Performance

Report

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| Name of service: | Edenfield Family Care - Ramsay |
| Service address: | 77 Seaview Road PORT AUGUSTA SA 5700 |
| Commission ID: | 6039 |
| Approved provider: | El-Jasbella Ramsay Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 26 September 2022 to 29 September 2022 |
| Performance report date: | 11 November 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 Edenfield Family Care - Ramsay (**the service**) has been prepared by M Glenn, 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 consumers, representatives, staff, management and others;
* the provider’s response to the Assessment Team’s report received 2 November 2022; and
* a Performance Report dated 24 January 2022 for a Review Audit conducted from the 17 November 2021 to 20 November 2021.

# 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 | **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 | **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.

**Standard 3 Requirements (3)(e) and (3)(g)**

* Ensure information relating to Medical officer reviews is documented and effectively communicated to others, including consumers and/or representatives.
* Ensure staff have the skills and knowledge to implement practices to promote appropriate antibiotic use; and liaise with Medical officers to ensure appropriate investigative measures are initiated prior to commencement of antimicrobials.
* Ensure policies, procedures and guidelines in relation to antimicrobial prescribing and usage are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to antimicrobial prescribing and usage.

**Standard 8 Requirement (3)(e)**

* Review processes relating to collection and analysis of infection data and antibiotic use to ensure deficits are identified and actioned.
* Ensure policies, procedures and guidelines in relation to antimicrobial stewardship are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to antimicrobial stewardship.

# 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

Requirement (3)(b) was found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service had not sufficiently recognised or supported one consumer’s cultural identity and staff demonstrated a limited understanding of what culturally safe care was. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing cultural awareness training to staff which will be an ongoing requirement; added Culture and diversity as an ongoing agenda item on Resident meeting minutes; and undertaking bi-monthly surveys to gauge consumer satisfaction and ensure inclusion is occurring.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 1 Consumer dignity and choice met. The Assessment Team found overall, consumers and representatives were satisfied consumers are treated with dignity and respect, and staff value who they are, with their identity, culture and diversity valued. Care plans sampled included details unique to each consumer, with information relating to their personality, goals, triggers, topics of conversation and how they can best be supported. Staff spoke of consumers with kindness and respect and displayed insight into preferences, care needs and backgrounds.

Care and services were demonstrated to be culturally safe, with attention and support for cultural needs through consultation with consumers and representatives. Consumers sampled confirmed staff are supportive of who they are and their individual backgrounds. Care files included consideration of consumer preferences and identified consumers’ cultural needs and preferences which was reflected in the delivery of care.

Consumers and representatives were satisfied consumers are supported to make choices about care and services, including who should be involved and consumers are encouraged to communicate their decisions and maintain relationships of choice. Care files sampled included individual choices relating to when care and services are delivered, such as daily routine, activities of choice, meals and areas for independence. Staff were knowledgeable of consumers and their preferences, and demonstrated an awareness of knowing who and what is important to them.

Consumers are supported to take risks which enable them to live the best life they can. Consumers confirmed how the service supports them to undertake risks via consultation. Care files sampled and consumers confirmed where a consumer chooses to engage in an activity with an element of risk, consultation with consumers and/or representatives occurs, risk assessments are completed and management strategies are developed. Staff described how they support consumers who choose to take risks and there are policies and forms in place to monitor, review and guide staff practice. Consumers confirmed the service supports them to undertake risks and they are consulted as part of the process.

Consumers and representatives confirmed they are satisfied with the communication and information provided. They indicated communication is adequate and they feel supported and are encouraged to provide feedback relating to consumers’ care and services. Consumers receive information through a number of avenues, including meeting forums, surveys, newsletters, information sessions and noticeboards. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

Based on the Assessment Team’s report, I find Standard 1 Consumer dignity and choice to be Compliant.

