Performance

Report

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| Name of service: | Elizabeth Lodge Hostel |
| Service address: | 79 Mt Pleasant Avenue, Wahroonga NSW 2076 |
| Commission ID: | 0179 |
| Approved provider: | Seventh-day Adventist Aged Care (Greater Sydney) Ltd |
| Activity type: | Site audit |
| Activity date: | 10 August to 15 August 2022 |
| Performance report date: | 21 September 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 Elizabeth Lodge Hostel (**the service**) has been prepared by G Cherry, 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 8 September 2022
* the Notice of Requirement to agree dated 26 August 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 | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 2(3)(b) - ensure assessment and planning processes identify and address consumer needs, goals and preferences, including advance care and end of life planning
* Requirement 2(3)(c) - ensure assessment and planning is based on ongoing partnership with those consumers wish to be involved, including other organisations/providers of care
* Requirement 2(3)(d) - effectively communicate outcomes of assessment and planning with consumers/representatives, ensuring they have knowledge of a plan readily available to them
* Requirement 2(3)(e) - ensure regular review of care and services for effectiveness when circumstances change, including when incidents impact consumer’s needs
* Requirement 3(3)(a) - implement an effective process to ensure consumers receive safe, effective personal/clinical care guided by best practice and tailored to their needs/preferences
* Requirement 3(3)(b) - ensure effective management of high impact, high prevalence risks
* Requirement 3(3)(c) - ensure effective systems to recognise and address the needs, goals/preferences of consumers nearing end of life
* Requirement 3(3)(d) - implement an effective process to recognise and respond to deterioration in a consumer’s condition in a timely manner
* Requirement 3(3)(e) - ensure information about consumers’ condition, needs/preference is documented/communicated within the organisation and to those where care responsibility is shared
* Requirement 3(3)(f) - ensure consumers are referred to appropriate organisations/care providers in a timely manner
* Requirement 3(3)(g) - implement an effective system to ensure staff consistently adhere to appropriate practices/processes to minimise infection related risks
* Requirement 6(3)(d) - implement an effective system of capturing/recording, trending and utilising feedback/complaints data to inform and improve quality care. Ensure consumers/representatives and staff have an awareness of these processes and are informed of outcomes
* Requirement 7(3)(c) - implement an effective system to ensure a competent workforce with knowledge, skills, training and organisational support to effectively perform their roles
* Requirement 7(3)(d) - implement an effective system to ensure staff have the knowledge and skills to provide care relevant to the Quality Standards
* Requirement 7(3)(e) - implement an effective system to demonstrate regular assessment, monitoring and review of the staff’s performance to ensure they have the skills and competency required to meet consumers clinical needs on an ongoing basis
* Requirement 8(3)(b) - ensure effective systems to demonstrate accountability of the governing in promoting a culture of safe, inclusive and quality care and services
* Requirement 8(3)(c) – implement effective governance systems
* Requirement 8(3)(d) – implement effective systems to manage high-impact, high-prevalence risks to support consumers to live their best life

# 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 find the service compliant in all requirements of Standard 1 based on the summarised evidence below.

The site audit report includes information the service:

* provides culturally safe and inclusive care and services to consumers, ensuring their identity and diversity is valued
* supports consumers to make informed choices and decisions about how their care and services should be delivered by providing them with current, accurate and timely information they can understand
* supports consumers to take risks to enable them to live the best life they can; and
* supports consumers to make connections with others and maintain relationships of choice

Most consumers consider services and supports for daily living provide emotional, spiritual, and psychological well-being. Most consider they are treated with dignity and respect, privacy is maintained, and they receive information about care and services to live the life they choose. Consumers feel staff know what is important to them, they feel culturally safe, their values and diversity are supported, and they are supported to stay connected to those important to them; expressing satisfaction this occurred throughout Covid-19 pandemic restrictions.

Staff demonstrated knowledge of consumers individual preferences, life history, cultural backgrounds, values, and how these aspects are considered in care provision. They advised of discussions with consumers to enable informed decision making and gave examples of supporting consumers to make and maintain connections/relationships and safely take risks as per their choice.

