Performance

Report

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| Name of service: | Doutta Galla Footscray Aged Care Facility |
| Service address: | 48 Geelong Road FOOTSCRAY VIC 3011 |
| Commission ID: | 3830 |
| Approved provider: | Doutta Galla Aged Services Ltd |
| Activity type: | Site Audit |
| Activity date: | 24 October 2022 to 27 October 2022 |
| Performance report date: | 20 December 2022 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Doutta Galla Footscray Aged Care Facility (**the service**) has been prepared by C Spiller, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 25 November 2022

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 2(3)(a)- the approved provider ensures assessment and planning is consistent for each consumer and informs the delivery of safe and effective care and services.
* Requirement 2(3)(e)- the approved provider ensures incidents are accurately and consistently responded to appropriately or in accordance with the service’s policy.
* Requirement 3(3)(a)- the approved provider ensures all consumers consistently receive best practice care tailored to consumer needs to optimise consumers’ health and well-being.
* Requirement 3(3)(b)- the approved provider is consistently identifying and managing the risks related with restrictive practices, responsive behaviours, fluid restriction, specialised diets, falls, skin integrity, pain and behaviour management.
* Requirement 7(3)(c)- the approved provider ensures the workforce is able to translate their knowledge and skills into practice and consistently implement policy and procedure for each consumer
* Requirement 8(3)(d)- the approved provider ensures that high impact or high prevalence risks associated are managed consistently and effectively for consumers
* Requirement 8(3)(e)- the approved provider ensures processes and policies are embedded to ensure the use of restraint is minimised.

# 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

I have assessed this Quality Standard as compliant as six out of six requirements are compliant.

The Assessment Team found requirement 1(3)(d) not met. I have come to a different finding and found it compliant.

In regard to 1(3)(d), the Assessment Team found the service has consumers taking risks that they choose to. However, the service cannot demonstrate these consumers are supported to take risks safely and in accordance with the documented policy and procedures at the service. Risks had not been assessed and care plans not created for four consumers sampled. In addition, staff were not monitoring or managing these consumers in relation to bed sticks and smoking.

In their response, the approved provider acknowledged that application of their policy and procedures related to the sampled consumers was not always consistent. The service has implemented several continuous improvements initiatives during and since the audit. This has included conducting a full review of dignity of risk documentation and consent for the named consumers. In addition, the service has completed a full review of all residents’ risk of dignity status to ensure all are current, held staff education toolbox sessions, reviewed all residents who choose to smoke to ensure a current smoking assessment is in place and reviewed smoking and non-smoking courtyards and arranged for signage(refer to 5(3)(b) for further details).

In making this decision, I have taken into consideration the approved provider actions detailed in their response. Not only have they fully acknowledged the gaps identified and have reviewed the named consumers with updates to dignity of risk as necessary but they have reviewed all consumer’s dignity of risk assessment and provided updates to staff through education sessions. Therefore, I find the service compliant with this requirement.

I am satisfied the remaining five requirements of Standard 1 Consumer Dignity and Risk are compliant.

Overall, consumers stated they are treated with respect and dignity by staff, that staff are aware of their individual and cultural preferences, and that they observe consumers’ right to privacy. Staff were observed treating consumers with respect and demonstrated understanding of individual choices and preferences. Consumers’ care planning documentation included information about their individual preferences and details about people important to them. The service has policies and procedures as well as other documents such as newsletters and handbooks which include consumers’ rights

Consumers described how staff respect consumers’ culture, values and diversity and how this informs the daily provision of care and services. Staff demonstrated knowledge of consumers’ cultural needs and history. Care planning documentation reviewed, reflected consumers’ cultural needs, interests and preferences

Consumers and their representatives expressed satisfaction that consumers can exercise choice and make decisions about their care and services, while being supported to maintain relationships that are important to them. Staff described how they best support the decisions of consumers. Consumer care documentation details how consumers wish their care to be delivered and who will be involved with this. Social and emotional care plans include details on maintaining connections and relationships of choice.

Consumers and their representatives expressed satisfaction that the information they receive is current, accurate, timely, communicated clearly and is easy to understand. A range of notices are on display within the service including in multiple languages.

Consumers and their representatives said consumers’ privacy is respected by staff and that their information is kept confidential. Staff discussed and demonstrated how they maintain consumers’ privacy. The service has policies and procedures regarding confidentiality of personal information and disclosure of information. Observations of staff practice demonstrated staff generally respected consumers’ privacy.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the requirements 2(3)a and 2(3)(e) are non-compliant.

