean and clutter free and doors to external areas were unlocked to support consumers to move freely throughout the service. Maintenance staff describe the process of preventive and corrective maintenance. Maintenance is attended to promptly. The Site Audit report contained information that observations in the service's secure living environment showed some areas with carpet stains and paint peeling. Management provided feedback at the time that refurbishment of the area had been approved and a dementia specialist had been engaged to provide advice on the plan and redesign of the environment to support consumers living with a cognitive impairment.

Consumers spoke of being satisfied with the furniture, fittings and equipment, and the service demonstrated effective systems in place for the cleaning and regular maintenance of the furniture, fittings and equipment. Service management advised the call bell system is not consistently reliable, however, the organisational governing body had approved the purchase of a new system and this process had been commenced.

# Standard 6

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

Findings

Consumers and their representatives were aware of how to provide feedback and make a complaint and spoke of satisfaction that they can provide feedback directly to staff or raise at consumer meetings. While not all consumers were aware of advocacy services available to them, they said they could advocate for themselves, or their families would support them. The service’s consumer handbook included information relating to internal and external complaints processes, and meeting minutes confirmed that consumers raised feedback at meetings, including the food focus group.

The service has an open disclosure process and a complaints management system detailing actions to address or resolve complaints. Most consumers and representatives advised that management promptly addresses and resolves their concerns after making a complaint. Management provided examples of recent actions in response to complaints and feedback from consumers and representatives, which evidenced a timely resolution. Training records identified staff have received training in the open disclosure.

While consumers and representative’s feedback and complaints are considered at the time they are raised, documented and reviewed by the facility manager, the Site Audit report contained information that the service does not effectively monitor or trend feedback and complaints including being documented in the service’s continuous improvement plan. For example, the plan for continuous improvement documented improvement actions identified in response to non-compliance issues identified in the previous Site Audit, there are no actions relating to consumer feedback and complaints and the plan for continuous improvement was updated in January 2023 with no new items have been recorded since this date, however issues have been raised through feedback from consumers and representatives since January 2023. I have come to a different decision following the submission of a response by the approved provider. I have decided that Requirement 6(3)(d) is Compliant. This was based on a lack of consumer feedback regarding complaints not being used to improve care and services and the response submission, which refuted the findings in the Site Audit report and provided clarifying information and evidence including:

* A copy of ‘Trending Analysis’ for date period January 2023 to August 2023, which evidences the service does trend consumer feedback.
* A copy of meeting minutes confirming consumer feedback and complaints are tabled at various service and organisational meetings.
* A copy of the service’s plan for continuous improvement dated 20 September 2023, which evidences the identification of feedback from consumers and actions taken in response to these. For example, actions in relation to the food focus group (dated October 2022, March 2023, April 2023, May 2023 and September 2023) and activities (with documented evidence this was reviewed each month including activities for each month).

# Standard 7

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

Findings

While overall feedback from consumers was positive about staff, some consumers advised there was insufficient staff, with some delays in response to requests for assistance, and one consumer spoke of lack of engagement with the workforce. Staff spoke of being very busy, and while agency staff replace some shifts this does not consistently occur, and service staff work extended shifts. Management confirmed there has been a high staff turnover, and currently a member of the management team is covering the roles of both clinical management and service management. The service does not currently have a registered nurse rostered on-site or on-duty 24 hours per day, across 7 days of the week and the service’s risk register identifies consumers with complex clinical care needs including (but not limited to) changed behaviours, falls management, schedule 8 medication and blood glucose monitoring. I have come to a different decision following the submission of a response by the approved provider. I have decided that Requirement 7(3)(a) is Compliant. This was based on a lack of consumer feedback regarding not receiving safe and effective care, and lack of evidence that insufficient numbers or mix of staff has impacted on consumers’ care. I acknowledge some consumer raised feedback about insufficient staff and timeliness of response to call bells, however, no specific evidence was included to corroborate interviewee’s statements. I have placed weight on consumer feedback and other evidence under Standard 3 where consumers and representatives spoke of individualised consumer care, with care documentation containing detailed information to guide staff in the delivery of care and services. I have considered this information alongside the Approved Provider's response, which provided information and evidence including:

* A copy of the service roster and the ‘on-call’ roster which evidenced during periods when the service does not have an RN rostered on site and on duty, an RN is rostered on-call. The RN on-call roster identified the RN on call and contact details, and evidence was provided of occasions when the RN has been ‘called in’ and attended site for consumer assessment and care.
* A copy of ‘Call Bell Response Analysis’ which identifies, the weekly review of call bell response times including service key performance criteria set at 12 minutes for call bells to be responded to. A review of the report identified on average 92% of call bells are responded to within the set criteria; the report includes information of an apology provided to consumers where response times are greater than the service benchmark.
* Information evidencing the recruitment of international RN and care staff, with a commencement date of October 2023.

Regarding requirement 7(3)(d), the Site Audit report contained reference to deficiencies in consumer assessment and care planning, and consumer care in Standard 2 and Standard 3 as evidence that staff training was not consistently effective. My decision is that Standard 2 and Standard 3 are Compliant, with information provided in the response submission to evidence effective consumer assessment and care planning, and delivery of care and services. The Site Audit report contained some conflicting information, in relation to staff’s training and understanding of anti-microbial stewardship and open disclosure. I have placed weight on evidence under other Requirements that identifies the worked are trained, equipped and supported to deliver the outcomes required by the Standards, such as staff receiving training in the open disclosure; staff education on privacy and dignity and evidence understanding in day to day care and service delivery by respecting consumers privacy and ensuring personal information is kept confidential; and the service orientation program including education on dignity of risk and staff demonstrating a shared understanding. Some examples brought forward in the Site Audit report were not relevant to the requirement, for example, several consumers and representatives commenting on insufficient staff and high workloads, I have considered this under Requirement 7(e)(a); and one staff member not recalling the name of a consumer, overall, I am not convinced this evidenced a lack of training to effectively perform their roles. I have considered the workforce training in the services RN on-call and escalation processes under Requirement 8(3)(e). In consideration of information provided as part of the service’s overall response, I am satisfied and consider staff are trained, equipped and supported to deliver the outcomes required by the Quality Standards. Therefore, I find requirement 7(3)(d) is compliant.

Regarding the remaining requirements, consumers and representatives spoke of staff being supportive and respectful, and observations showed that staff always interacted with consumers using a kind and respectful manner. The service demonstrated process to ensure the workforce is competent, and have the qualifications and skills to perform their roles including an onboarding program, supported ‘buddy’ shifts, and processes for monitoring national criminal history, qualification and reference checks.

# Standard 8

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| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant |

Findings

Consumers spoke of being supported to have input into their care and services, and the organisation demonstrated the engagement of consumers in the development, delivery, and evaluation of care and services through surveys, meetings and care consultations.

*In relation to Requirement 8(3)(b)*

The site audit report contained information that the organisation’s governing body was unable to demonstrate accountability for the delivery of safe and quality care and services due to ineffective reporting systems with clinical reports managed at a service level, and limited information being provided to the governing body.

I have considered this information alongside the Approved Provider's response, which provided clarifying information and evidence including various service reports which are provided to the governing body including detailed in management reports such as the Clinical Risk Meeting minutes, Quarterly Facility Manager, Quarterly National Quality Indicator Analysis and Feedback and Recommendations. The Board includes membership of a nurse consultant who provides guidance to the governing body. Therefore, it is my decision Requirement 8(3)(b) is Compliant.