An effective system to ensure consumers are provided with current, accurate and timely information was demonstrated. Staff described methods of communicating and providing information to consumers, including those experiencing communication and/or cognitive deficits. Documentation review detailed information provided to consumers/representatives, and expectations relating to confidentiality of personal information.

Documentation generally contained detail of consumers preferences, cultural and spiritual beliefs and methods to support consumers in risk taking activities, including strategies to minimise risks. Organisational policy and procedural documentation are available to guide staff in requirements relating to this Quality Standard.

While the service demonstrates consumer’s identity, culture and diversity are valued, the assessment team bought forward deficits relating to each consumer not consistently treated with dignity and respect in all aspects of care.  Review of documentation, and observation of care for some consumers deemed as requiring palliative care, did not have palliative care plans in place to guide staff in providing care, including effectively maintaining dignity and respecting consumers specific needs at end of life.

The assessment team observed most staff interacting with consumers in a respectful manner however this was not consistent. Staff were observed assisting consumers in meal service without acknowledging/interacting with them; review of documentation detailed wound photography not consistently conducted in a manner demonstrating respect for consumer’s dignity; and the assessment team received dissatisfaction regarding a consumer dressed in clothing not belonging to them.

In their response, the approved provider acknowledged wound photography for one consumer occurred in a less than respectful manner however maintain it transpired in the least invasive/disruptive circumstance and in a private environment to ascertain current wound status. Further, they acknowledged inconsistencies in documentation relating to palliative/end of life care needs however contend lack of documentation did not impede care provision relating to dignity and respect. I have considered the lack of documentation relating to palliative care and subsequent care related issues within Standards 2 and 3. I am persuaded by the volume of positive feedback received from most consumers and representatives in relation to consumers being treated with dignity and respect, and their identity, culture and diversity valued. I find requirement 1(3)(a) is 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. | Non-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. | Non-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. | Non-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 find the service non-compliant in Standard 2. The non-compliance is in relation to requirements 2(3),(b),(c),(d) and (e) based on the summarised evidence below.

The site audit report includes information the service is not:

* undertaking assessment and planning to ensure delivery of safe and effective care considering risks to consumer’s health and well-being
* identifying and addressing consumer needs, goals and preferences, including advance care planning and end of life planning
* undertaking assessment and planning based on ongoing partnership with those consumers wish to be involved, including other organisations/providers of care
* effectively communicating outcomes of assessment and planning with consumers and representatives and ensuring a plan is readily available to consumers/representatives
* regularly reviewing care and services for effectiveness when circumstances change or when incidents impact consumer’s needs

The assessment team bought forward evidence of a lack of comprehensive assessment and care planning in consideration to risk. Via review of documentation they noted organisation policies/procedures are accessible to staff however lack guidance in relation to care planning. Review of 4 consumer’s files did not detail evidence of comprehensive assessment/care planning processes and/or assessments were incomplete in guiding staff in appropriate care provision. A skin assessment was not completed for one consumer experiencing wound deterioration, falls assessments not completed following a fall and/or return from hospital after experiencing a fall, and palliative care plans not completed for two consumers deemed as requiring palliative care.

In their response the approved provider addressed issues relating to each consumer. While acknowledging discrepancies in skin assessment documentation, the approved provider evidenced regular review by a medical officer noting progression of wound healing and assert priority of care provision related to a confirmed diagnosis of Covid-19. In relation to falls they provided details of assessment/review being conducted for the same consumer on multiple occasions citing the delay on this one occasion was due to a confirmed diagnosis of Covid-19. While acknowledging care plans did not exist relating to palliative care for two consumers the approved provider evidenced guidance and directives were accessible to staff via other documents to direct medication/pain management and related care needs. They disagree policy documentation does not guide care planning however evidence was not provided. I note the approved provider’s plans to review all policy documentation.