In regard to Requirement 2(3)(a), the Assessment team found assessments and validated risk assessment tools, had not been consistently applied to the sampled consumers. Assessments and care plans did not consistently provide adequate information to mitigate risk or to ensure the safe delivery of care in relation to a broad range of areas of care.

The Assessment Team noted consumers with care needs, including special diet requirements, fluid restriction, transmission-based precautions, pain, medication management, behaviour support, smoking and use of a bed stick, did not have appropriate assessments completed for information to guide staff. Where risks were identified, care planning documents lacked interventions to mitigate risks and did not reflect recommended strategies to reduce risks.

In regard to 2(3)(e), the Assessment found the service was not consistently reviewing care needs post incidents. Incidents occurring were noted in progress notes but not consistently documented in incident reports. As a result, incidents were not all responded to appropriately or in accordance with the service’s policy. The service did not consistently identify when strategies are ineffective, or when reassessment or new interventions are required. Consumer files reviewed demonstrated that information to guide staff was not always available, accurate and current.

In their response, the approved provider did not support the Assessment Teams findings of not met for requirements 2(3)(a) and 2(3)(e). For requirement 2(3)(a), they acknowledged the incidences of inconsistency with the named consumers found by the Assessment Team. The approved provider submitted an Assessment and Care Planning policy and a number of other documents to demonstrate the policy framework in place. Their response also provided details of remedial actions taken since the audit, including but not limited to; undertaking risk assessments, case conference and updated care plans for the named consumers, provided toolbox education sessions to staff, reviewed psychotropic consent forms. In regard to 2(3)(e), their response included the submission of a clinical care policy and details of an number of quality improvement actions to address the deficits found by the Assessment Team, such as; reintroduction of an audit program for incident reporting and staff toolbox education sessions.

In making this decision, I have considered the response from the approved provider and the Assessment Team report. The evidence complied during the site audit was acknowledged by the approved provider. The approved provider acknowledged application of policy and procedure, with respect to the named consumers was not consistently applied. While I note, the approved provider has taken prompt action in response to the issues raised in the Assessment Team report, there were a significant number of gaps and deficits identified for a number of consumers across a broad range of care areas, where consumer care was adversely impacted. This included; special diet requirements, fluid restriction, transmission-based precautions, pain, medication management, behaviour support, smoking and use of a bed stick. In addition, the Assessment team compiled evidence demonstrating inconsistencies in incident reporting and the associated review of care needs for a number of consumers. I note, the service has policies and procedures in place, however, the breadth and number of deficits demonstrates to me they are not always consistently applied or translated into practice for each consumer. The impact and outcomes of the continuous improvements actions taken, such as the extensive range of toolbox education for staff and results from the incident reporting audit are yet to be evaluated for effectiveness. Therefore, I find the service non-compliant with requirement 2(3)(a) and 2(3)(e)

I am satisfied the three remaining requirements 2(3)(b), 2(3)(c) and 2(3)(d) in Standard 2 Ongoing assessment and planning with consumers are compliant.

Consumers said their care and services are planned around what is important to them. Care planning documentation overall reflects consumers’ current goals, needs and preferences and includes documentation of advance care wishes. Staff understanding of consumers’ needs, goals and preferences is consistent with care planning documentation.

Consumers and their representatives confirmed their participation in assessment, planning and review of consumer care and services. Care planning documentation demonstrated consumers and/or representatives and other health professionals and organisations are involved in assessment and planning of consumers’ care and services. Others involved in consumer care include physiotherapists, medical officers, an osteopath, dietitian and podiatrist.

Consumers and or their representatives could describe how they are kept updated with changes to their care. Care planning documentation reflects the communication of relevant information with the consumer and/or representative. Staff described how they electronically access consumer care plans and demonstrated the use of handover sheets to deliver care.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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

This Quality Standard is assessed as non-compliant as I am satisfied requirements 3(3)(a) and 3(3)(b) are non-compliant.