# 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

Requirements (3)(a) and (3)(e) were found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service did not demonstrate:

* effective implementation of assessment and planning processes to ensure assessment and planning was personalised and reflective of consumers’ current needs, specifically in relation to restrictive practices and behaviour management; and
* care and services were regularly reviewed for effectiveness in response to changes in consumers’ care and service needs.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed and updated all assessments and care plans, including in relation to restrictive practices, to ensure consumers’ current and personalised needs, risks and associated management strategies were identified and documented.
* Reviewed electronic assessment tools and provided staff training in their use.
* Purchased a Risk Identification Analysis Management (RIAM) system to enable more effective identification and monitoring of risk.
* Provided training to staff in relation to clinical documentation.
* Updated the Acute deterioration policy.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 2 Ongoing assessment and planning with consumers met. Care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are completed on entry and on an ongoing basis, including at scheduled care plan reviews. A range of validated risk assessment tools are also used to inform care planning and care plans sampled identified risks to consumers’ mental and physical health and well-being, including in relation to behaviours and restrictive practices, and included personalised strategies to minimise risk of harm. Monitoring processes, including daily progress note and care plan reviews, ensure risks are captured. Staff were familiar with assessment processes and confirmed care plans contained sufficient information to inform care. Consumers and representatives confirmed staff are knowledgeable of consumers’ individual risks and expressed satisfaction with care and services provided.

Consumers’ current needs, goals and preferences, including in relation to aspects of personal and clinical care were documented in care files and all consumers and representatives sampled confirmed these had been addressed. End-of-life needs, goals and plans were captured in a palliative care plan and the End-of-Life Care Pathway were generally included in care files for two consumers sampled. Monitoring processes, including clinical audits and 24-hour progress note reviews ensure assessment and planning is accurate and current. Staff described what was important to consumers and how care is tailored accordingly.

Care files demonstrated staff work with the consumer and/or representative to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Medical officers and Allied health professionals was also noted. All consumers and representatives sampled considered the assessment and planning processes to be based on partnership.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which is readily available to staff to guide provision of care and services. Care plans are accessible to all staff, including members of the Allied health team, and a printed summary care plan is kept in consumers’ rooms. Consumers and representatives confirmed they had sighted and been offered a copy of the care plan and they are always notified of the outcomes to assessments and planning with two representatives stating the ‘communication is fantastic’.

There are processes to ensure care plans are up-to-date and meet consumers’ current needs, including in response to incidents and changes in consumers’ health condition. All assessments and care plans had been completed and reviewed in line with the admission checklist and care plan review schedule. Where circumstances had changed or incidents occurred, sampled consumers had been assessed, management strategies reviewed and care plans updated. This was confirmed by consumers and representatives, and staff demonstrated knowledge of the service’s policies and procedures, including incident reporting.

Based on the Assessment Team’s report, I find Standard 2 Ongoing assessment and planning with consumers to be Compliant.

# 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. | Non-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. | Non-compliant |

Findings

Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) were found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service did not demonstrate:

* each consumer was provided safe and effective personal care and/or clinical care that was best practice, tailored to their needs and optimised their health and well-being;
* high impact or high prevalence risks, specifically in relation to skin integrity, wound management and changes to a consumer’s condition were effectively managed for each consumer;
* changes or deterioration in consumers’ condition were effectively recognised or responded to in a timely manner;
* information about consumers’ condition was effectively documented and communicated; and
* effective practices to minimise infection related risks or to promote appropriate antibiotic use to reduce the risk of antimicrobial resistance.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed all consumers to identify psychotropic medication prescribed and ensure informed consent, three-monthly medication reviews and use of non-pharmacological strategies as a first-line response.
* A clinical high-risk report is now formulated and reviewed in weekly meetings, which identifies consumers subject to restrictive practice, have experienced changed behaviours, unplanned weight loss and falls.
* Policies were reviewed and updated, including those relating to medications, restrictive practices and behaviour management, acute clinical deterioration, to ensure they reflect best practice.
* Provided training to staff in relation to wound management, skin integrity, medication, weight loss, dementia care, clinical deterioration, infection control, antimicrobial stewardship and behaviour management.
* Reviewed all wound care plans and initiated referrals to wound specialists, as required.
* Reviewed and updated all medication charts to ensure indication for use of medication was documented.

However, in relation to **Requirements (3)(e) and (3)(g)**, whilst some improvements had been implemented to address deficiencies identified at the Review Audit, the Assessment Team were not satisfied:

* clinical information about sampled consumers’ condition and needs was effectively documented following Medical officer reviews; and
* principles of antimicrobial stewardship in relation to antibiotic use was consistently or effectively demonstrated.