Consideration is given to evidence from the approved provider and lack of staff feedback regarding lack of documentation to guide care provision. I am satisfied the service demonstrates consumer’s care needs are accessible to staff. I find requirement 3(2)(a) is compliant.

I find requirements 2(3),(b),(c),(d) and (e) are non-compliant.

Sampled consumers and representatives expressed positive feedback. However, the assessment team bought forward evidence via review of 5 consumer’s files, documentation did not adequately address individual preferences/current needs including advance care and end of life planning; plus, some documented needs/goals were of a generic nature. Management staff acknowledged the generic nature of some goals attributing this to the electronic documentation system.

The assessment team observed a consumer grimacing and displaying symptoms of pain; staff were alerted however did not respond by conducting a pain assessment and/or providing pain relief medication. For three consumers receiving palliative care, advanced care directives and/or details of consumer’s wishes were not documented to guide care. For one consumer receiving palliative care, neither pain management and/or psychotropic medication directives were documented on a care plan to guide staff. Care planning documentation, for a consumer requiring complex clinical care needs, did not detail care requirements in relation to their needs.

In their response, the approved provider evidenced some documented directives in alternate records, however acknowledged documentation inconsistencies required strengthening of assessment and care planning processes. Their action plan includes addressing these issues by reviewing current policy/procedure documentation and providing education/training to staff in relation to comprehensive assessment and care planning processes focused on consumers specific needs.

Consideration is given to evidence from the approved provider in relation to some consumers noted in the site audit report and their planned actions. However, I am satisfied it will take some time to fully implement the improvements outlined in the provider’s plan for continuous improvement and to evaluate the effectiveness and sustainability of those actions.

While the service’s processes require assessment/planning based on partnership with consumers, and those they wish to be involved, including other organisations/providers of care, through interview and document review the assessment team bought forward evidence this is not consistently occurring. Representative feedback included not being involved in discussions and/or informed of risks relating to prescribed medications.

Via documentation review the assessment team bought forward evidence consumers experiencing unplanned weight loss were not consistently referred to a dietitian, physiotherapy review did not occur when a consumer experienced a fall and specialist review did not consistently occur in relation to wound care.

In their response the approved provider detailed requirements and policy guidance in relation to referral processes, specialist review and involvement of others. They advised delay in specialist visitations occurred due to Covid-19 outbreak management processes however they did not evidence alternative methods of health professional/specialist involvement during these times to demonstrate meeting consumer’s needs. Their action plan includes reviewing current policy/procedure documentation, providing staff education/training and implementation of a specialist review process. I am satisfied it will take time to fully implement the improvements outlined and to evaluate the effectiveness and sustainability of these actions.

The service has processes for outcomes of assessment and planning to be documented on a care plan and communicated to consumers. However, the assessment team bought forward evidence of feedback received from some consumers/representatives they were not included in discussions of care planning, nor provided with a copy of care planning documentation. The assessment team noted documentation did not consistently demonstrate care plans were offered to consumers and/or their nominated representative. Management staff acknowledged care plans are not offered to consumers and representatives however assert they would be provided if requested.

The service demonstrated some care plans are reviewed on a regular basis and some case conferencing occurs, however this is not consistent. The assessment team bought forward evidence review of care is not consistently conducted when consumer’s circumstances change and/or incidents impact their needs. Via documentation review the assessment team bought forward evidence skin and pain assessments are not consistently completed when consumers experience pressure area/wound deterioration, nor when a consumer experienced a fall.

In their response the approved provider stated the process of providing care plans to consumers and representatives resulted in some confusion, and some directives were noted in alternate records other than care plans. They acknowledged documentation inconsistencies required strengthening of assessment and care planning processes and deficiencies in review when circumstances change. Their action plan details review of named consumers, review of current policy/procedure documentation and provision of staff education/training in comprehensive assessment/care planning processes focused on consumer’s specific needs.

While consideration is given to evidence from the approved provider in relation to some consumers noted in the site audit report, and subsequent planned actions, I am satisfied it will take time to fully implement improvements outlined and evaluate the effectiveness and sustainability of these actions. In addition, while they assert care plans will be provided upon request, they have failed to persuade me consumers and representatives have knowledge of this process.