In regard to 3(3)(a), the Assessment Team found not all consumers are consistently receiving appropriate and safe personal or clinical care, tailored to their needs and according to best practice. Staff could not describe best practice in relation wound and pain management and behaviour support. Skin integrity issues were not consistently prevented, and pressure injuries were not identified in a timely manner for some consumers. Pressure area care was not provided appropriately and not in accordance with assessed need. The service did not demonstrate restrictive practices in relation to chemical restraint are minimised. Psychotropic medication was not consistently administered as last resort, when non-pharmacological strategies have been exhausted. Psychotropics were not consistently reviewed when circumstances change, with the aim to minimise or cease. Factors contributing to consumer changed behaviours were not consistently identified and managed. Behaviour support strategies were not targeted on the possible triggers and not tailor based to consumer background. Staff were not identifying the impact the use of psychotropic medication is having on consumers. The service had not evidently obtained informed consent when there have been changes to medication in relation to chemical restraint. The Assessment Team observed consumers subject to chemical restraint asleep in communal areas for extensive periods on 4 of 4 days. They were observed to miss meals, prescribed medication times were not able to be adhered to and they were not engaged in meaningful activities. Consumers with pain were not identified and managed consistently. Pain monitoring charts and pain assessments did not consistently reflect current care needs. The service did not always identify, action, and review pain in a timely manner for some consumers.

In regard to 3(3)(b), the Assessment Team found the service did not always demonstrate that high impact or high prevalence risks related to responsive behaviours, psychotropic medication, falls, skin integrity, pain, specialised diet, fluid restriction, weight loss and medication management are consistently identified and mitigative actions are considered and consistently implemented.

The Assessment team found some consumers with changed behaviours, posing a risk to themselves or others, were managed primarily with psychotropic medication; evident risks of sedation, disengagement, dehydration, weight loss and falls most likely linked with the regular use of antipsychotics and benzodiazepines was not consistently identified and monitored.

Skin integrity and pressure area care was found to be problematic; pressure injuries were not always identified in early stages. Aids and equipment, such as air mattresses, tubigrips and specialised cushions were not always applied as prescribed to consumers with compromised skin integrity.

Falls and behaviour incidents were not routinely reported, and relevant risks were not identified and managed proactively to avoid re-occurrence. A falls risk assessment was not routinely performed after a fall, and the circumstances of the fall did not always direct the falls prevention strategies for one consumer. Neurological observations were not always completed in line with best practice and the service’s policy. High risk medication, such as a hepatitis C antiviral agent prescribed for hepatitis treatment, was not monitored consistently; staff were not aware if treatment was completed or the medication was out of stock. Specialised diet and fluid restriction for a consumer had not been implemented and staff were not aware of their specific requirements.

In their response, the approved provider did not support the Assessment Teams finding of not met for 3(3)(a) and 3(3)(b). The approved provider acknowledges that there are opportunities for continuous improvement. The response stated a review of each of the Standard area has been undertaken and provided details of the actions taken to address the findings of the report. In their response, the approved provider has implemented clinical portfolio areas of responsibility, overseen by the Clinical Care Coordinator. The approved provider, acknowledged the issues raised by the Assessment Team and has undertaken significant education and training as a continuous improvement action. In addition, they provided a detailed description of actions taken to address the gaps and deficits in care identified by the Assessment Team for the named consumers in the Assessment Team report.

In making this decision, I have assessed the information provided by the Assessment Team and the approved providers response. I note, that the Assessment Team Report overview of recommendations states ‘not met’, but the standard requirement states ‘met’ for Requirement 3(3)(a). The Assessment Team assessed this requirement as not met, this was a typographical error and will be amended in the report and reissued to the Approved provider. There were numerous adverse impacts on a number of consumers across an extensive range of areas of care described in the Assessment Team report. The gaps and deficits identified were not isolated to one aspect of care, indicating that policy and procedure is not being applied consistently at the service and optimally translated into practice for every consumer.

While I note the actions undertaken by the approved provider to address the issues identified, the evidence compiled by the Assessment Team is compelling. I commend the approved providers commitment to continuous quality improvements, however the outcomes of these actions are yet to be evaluated for impact and effectiveness. Therefore, I find the service non-compliant with requirement 3(3)(a)and 3(3)(b).

I am satisfied the remaining five requirements of Standard 3 Personal care and clinical care are compliant.

Staff could describe the palliative care pathway and the resources available to them to support consumers nearing the end of life. Care planning documentation shows how the service plans to meet the needs and preferences of consumers in palliative care to ensure comfort care with dignity.

Consumers expressed satisfaction in how the service has responded to a change or deterioration in their condition. Clinical staff described how deterioration or changes are identified, actioned, and communicated.