*In relation to Requirement 8(3)(c)*

The Site Audit report contained information that the organisational governance systems regulating information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints were not embedded and operating effectively at the service level:

*Information management*

* Organisational policies and procedures to guide staff are general in nature and not readily accessible to staff. While the service had some policies and procedures to guide staff, the service did not evidence policies and procedures in relation to on-call arrangements including clear protocols for how staff are made aware of and initiate the on-call arrangements and escalation processes when there is not an RN rostered on site and on duty. I have considered under my decision for Requirement 8(3)(e).
* Deficiencies in consumer care documentation including assessments, charting and recording of incidents. I have considered this information under Requirement 2(3)(a), Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(e). My decision is that these requirements are compliant.
* Ineffective systems and processes for data retrieval for the reporting of clinical indicators and clinical incidents. For the named consumers where gaps in recording of clinical incidents were identified, I have considered this under Requirement 3(3)(b) and the response submission provided information which identified the recording of all incidents of falls.

*Continuous improvement*

The Site Audit report contained information that the organisation did not have effective continuous improvement systems in place, including the service’s plan for continuous improvement only documenting improvement actions identified in response to non-compliance issues identified in the previous Site Audit and not updated since January 2023. The response submission included a copy of the service’s plan for continuous improvement dated 20 September 2023, which evidences the identification of improvement opportunities date between the period of January 2023 to October 2023, and documented evidence this was reviewed each month. I am satisfied the organisation demonstrated continuous improvement systems and processes to assess, monitor and improve the quality and safety of the care and services provided by the organisation.

*Workforce governance*

The Site Audit report contained information that the organisation did not have effective workforce governance systems in place including a sufficient mix of staff and skills, and staff trained and equipped to deliver the outcomes of the Standards. The Approved Provider’s response acknowledges the challenges experienced in the recruitment of staff; however, I am persuaded by the response submission which evidenced a planned workforce, including when there is not an RN rostered on-site and on-duty at the service and demonstrated ongoing strategies the organisation is taking to attract and retain more staff.

*Regulatory compliance*

While the organisation had systems for receiving information about regulatory obligations, however, systems and processes to ensure the service is complying with all relevant legislation and regulatory requirements was not consistently evidenced. The Site Audit report identified:

* Ineffective incident management:
  + Including gaps in the reporting of clinical incidents. From the evidence before me, contained within the Site Audit report and further information provided in the response submission, clinical incidents are being reported, analysed and trended.
  + Staff have not received training in the incident management system. The response submission included evidence of numerous staff training sessions in the incident management system and evidence in the response submission identified clinical incidents are being reported.
* Policies and procedures for the service were general in nature, it was unclear when policies and procedures were last reviewed and if they had been updated in alignment with legislative changes. The response submission stated that the manual was updated in June 2022 and was currently under review. A review of the organisation’s procedure manual was considered as part of my decision, and identified policies and procedures did not included reference to relevant legislation or describe processes to guide staff including:
  + The Incident Management section of the manual included information on was an incident is and some general information on reporting and the Serious Incident Response Scheme. However, the procedure did not include the specifics of Incident Management Procedures in accordance with the Quality of Care Principles 2014, Division 3 – Incident management system requirements. Including, describing which incidents are reportable incidents under the SIRS, and identifying who is responsible for reporting incidents that are notifiable under the SIRS to the Commission.
  + The Restrictive Practices section of the manual provides general guidance for staff on management of changes behaviours and some elements of restrictive practice. The information does not include details of legislative amendments brought into force in 2022, clarifying the requirement that alternative behaviour support strategies must be used or applied before considering any form of restrictive practice. These interventions must be documented in a behaviour support plan in accordance with the Quality of Care principles 2014. I do acknowledge that the service does have assessments, consents and authorisations in place as evidenced under Requirement 3(3)(a).

Whilst the organisation’s policies and procedures are not contemporary to current legislation, there is insufficient evidence to show regulatory management governance systems are ineffective.

The service identified that they do not have an RN on-site and on duty 24 hours a day, 7 days a week. However, I am satisfied that the service demonstrated effective alternative clinical care arrangements when are RN is not rostered on-site or on duty at the service, with the implementation of an on-call RN. There was insufficient evidence to ascertain whether these arrangements are effect, however, I have considered policies and procedures relating to the RN on-call and escalation processes under Requirement 8(3)(e).