I am satisfied the evidence bought forward by the assessment team demonstrates a lack of effective processes. I find requirements 2(3)(b),(c),(d) and (e) are non-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. | 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. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission-based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

I find the service non-compliant in Standard 3. The non-compliance is in relation to all requirements and is based on the summarised evidence below.

The site audit report includes information the service is not:

* demonstrating an effective process to ensure consumers receive safe, effective personal/clinical care guided by best practice and tailored to their needs/preferences
* demonstrating effective management of high impact, high prevalence risks
* recognising or addressing the needs, goals and preferences of consumers nearing end of life
* recognising and responding to deterioration in a consumer’s condition in a timely manner
* documenting and communicating information about the consumer’s condition, needs and preference within the organisation and where care responsibility is shared
* referring consumers to appropriate organisations/care providers in a timely manner
* ensuring an effective system to ensure consistent adherence to appropriate practices/processes relating to minimisation of infection related risks

Most sampled consumers and representatives expressed positive feedback relating to clinical care and access to health professionals; one representative expressed concern regarding regular administration of anxiety relieving medication. Interviewed staff generally demonstrated knowledge of consumers’ needs.

Via observation and review of 7 consumer files, the assessment team bought forward evidence appropriate care is not consistently provided in relation to wound care, pain management, unplanned weight loss, falls management, monitoring processes to ensure fluid restrictions are adhered to and documentation demonstrating informed consent for restrictive practices.

The assessment team bought forward evidence the service does not demonstrate effective management of high impact or high prevalence risks associated with each consumer’s care. Appropriate follow-up was not evident for some consumers after experiencing a fall, wound management processes are not consistently conducted as per directives and/or detail current wound status, and appropriate referral for unplanned weight loss was not evident.

The service demonstrated systems to identify end-of-life needs and preferences, including discussions around advanced care planning for some consumers. However, not all consumers/representatives said they had been consulted in relation to this. Interviewed staff noted they require palliative care training; management staff advised this would occur. Via documentation review the assessment team bought forward evidence consumers do not consistently have appropriate end of life directives, and not all consumers (deemed as requiring palliative care) have instructions to guide staff in providing care as per their needs and wishes.

Via review of 4 consumer files, the assessment team bought forward evidence the service did not consistently demonstrate changes/deterioration such as infection, wound deterioration, unplanned weight loss, is recognised or responded to in a timely manner.

The assessment team noted systems for communicating consumer information are effective for some consumers, this is not consistently the case. Via review of 4 consumer files they noted unplanned weight loss was not consistently referred to a dietitian, monitoring of blood glucose records not consistently communicated to medical officers as per directives, medication changes not advised to clinical staff, complex clinical care needs not consistently recorded to guide staff in care provision, and a representative not advised when a change to a consumer’s living environment occurred.

Sampled consumers and representatives expressed positive feedback regarding access to health professionals, and interviewed staff generally described referral processes. However, via review of 5 consumer files the assessment team bought forward evidence appropriate referrals to relevant health professionals did not consistently occur. Consumers experiencing wound deterioration were not referred to wound specialist/dietician in a timely manner; psychogeriatric review recommended by dementia specialist did not occur, physiotherapy review post fall did not occur in a timely manner for one consumer and unplanned weight loss not consistently referred for review.

In their response, the approved provider demonstrated some evidence to negate issues noted in the site audit report. They acknowledged discrepancies in assessment/care planning records, demonstrated medical officer review of wound healing and acknowledged some conflicting directives between medical officer and dietician. The provider asserts priority of care provision during a period of outbreak related to confirmed cases of Covid-19. In relation to falls management, they provided details of assessment/review conducted for the same consumer on multiple occasions citing delay on one occasion due to a confirmed diagnosis of Covid-19. While acknowledging care plans did not exist relating to palliative care for two consumers, they demonstrated guidance/directives were accessible via other means to direct medication/pain management and related care. They disagree policy documentation does not guide care planning however evidence was not provided.