In relation to **Requirement (3)(e)**, the Assessment Team’s report provided the following evidence relevant to my finding:

* Progress notes and medical assessments for Consumers A and B contained minimal information from the Medical officer to inform care and services, specifically in relation to management of a medical and skin condition. This included findings and outcome of medical assessments, prescribed treatment plans and medical directives. While Consumer A and their representative were satisfied with care and services, neither could recall having a medical assessment or being informed of the treatment plan for the medical condition.
* Limited medical notes for of five other sampled consumer files was noted and with clinical staff documenting medical directives and information on behalf of visiting Medical officers.
* None of the 5 staff sampled said documentation from Medical officers had improved, with two confirming the Medical officer does not document in any of the service’s document management systems and said they rely on verbal instructions in person or over the phone or email responses and try to relay messages in progress notes and via staff handover. Management acknowledged the Medical officer still refuses to document in the electronic system or on paper.

The provider’s response indicates they accept and understand the deficits highlighted in the Assessment Team’s report. The response included further commentary in relation to actions taken in response to the Assessment Team’s report and a Plan for continuous improvement outlining actions and measures of improvement to address the deficits identified. The provider’s response included, but was not limited to:

* Formalising schedules for Medical officer visits so clinical staff can be rostered to support the visits.
* Additional staff training provided to discuss processes of supporting Medical officers during visits.
* Registered staff are being rostered to meet with Medical officers during visits and changes to treatments, medication charts and referrals are being recorded and communicated.
* Internal auditing processes monitor outcome of Medical officer visits.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not demonstrate information about consumers’ condition, needs and preferences, specifically Medical officer directives, was effectively communicated and documented. Care files for Consumers A and B, as well as five other consumers included minimal information from Medical officers following review and resulting recommendations for care. As such, I have considered that communication systems are not effective to ensure the workforce has access to information to effectively provide and coordinate care and services. I have also considered feedback from Consumer A and their representative indicating outcomes of Medical officer reviews and resulting recommendations for care have not been effectively communicated to them. I find this has not ensured consumers and/or representatives are fully informed of the care being provided or enabled them to have a say in the way care and services are delivered.

Based on the Assessment Team’s report and the provider’s response, I find **Requirement (3)(e)** in Standard 3 Personal care and clinical care Non-compliant

In relation to **Requirement (3)(g)**, the Assessment Team’s report provided the following evidence relevant to my finding:

* Pathology was not consistently used to determine the organism and appropriate antimicrobial treatment for three consumers.
* Consumer A received has received five courses of antibiotics since March 2022 (two courses in March 2022 and three courses between August and September 2022), however, pathology reports were not used to determine or review effectiveness of treatment. Antibiotics were prescribed in March 2022 based on photographs emailed to the Medical officer.
* Consumer B was commenced on antibiotics for a skin condition at the request of the representative without clinical indication of infection.
* Consumer C received antibiotic treatment without timely pathology and has endured prolonged antibiotic use. Three courses of antibiotics have been prescribed since August 2022.
* Management said staff routinely request Medical officers undertake pathology prior to prescribing antimicrobials, however, this is often declined, and staff should make note of the conversation in the clinical management system as well as completing the monitoring record. This was not demonstrated on all occasions.
* Three clinical staff were not aware of the latest best practice guidelines in relation to urine testing and two clinical staff said they rely on their judgement for knowing when to undertake pathology testing, rather than policies and procedures
* The infection log for a 42 day period between August to 20 September 2022, identified 16 consumers had experienced 21 infections, of which 15 infections were treated with antibiotics. Pathology was confirmed only three of the 21 infections where antibiotics were prescribed.

The provider’s response indicates they accept and understand the deficits highlighted in the Assessment Team’s report. The response included further commentary in relation to actions taken in response to the Assessment Team’s report and a Plan for continuous improvement outlining actions and measures of improvement to address the deficits identified. The provider’s response included, but was not limited to:

* Provided training to staff relating to updates and changes made to the Antimicrobial stewardship policy.
* Wound healing rates to be monitored monthly with data used to inform clinical review of wound care practices.
* Each consumer has been reassessed in relation to skin and wound care and use of antibiotic therapy as an ongoing intervention in infection control processes.
* Continuing to work with the Medical officer to improve outcomes with pathology requests and use of antimicrobial practices.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, staff and Medical officer practices did not effectively promote appropriate antibiotic use to reduce the risk of antimicrobial resistance.