Overall, the service demonstrated information about consumers’ condition, needs and preferences is documented in the handover sheet and progress notes and is communicated within the service. Information is shared with external services involved in care as required. Staff confirmed they receive up to date information about consumers at handover.

Consumers and/or their representatives are satisfied with the access and referral to medical officers and allied health professionals, and other external specialist services. Care planning documents reflect timely and appropriate referrals to individual health professionals, other organisations and providers of other care and services. Management and staff described the service’s referral processes.

Consumers and/or their representatives said the service manages infections and outbreaks effectively and embraces optimal use of antimicrobials. Staff were confident they have the support and the skills to manage infectious diseases and outbreaks. The Assessment Team observed staff overall compliant with hand hygiene and personal protective equipment (PPE) donning and doffing practices.

# 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

I have assessed this Quality Standard as compliant, as I am satisfied all seven requirements in this Quality Standard are compliant.

Consumers and/or their representatives indicated that the consumer is provided with support to optimise their independence, health, well-being and quality of life. The service demonstrated that each consumer’s individual goals, needs and preferences in relation to their independence, health, well-being and quality of life are identified, documented and communicated to staff. Social and lifestyle care plans include individualised goals and preferences. Individual support is also provided for consumers who do not wish to participate in group activities. Staff provided examples of how consumers are supported to engage in activities, maintain their independence and how they are supported to have a good quality of life.

Consumers and/or their representatives said the service provides good supports for the emotional, spiritual, and psychological well-being of consumers. Staff demonstrated knowledge of consumers’ emotional and spiritual needs and could describe how they support individual consumers. Care planning documentation included information on emotional, spiritual, and psychological needs and preferences.

Consumers and/or their representatives said the services and supports enable them to participate in the community, have relationships and do things of interest to them. Staff described how they support consumers to do the things of interest to them, participate within and outside the service environment and have social relationships. Care planning documents contained information on individual consumers’ interests and identified the people important to them.

Consumers and/or their representatives expressed satisfaction with how information is shared. Staff said they are informed of changes to consumer needs and that this is communicated through care plans, handover sheets and hand over meetings.

The service demonstrated that timely and appropriate referrals to individuals, other organisations and providers occur. Consumers and/or representatives confirm that referrals occur promptly, document review demonstrates a range of services and organisations are available for staff to refer consumers to.

Consumers and/or their representatives expressed satisfaction with the quality and quantity of meals. Staff are knowledgeable about individual consumers' preferences and dietary requirements. Staff were observed to be assisting and encouraging consumers with nutrition and hydration during the site audit. Care planning documents note consumers' food needs, dislikes, allergies, and preferences, with any changes to the care plan being communicated and updated on dietary information sheets stored in the kitchen. The service has processes to gather consumer feedback on meals, which is incorporated into the menu.

Consumers and/or their representatives said that equipment is safe, suitable, clean and well maintained for staff and consumer use. Staff were observed cleaning equipment during the Site Audit. Cleaning documentation demonstrates regular cleaning of equipment occurs.

# 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

This Quality Standard has been assessed as compliant as three of the three requirements have been assessed as compliant.

The Assessment team found requirement 5(3)(b) as not met, however I have come to a different finding and find it compliant. The Assessment Team found the service is not ensuring smoking areas are safe and well maintained and that consumers who do not smoke have access to outdoor areas free of smoke. Management advised that the service has one designated smoking area, however the Assessment Team observed 5 of 6 external areas being used as smoking areas by consumers.

The approved provider submitted a response, acknowledging concerns raised in relation to smoking areas and have immediately taken remedial actions; including revised courtyard area allocations, providing access to smokers and non-smokers, reiterated ashtray cleaning requirements with cleaning company, initiated the purchase and installation of additional ashtrays, smoking signs, smoking aprons and other fire equipment, and consulted with consumers and staff about the changes. There are now two courtyard areas allocated for smoking and three non-smoking courtyards with signage to distinguish the different areas.

In making this decision, I have reviewed both the Assessment Team report and the approved provider’s response. The approved provider acknowledged concerns raised by the Assessment Team at the site audit and provided details of all the remedial actions. The Assessment team did not find any other issues with the service environment, therefore, with these concerns now addressed, I find the service compliant with this requirement.

I am satisfied the remaining two requirements in Standard 5 Organisation’s service environment are compliant.