In response to evidence within the site audit report the provider took immediate actions such as providing clinical staff with education/training, implementing new processes relating to recording of wound management, engaged an experienced clinician to review wound management policy/procedures, and consumer’s wounds. They evidenced appropriate consent in relation to restrictive practices although noted one consumer’s details had not been recorded on the service’s psychotropic register; noting increased monitoring/auditing processes will occur. They attribute recurring infections for one consumer related to respecting consumer choice. While acknowledging palliative care directives are not consistently available for all consumers they contend consumer needs are met. In addition, the provider acknowledged documentation inconsistencies required strengthening and some deficiencies in review when circumstances change. Their action plan notes reviewing care for named consumers, reviewing current policy/procedure documentation; providing staff education/training in comprehensive assessment and care planning processes focused on consumer’s specific needs.

The service demonstrated systems for outbreak management/minimisation of infection related risks, including antibiotic use; staff demonstrated knowledge of antimicrobial stewardship. However, the assessment team observed staff not adhering to appropriate infection control practices, such as inappropriate wearing of personal protective equipment (PPE); lack of individual equipment for use when assisting consumers to mobilise, and a lack of ensuring appropriate hydration as a method of infection prevention for one consumer.

While the approved provider contends adherence to consumer choice as a contributing factor in lack of infection prevention for one consumer, they did not offer evidence to negate/refute deficits relating to inappropriate PPE use by staff. In their response, they advised of review/completion of policy guidance, increase auditing processes to monitor staff practices/infection rates and ensure completion of staff training.

While consideration is given to evidence from the approved provider in relation to some consumers noted in the site audit report, and subsequent planned actions, I am satisfied it will take time to fully implement improvements outlined and evaluate the effectiveness and sustainability of these actions. The approved provider has failed to persuade me effective systems and processes are imbedded to ensure consumers personal and clinical care needs are consistently met. I am satisfied the service does not currently demonstrate safe, effective clinical and personal care systems.

I find all requirements in Standard 3 are non-compliant.

# 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 find the service compliant in all requirements of Standard 4 based on the summarised evidence below.

The site audit report includes information the service:

* provides services and support for daily living that are important for consumers’ health and well-being enabling them to do things they want
* provides a range of leisure and lifestyle activities planned with consumer/representative involvement to optimise consumer’s quality of life
* demonstrates supporting consumers to keep in touch with those who are important to them, maintaining connections to (and involvement from) local community groups, spiritual guidance, volunteers and the local school
* ensures information about consumer’s condition, needs/preferences is communicated within the organisation, and with others where responsibility for care is shared
* ensures referrals to external services, linking consumers with various community services
* provides consumers a suitable dining experience and environment with varied meals of suitable quality/quantity to meet dietary needs/preferences

Overall, sampled consumers expressed satisfaction services and supports for daily living meet their needs, goals and preferences and they receive safe and effective services to maintain/enhance independence, well-being and quality of life. Consumers gave examples of enjoyment/participation in organised outings, engaging with others in meaningful activities and expressed knowledge of the process to suggest inclusion of new activities to the program. They described support received relating to emotional and spiritual needs; examples included spiritual services, maintaining connection with community churches, support for consumers when new to the service and assistance received for those living with visual impairment.

Consumers consider their needs and preferences are communicated to staff and others involved in their care and expressed satisfaction meals are varied and of suitable quality/quantity. Consumers are included in menu development and a recent example of improving menu selection by including a description of the meal was noted for some consumers – however management staff acknowledged a pictorial version to assist consumers living with cognitive deficits had not yet progressed. Consumers said they felt safe when using the service’s equipment which is suitable for their needs and they expressed satisfaction regarding cleaning/repair/replacement of equipment when needed.

The service has processes and systems in place for identifying and recording each consumer’s condition, needs and preferences, including changes as they occur. Care planning documentation demonstrated collaboration with external providers to support consumer’s diverse needs. Staff gave examples of referrals to other care providers, processes to communicate consumer’s needs, use of electronic documentation system and demonstrated knowledge of consumers’ needs/preferred activities.