For Consumers A and C, multiple courses of antibiotics were prescribed, including three courses each between August and September 2022. However, further investigative measures were not consistently initiated to determine the type and/or source of infection to support appropriate antibiotic use. In relation to Consumer B, antibiotics were prescribed for a skin condition with minimal clinical indication of infection. I have also considered staff were not aware of best practice guidelines relating to urine testing following completion of antibiotics or when pathology testing should be initiated. The organisation’s Antimicrobial stewardship policy, which guides staff practice, did not provide sufficient information relating to pathology testing prior to commencement of antimicrobials.

In relation to the infection log, I have considered this evidence in my finding for Requirement (3)(e) in Standard 8 Organisational governance.

Based on the Assessment Team’s report and the provider’s response, I find **Requirement** **(3)(g)** in Standard 3 Personal care and clinical care Non-compliant.

In relation to Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(f), validated risk assessment tools are undertaken on entry and an ongoing basis to identify consumers’ personal and/or clinical care needs and preferences with information gathered used to develop individualised care plans aimed at optimising health and well-being. Care files sampled demonstrated appropriate, individualised management and monitoring strategies had been implemented in relation to nutrition and hydration and personal care needs. Staff demonstrated familiarity with sampled consumers’ personal and clinical care needs and all consumers and representatives sampled expressed satisfaction with personal and clinical care provided, including in relation to management of wounds and continence.

High impact or high prevalence risks associated with the care of consumers are identified through assessment processes and management strategies are developed and documented in care plans to ensure care and services are delivered in line with consumers’ assessed needs and preferences. Care files demonstrated appropriate assessment and management of risks relating to skin integrity, wound management, falls and pain. Consumers identified with high impact or high prevalence risks are discussed at weekly high risk clinical meetings, with action tasks delegated to Registered nurses and outcomes communicated to staff through handover processes. All care and clinical staff described high impact or high prevalence risks and management strategies for sampled consumers. Consumers and representatives confirmed staff had identified risks, such as falls and impaired skin integrity and implemented strategies to minimise harm.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Two sampled consumer files demonstrated needs, goals and preferences during end of life had been recognised and, whilst not consistently documented, were addressed to the families’ satisfaction. Staff described how they maximise comfort and preserve dignity during end of life and progress notes sampled demonstrated staff work closely with consumers, their families, the Medical officer and local palliative care team to ensure high quality care is provided during this phase of a consumer’s life.

Where changes to consumers’ health are identified, care files demonstrated, assessments and monitoring processes are implemented and referrals to Medical officers and/or Allied health professionals initiated. All clinical staff were familiar with referrals processes and said the system works efficiently and effectively. Consumers and representatives confirmed consumers had been referred to members of Allied health, Medical officers and external organisations as appropriate and in a timely manner.

Based on the Assessment Team’s report, I find Requirements (3)(e) and (3)(g) Non-compliant and Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(f) Compliant in Standard 3 Personal care and clinical care.

# 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

Requirement (3)(c) was found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found consumers were not being assisted to participate in activities of interest to them. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, engaging Dementia Services Australia to assist consumers living with dementia and the Lifestyle coordinator facilitating the Resident meetings and undertaking frequent surveys to ensure consumer input and feedback.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 4 Services and supports for daily living met. The Assessment Team found care files included consumers’ goals and preferences, with information relevant to services and supports and how consumers choose to undertake them. The Lifestyle coordinator demonstrated an extensive knowledge of individual consumers’ goals and preferences and described tailored strategies to support and encourage their independence, health, well-being and quality of life. Consumers and representatives sampled said consumers feel supported to engage in activities of interest to them and their independence is optimised, where possible.

Consumers and representatives sampled indicated consumers’ emotional, spiritual and psychological needs are supported and they can speak with their families, staff, and friends both within and externally of the service. Consumers described staff as friendly and supportive of their well-being and indicated staff know them quite well. Staff provided examples of supporting consumers in relation to their well-being and care files included detailed information relating to consumer’s well-being needs, with clear strategies on how to support consumers when delivering care and services.

Consumers are provided with appropriate services and supports for daily living, including participating in their internal and external communities, doing things of interest them and maintaining social and personal relationships within the service and in the community. The service encourages engagement both within the service and externally via family and friends. Care files identified various activities, interests and people of importance to support the daily living of consumers. Staff described how they support consumers to undertake activities of choice or remain engaged via social activity, relationships and community. Consumers said they felt supported to participate in their community and to maintain relationships of choice.