Consumers and/or their representatives said they feel welcome and comfortable at the service and are encouraged to personalise their rooms. The service is welcoming and provides comfortably furnished communal areas that optimise consumer interaction.

Consumers are satisfied the furniture, fittings and equipment at the service are well maintained and cleaned regularly. Documentation including preventative and reactive maintenance systems demonstrated ongoing monitoring and timely response to breakdowns and repairs required.

# 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

I have assessed this Quality standard as compliant as I am satisfied that all four requirements in this Quality Standard are compliant.

Consumers and their representatives are comfortable providing feedback and making complaints. Management and staff described how they respond to a concern raised by a consumer. Information about how to make a complaint and mechanisms to do so are available at several locations around the service. Documentation including newsletters, meeting minutes and feedback systems demonstrated the service encourages and actions feedback.

Consumers and their representatives are aware of how to access an advocate and of other methods to raise and resolve a complaint. Information is prominently displayed in multiple locations regarding advocates and other methods of raising a complaint. Handbooks, meeting minutes and newsletters also provide information and contact details. Management described how they provide information on advocacy and complaints services to consumers.

Consumers and their representatives who had provided feedback or raised a complaint are satisfied with the process used to resolve issues. Documentation demonstrated how the service actions complaints in a timely manner, including the implementation of improvements. The Assessment Team sampled complaints and Serious Incident Response Scheme (SIRS) reports that demonstrated appropriate action was taken and an open disclosure process was applied when things went wrong. Management and staff described using open disclosure principles in the handling of complaints, including working collaboratively with consumers and representatives and apologising when necessary.

Consumers and their representatives who had raised concerns are satisfied their concerns had been addressed and resulted in change. Management discussed how feedback and complaints result in improvements and provided recent examples of this occurring. Documentation demonstrated how concerns raised result in a change, being captured on the plan for continuous improvement and include actions taken to review and improve services.

# 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. | Non-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

This Quality Standard is assessed as non-compliant as requirement 7(3)(c) is assessed as non-compliant.

In regard to 7(3)(a), the Assessment Team found that although roster schedules indicated that all designated shifts are covered, significant deficits in the provision of safe and quality care for consumers had occurred. I have come to a different finding and find that on balance requirement 7(3)(a) is compliant. The service indicated that there was a full complement of staff at the service for each shift in the last month to adequately meet the needs of consumers. Consumers and/or their representatives said that there is an adequate number of skilled staff available in all areas to meet their care and service needs. Two consumers and/or their representatives commented that staff always have time to interact with them and attend to their needs, and that call bell responses are usually dealt with in a timely manner.

In regard to 7(3)(c) the Assessment Team identified significant deficits in the planning and delivery of clinical care and services, although generally, consumers and/or their representatives expressed satisfaction that staff were suitably trained and experienced to deliver safe and effective care. The service’s training records indicated that staff are sufficiently trained for their respective roles, however, the Assessment Team observed deficits in clinical and care delivery relating to high impact or high prevalence risks, assessments and care planning. Pressure injuries were not promptly identified and treated until they were in the advanced stages for three consumers. Some consumers did not have smoking risks assessments completed indicating a lack of understanding by some staff regarding legislative requirements in relation to risk assessment and documentation. Deficits in medication management were identified for two consumers. Staff were unable to determine the safety concerns associated with a bed stick for one consumer. Pain was not being managed appropriately, no assessment, charting or care plan was completed for one consumer.

The Assessment Team found that the daily review of progress notes was not being completed. Staff failed to identify and report 2 SIRs incidents and numerous other incidents were found to not have been reported as per policy such as falls, and unsafe behaviours. Required processes for chemical restraint were not been consistently implemented by staff. Several consumers who were subject to chemical restrictive practice did not have the necessary consent of the consumer or their legal guardians. Clinical and care staff were not aware of a specific diagnosis for two consumers and their clinical records did not reflect this.

In their response, the approved provider did not agree with the not met Assessment Team finding for the two requirements 7(3)(a) and 7(3)(c). The approved provider, acknowledges there are significant opportunities to build further knowledge on clinical best practice and regularly evaluate effectiveness through internal audit and compliance programs. Furthermore, the approved provider acknowledged there is an opportunity to review staff practice to ensure consistent assessment and care planning policy compliance. Improvement actions include; implementing a renewed focus on role accountability, staff performance and clinical documentation expectations. In addition, they are developing a leadership program to ensure consistency in care and services, and a number of other continuous improvement initiatives, including numerous staff education sessions.