*Feedback and complaints*

I find the feedback and complaints system is effective, consumers are supported to provide feedback through various avenues, and feedback and complaints used to improve care and services for consumers.

*In relation to Requirement 8(3)(d)*

The Site Audit report contained information that the organisation’s risk management systems and processes are not effective resulting from deficiencies in the care documentation system and workforce impacts. Deficits included:

* In the management of consumers clinical care post falls, wound management, medication management and pain management for consumers. I have considered this information under my decision for Requirement 2(3)(a) and Requirement 3(3)(b), and I am satisfied the service ensures consumer assessment and care planning processes, including the identification of individual consumer risks and the implementation of strategies to monitor and mitigate these risks.
* The organisation is not using incident data and information to identify and analyse trends and common incidents, and that quality improvements are made as a result. However, I have come to a different view, and considered evidence contained in the Site Audit report under this and other Requirements. The service maintains a clinical risk register and undertakes weekly risk meetings to discuss consumers' clinical risks, a copy of the ‘Clinical Risk Register’ was provided as part of the response submission and reflects a detailed recording of clinical risks associated with consumers’ care. Care and clinical staff described individual consumers’ risk and strategies implemented to mitigate these and the service demonstrated the effective management of risks for consumers associated with nutrition and hydration, including the risk of choking and minimising restrictive practices.
* Observations and documentation showed adequate or appropriate clinical care is not being provided by the service. I have considered this information under Requirement 3(3)(a) and organisational processes of clinical governance under Requirement 8(3)(e).

From the evidence before me, I have decided that Requirement 8(3)(d) is compliant.

*In relation to Requirement 8(3)(e)*

The Site Audit report contained information that the organisation does not have a documented clinical governance framework and clinical oversight is not effective. Procedures for clinical governance, antimicrobial stewardship, the use of restraint and open disclosure are general in nature and do not provide sufficient information to guide staff in clinical care.

I have considered this information alongside the Approved Provider's response, which provided information and evidence including:

* A copy of the ‘Procedure Manual’ which includes the Clinical Governance Framework, including roles and responsibilities, reporting and reviewing processes to identify opportunities for improvement. The procedure also provides information to guide service processes and staff in antimicrobial stewardship, restrictive practices and the Serious Incident Response Scheme. I have placed weight on information under other requirements that evidenced implementation of these at service level, and demonstrated shared understanding by the workforce.
* However, in relation to alternative clinical care arrangements the clinical governance framework (or procedure manual) does not:
  + Evidence clear protocols for how staff are made aware of and initiate the on-call arrangements. I acknowledge the service has an on-call RN rostered to provide support, however, the clinical governance framework (procedure manual) does not include escalation protocols and associated guidance for staff when there is not an RN rostered on site and on duty.
  + A review of the services ‘clinical risk register’ identified consumers with complex clinical needs including consumers prescribed as required psychotropic medication, complex pain management, medication management, wound management, diabetes management and at risk for falls. While the procedure manual provides some information to guide staff in relation to these clinical risks, for example falls management and post falls processes. However, some information is general in nature and does not consistently identify specific roles and responsibilities of staff and actions to be taken by staff when there is not an RN rostered on site and on duty at the service.

I acknowledge the actions taken by the service since the last Site Audit, and the improvements made. However, this Requirement requires organisations to have effective clinical governance systems and processes in place that support the delivery of safe and quality clinical care. The service does not have an RN rostered on-site and on-duty 24/7, and while I acknowledge the service has implemented an on-call RN process, the organisation has not demonstrated the Clinical Governance Framework includes policies and procedures to support the alternative clinical care arrangements. Including giving all staff (including agency staff) clear directions about on-call arrangements, document clear escalation processes that have clear responsibilities for staff and protocols for when escalation is needed, guide onsite staff on how to communicate and record any advice asked for and given and clearly guide staff on what they need to do when a consumer’s condition deteriorates, or a clinical event occurs. It is my decision Requirement 8(3)(e) is Non-Compliant.

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