Consumer files demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely are referrals are initiated. Consumers and representatives sampled said consumers’ needs and preferences were known by staff and generally communicated well across the service and they are supported by other individuals, organisations, support services and providers of other care and services.

Most consumers sampled expressed satisfaction with the quality, quantity and variety of the meals provided and indicated alternative choices are available each day. A few consumers indicated the food was at times inconsistent, specifically the quality and temperature but overall, it was generally satisfactory. There are processes to seek input and feedback from consumers regarding the menu and dining experience, including meeting forums and surveys.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Internal monitoring processes ensure equipment provided is maintained. Consumers sampled said staff keep the equipment clean.

Based on the Assessment Team’s report, I find Standard 4 Services and supports for daily living to be Compliant.

# 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

Requirement (3)(b) was found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service environment was not safe or well-maintained and did not enable all consumers to move freely within the service environment. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing staff training in relation to restrictive practices and conducting audits to ensure staff compliance.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 5 Organisation’s service environment met. The Assessment Team observed, and consumers sampled stated, the service environment to be welcoming, enabling each consumer to personalise their level of independence, interaction and function. The environment was easy to navigate, with both indoor and outdoor areas allowing consumers with varying degrees of mobility to optimise their independence. Corridors and communal areas provided appropriate seating and places to rest as well as covered courtyards and patio gardens and consumers rooms were personalised.

The service was observed to be safe, clean, reasonably well maintained and comfortable and the service environment supports free movement of consumers both indoors and outdoors. Consumers who are able to exit the building independently are encouraged and supported to do so. Cleaning and preventative and reactive maintenance processes are in place and contracted services are utilised to maintain and inspect aspects of the environment and equipment. Staff described how they report and manage maintenance issues, as well as hazards. Environmental audits of both the internal and external environment are regularly conducted to monitor any potential hazards and level of cleanliness. The majority of consumers and representatives were satisfied with the cleanliness of the service environment, however, some felt this could be improved highlighting surfaces in bedrooms to be either vacuumed more regularly or wiped down. Consumers said the equipment and furnishings were clean and safe to use.

There are processes to ensure furniture, fittings and equipment are safe, clean, well maintained, and suitable for the consumer. However, the Assessment Team identified some outdoor chairs which were not safe for consumer use. These issues were addressed during the site audit. Consumers were satisfied the equipment and furnishings were clean and safe to use.

Based on the Assessment Team’s report, I find Standard 5 Organisation’s service environment to be Compliant.

# 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

Requirements (3)(a), (3)(c) and (3)(d) were found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service did not demonstrate:

* consumers, representatives and others were encouraged and supported to provide feedback and make complaints;
* appropriate action was taken in response to complaints; and
* actions taken in response to feedback were monitored, reviewed, and evaluated for effectiveness.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Completed an audit of the complaints management system and policy and introduced a Feedback log for capturing and monitoring complaints through to finalisation.
* Consumers and representatives were informed of complaint management processes and methods available to voice their concerns and provide feedback through meeting forums.
* Updated complaints management policies and procedures to define complaint management process.
* Provided training to staff relating to open disclosure and complaint management.
* All feedback is being tabled at Resident meetings to discuss improvements and the Plan for continuous improvement is being updated to include feedback.
* Introduced a monthly Quality audit report to capture all feedback received for the month and identify any trends and areas for improvement.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 6 Feedback and complaints met. The Assessment Team found most consumers and representatives sampled were aware of mechanisms available to make a complaint, give feedback and suggestions and felt supported by management to give feedback without fear of retribution. Staff described how they support consumers who wish to make a suggestion, compliment or a complaint, including completing feedback forms on consumers’ behalf, and were aware of the organisation's complaints handling processes. The feedback log showed various feedback methods are utilised by consumers and representatives, including through surveys, meeting forums, email, phone, feedback forms and in person.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services, on entry and written materials relating to these avenues was also observed to be displayed within the service. Three consumers and representatives said they have access to interpreters, advocacy and external complaint handling services. Staff described how liaise with consumers’ family or friends when consumers have difficulty communicating and will assist consumers in raising concerns or complaints with the service.

Management and staff described processes for addressing feedback and complaints, including use of open disclosure principles. Feedback, complaints and open disclosure policies and procedures are available to guide management and staff practice. A feed back log is maintained and the Feedback log and resident meeting minutes sampled demonstrated action taken in response to consumer and staff complaints. Most consumers and representatives confirmed appropriate action is taken to address feedback and complaints and felt the service has a transparent approach when things go wrong. All consumers and representatives sampled confirmed management and staff inform them when incidents occur and apply an open and transparent approach.