While I note the actions taken and planned to address the issues raises by the Assessment Team, some of these strategies have not yet been fully embedded or evaluated for effectiveness. In particular, the leadership program and role accountability will need to be evaluated for impact on consumer care. The service is not able to fully demonstrate that there is effective and consistent staff understanding and practices in place with respect to the management of high impact or high prevalence risks, care planning and clinical assessments. The weight of evidence collected by the Assessment Team persuasively demonstrates that although the workforce may have the required qualifications skills and knowledge, the translation of these skills and knowledge into practice is not optimally or consistently applied, given the breadth of issues found at the service and negative impact on consumers. The Assessment team found numerous examples where consumers’ personal and clinical care has been negatively impacted refer to Standard 2 and 3 for further details. Therefore, I find the service non-compliant with requirement 7(3)(c).

I am satisfied the remaining three requirements in Standard 7 Human Resources are compliant.

Consumers provided positive feedback about staff being kind and caring and having an awareness of what is important to each consumer. Staff were observed engaging with consumers and representatives in a kind and respectful manner.

Consumers and their representatives said they feel staff who are recruited by the organisation are provided with adequate training to ensure the safe provision of care and services. Training attendance records confirmed staff completion of training, including that which relates to legislative/regulatory changes such as SIRS, restrictive practices, infection control and specialised care topics.

The service demonstrated that performance monitoring and annual reviews are conducted for all clinical, care and service staff.

# 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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

This Quality Standard is assessed as non-compliant as requirement 8(3)(d) and 8(3)(e) is assessed as non-compliant.

In regard to 8(3)(d), the Assessment team found the service could not effectively demonstrate how high impact or high prevalence risks are consistently identified and actioned by staff, and accurately monitored via consumer care assessments such as smoking risk assessments, internal audit processes, and the ongoing review of the clinical care needs of consumers. Document reviews conducted by the Assessment Team identified that the service is not consistent in obtaining informed consent prior to changes being made to a consumer’s medication, and in relation to chemical restraint. For two consumers, staff were unaware of a specific diagnosis, that should have been documented as care precautions were necessary. Assessments for use of a bed stick was incomplete and staff were unable to explain the inherent risks or describe mitigation strategies for one consumer. During the site audit the service was unable to demonstrate an action plan to adequately manage the risks involved and ensure the ongoing safety and wellbeing of consumers and staff for a consumer who chose to smoke. Deficits were found in staff members’ understanding of SIRS reporting procedures with two SIRS reports not reported.

In regard to 8(3)(e) the Assessment Teams document review confirmed that the service does not consistently identify what constitutes a restrictive practice, and in some cases, informed consent is not obtained before commencing restrictive practices. Deficits were found in, Behavioural support plans, obtaining consent and review for a few consumers.

Several care staff interviewed were not familiar with the specific term ‘open disclosure’, although they successfully explained their work practice of acknowledging an incident and apologising to a consumer when something goes wrong.

In their response, the approved provider does not agree with the finding of not met for requirement 8(3)(d) and 8(3)(e), however they acknowledge there have been several opportunities for improvement identified to support best practice governance. They also acknowledged the work practice to minimise restraint/restrictive practices is not consistently followed and have addressed by arranged further staff training. A number of continuous improvement actions were detailed in the response, including but not limited to; a review of the Behavioural support plans for the names consumers, tool box talks for staff on open disclosure, high prevalence risks and restrictive practices. While I note the approved providers commitment to continuous improvement and the details provided to address the issues raised, on balance the evidence presented by the Assessment Team is compelling and the impact of the improvement actions is yet to be evaluated for effectiveness.

I am satisfied the remaining three requirements in Standard 8 Organisational Governance are compliant.

The service demonstrated that consumers are supported and encouraged to be engaged in the delivery and evaluation of care and services.

Management demonstrated that the organisation has overarching policies and procedures which promote a positive culture of safe, inclusive care and quality services, and explained how the service is accountable for their delivery.

The service generally demonstrated effective governance systems in relation to information management, continuous improvement, financial accountability, regulatory compliance and feedback and complaints. The organisation’s board has established processes in place to satisfy itself that systems for appropriate care and services operate in accordance with the Aged Care Quality Standards.

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)