The organisation has processes to ensure all feedback is captured, monitored, analysed, trended and reviewed for areas of continuous improvement. Management described how various sources of feedback are reviewed to improve care and services and how this is factored into the Plan for continuous improvement. The Plan for continuous improvement detailed how the improvement had been identified, which included consumer and representative feedback, incident data, internal audits and staff suggestions. The majority of consumers and representatives sampled were generally satisfied with the way in which management manage and respond to complaints and feedback to improve the quality of care and services.

Based on the Assessment Team’s report, I find Standard 6 Feedback and complaints Compliant.

# 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

Requirements (3)(a), (3)(c) and (3)(d) were found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service did not demonstrate adequate numbers and mix of staff to deliver safe and quality care and services; the workforce was sufficiently competent or had the qualifications and knowledge to effectively perform their roles; and processes to ensure the workforce was trained, equipped and supported to deliver the outcomes required by these Standards.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the roster with adjustments and provisions made to accommodate for short notice leave and reviewed the staff appraisal system.
* Purchased an electronic education and competency system for all mandatory training and additional training modules for targeted training when deficiencies are identified.
* Provided staff ongoing training relating to wound and pressure injury care, identifying clinical deterioration, restrictive practices, challenging behaviours and general care and clinical topics.

At the Site Audit, the Assessment Team recommended all Requirements in Standard 7 Human resources met. The Assessment Team found rosters are reviewed regularly in response to constant changes in consumer care needs and are altered when required. Data, such as feedback, clinical indicators and progress note reviews are also monitored to ensure sufficient staffing levels and appropriate skills mix. There are processes for planned and unplanned leave. Most staff reported sufficient staff are rostered and there are processes to cover vacancies. The majority of consumers and representatives sampled were satisfied with staffing levels and said the service provides quality care and services to meet consumers’ needs and they don’t have to wait long for assistance.

Observations confirmed staff are kind, caring and respectful with consumers. Most staff said they feel comfortable raising concerns with management if they believed staff were treating consumers poorly. All consumers and representatives were complimentary of staff.

The organisation has processes to monitor, assess and ensure the workforce have the appropriate registrations and qualifications specific to their individual roles. Audits, including daily progress note reviews, ensure staff are competently performing in their roles and actions are initiated where deficits are identified. Staff confirmed they are supported by management and have the tools and training to undertake their duties confidently. All consumers and representatives sampled said both care and clinical staff are competent in their roles and understand the care needs of consumers, ensuring their complex needs, preferences and goals are met.

Recruitment and onboarding process include induction and buddy shifts, with police clearance and visa checks undertaken. Policies and procedures are available to guide staff in their duties, with responsibilities clearly defined. Documentation sampled demonstrated face-to-face training includes competency-based assessments, where required, to test effectiveness of training, and additional targeted training has been provided where deficiencies in knowledge have been identified. Feedback and complaints, staff performance appraisals, clinical indicators, call bell responses, incident data and audits are monitored and used to identify additional training. Staff confirmed the service has mechanisms for them to provide feedback about training delivered and support needs, including through feedback forms, staff meetings and performance appraisals. All consumers and representatives sampled indicated they were confident in the abilities of the workforce to deliver care and services.

The service has a staff performance framework which ensures staff performance is regularly assessed, monitored and reviewed. Staff performance appraisals are conducted during the probationary period and then at regular intervals and staff performance is monitored on an ongoing basis through complaints data, surveys, auditing processes and regular observation of practices. There are processes to address poor performance, which are supported by a performance management framework. Staff stated they participate in performance reviews where they can discuss their performance and identify areas they would like further support or training in.

Based on the Assessment Team’s report, I find Standard 7 Human resources Compliant.

# 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. | Non-compliant |

Findings

Requirements (3)(b), (3)(c), (3)(d) and (3)(e) were found Non-compliant following Review Audit undertaken from 17 November 2021 to 20 November 2021 where it was found the service did not demonstrate:

* the governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery;
* effective organisational governance systems, specifically in relation to continuous improvement, workforce governance and feedback and complaints;
* effective risk management systems and practices, specifically the risk management framework was not effective in relation to managing high impact or high prevalence risks or managing and preventing incidents; and
* an effective clinical governance relating to minimisation of restraint and appropriate use of antimicrobials.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed reporting mechanisms to ensure the governing body are aware and accountable for the delivery of services and appointed an Operation manager to provide oversight and monitoring of service delivery.
* Introduced a feedback log and provided training to ensure the complaints management procedure is followed and all complaints are captured.
* Purchased an electronic education and competency system for all mandatory training and additional training modules for targeted training when deficiencies are identified.
* Reviewed the roster to ensure appropriate number and mix of staff with the addition of two staff rostered each day to cover short notice shifts.
* Ongoing training provided to staff relating to the Serious Incident Response Scheme and incident reporting requirements, antimicrobial stewardship and restrictive practice legislation and requirements.
* Implemented monitoring systems to identify, monitor and communicate consumer risks.
* Reviewed and updated the clinical governance framework and associated policies and procedures relating to antimicrobial stewardship and restrictive practices.

However, in relation to **Requirement (3)(e)**, while actions had been implemented by the service to address deficiencies identified at the Review Audit, the Assessment Team were not satisfied the service was identifying whether infections were new or ongoing, if the organism had been identified and whether antimicrobial treatment was effective. The Assessment Team’s report provided the following evidence relevant to my finding:

* The infection log dated for a 42 period in August to September 2022, identified pathology was confirmed in three of 21 infections where antibiotics had been prescribed and for two sampled consumers, repeat antibiotic use had not been identified.
* Infection trends are monitored via an infection log, audits a weekly high-risk report and monthly quality reports. Audits from June and September 2022 showed 100% compliance with infection control processes. The reports did not identify repeated antibiotic use for the same infection for two consumers which was not resolving.
* The Antimicrobial stewardship policy identifies staff and/or prescribers are encouraged to obtain appropriate pathology results prior to initiation of treatment. However, there is no further information to guide staff in practice in relation to antimicrobial stewardship, pathology testing and documenting or monitoring.

The provider’s response indicates they accept and understand the deficits highlighted in the Assessment Team’s report. The response included further commentary in relation to actions taken in response to the Assessment Team’s report and documentation to support actions some of the actions implemented. Additionally, the provider’s response included a Plan for continuous improvement outlining actions and measures of improvement to address the deficits identified. The provider’s response included, but was not limited to:

* Reviewed and updated the Antimicrobial stewardship policy and provided training to staff relating to policy changes.
* Internal clinical indicator data sets have been expanded to track multiple use of antibiotics and the rate of pathology testing that is used to inform correct antimicrobial treatment.
* Undertaken a detailed review of the past six months of antibiotic usage which will inform quality activities in managing the over-arching antimicrobial systems.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not demonstrate an effective clinical governance framework, specifically in relation to antimicrobial stewardship. I have considered the service’s and organisation’s infection and antibiotic use monitoring systems were not effective to sufficiently inform clinical performance indicators and lead improvements in clinical care. Monitoring systems had not identified consumers who had been prescribed multiple courses of antibiotics within a short period of time and while data indicated only three of 21 infections had pathology confirmed prior to use of antimicrobials, actions to address this were not evidenced. I have also considered antimicrobial stewardship policy documents did not provide sufficient guidance for staff in relation to pathology testing, documenting or monitoring or best practice care.

Based on the Assessment Team’s report and the provider’s response, I find **Requirement (3)(e)** in Standard 8 Organisational governance Non-compliant.

In relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(d), consumers sampled considered that the organisation is well run and they are actively involved in improving the delivery of care and services. Consumers are engaged in the development, delivery and evaluation of care and services through meeting forums, feedback processes, surveys and care and service review processes.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The governing body comprises of a Managing director who is supported by an Operations manager and Quality Manager. The organisation has policies, procedures and frameworks which generally describe responsibilities, accountabilities and service expectations, and a range of reporting mechanisms to ensure the Board and sub-committees are aware and accountable for the delivery of care and services. The Operations manager provides weekly reports to the Managing director, which include various governance and clinical information, such as quality indicators, mandatory reporting, accreditation information, critical incidents, consumer feedback, workforce and identified risks.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and the governing body is aware and accountable for the delivery of services.

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including use of an incident management system. Staff awareness of organisational

policies and procedures relating to risk management systems and practices was demonstrated through evidence presented in other Standards.

Based on the Assessment Team’s report, Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 8 Organisational Governance Compliant.

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