There are established processes to ensure meals and drinks are served according to consumers’ dietary needs/preferences, including texture modified meals and fluids. Staff described specific dietary needs/preferences and processes to accommodate these into the menu. Care planning documentation noted people important to individual consumers, activities of interest, emotional support strategies and methods of implementation. Care planning documentation demonstrated consumer’s choice and information relating to services/supports consumers need.

Equipment used for activities of daily living was observed to be safe, suitable, clean and well-maintained. Organisational policy and procedural documentation guide staff in requirements relating to this Quality Standard.

# 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

I find the service compliant in all requirements of Standard 5 based on the summarised evidence below.

The site audit report includes information the service:

* ensures consumers feel safe and comfortable and representatives/visitors are welcomed
* provides an inviting, comfortable environment with an easily navigable design
* provide a clean, well-maintained environment with quiet, private areas – both indoors and outside
* provide suitable quality/quantity of resources and equipment, plus safe recreational areas
* promotes consumer independence and ability to freely move in/out of the facility and/or with staff assistance
* demonstrates staff knowledge of processes to address equipment and environmental maintenance

Sampled consumers and representatives consider the environment to be safe, clean and well-maintained, with several indoor/outdoor private and communal areas to engage with others. Consumers consider resources and equipment are of suitable quality/quantity and expressed satisfaction of support received to maintain independence, participate in meaningful activities, and enjoy outside garden areas. Consumers were observed accessing all areas of the service. They expressed satisfaction furniture, fittings and equipment are safe, clean, well maintained, and meet their needs. Consumers gave examples of feeling they belong; the service has a home-like environment which aids in supporting independence/mobility and visual impairment.

The assessment team observed a safe living environment with well-appointed items of furnishings and art works, plus communal areas and individualised rooms. The assessment team observed the environment to be comfortable and easy to navigate, and consumers were independently mobilising throughout internal and external environments. Hallways, lifts and general communal areas were observed to be mostly free of obstacles, however when the assessment team observed a walkway obstructed by equipment, this was immediately rectified.

Management and staff explained the systems in place for cleaning and regular maintenance of furniture, fittings, and equipment. The assessment team observed furniture, fittings and equipment appeared safe, clean, well maintained and suitable for consumer use however noted consumers were not allocated individual equipment used to assist with mobilisation [considered in requirement 3(3)(g)].

Organisational policy and procedural documentation are available to guide staff in requirements relating to this Quality Standard.

# 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. | Non-compliant |

Findings

I find the service non-compliant in Standard 6. The non-compliance is in relation to requirement 6(3)(d).

The assessment team noted consumer feedback resulted in the inclusion of a meal description to improve menu selection for some consumers; however, management staff acknowledged a pictorial version to assist consumers living with cognitive deficits had not yet progressed. The assessment team bought forward evidence the service is not effectively capturing/recording, trending and/or utilising complaints data as a mechanism to inform and improve quality care and services. Sampled consumers and staff were unable to describe changes made as a result of feedback/complaints. Management staff said no trends in complaints data was identified; however, acknowledged effective documentation of complaints did not occur and demonstration of resolution was not evident.

The approved provider did not offer evidence to negate/refute deficits bought forward by the assessment team. In their response to the evidence in the site audit report, they acknowledged feedback and complaint management processes required strengthening, noting planned changes to include discussion of feedback/complaint management processes at future consumer/representative and staff meeting forums, and review of organisational policy and processes. I am satisfied it will take some time to fully implement the improvements outlined in the provider’s response and to evaluate the effectiveness of actions.

I am satisfied the evidence bought forward by the assessment team, including consumer/representative/management and staff feedback relating to a lack of processes supports a finding of ineffective systems to ensure feedback and complaints are reviewed and utilised by the service to improve quality of care and services.

I find requirement 6(3)(d) is non-complaint.

I find the service demonstrates compliance in requirements 6(3)(a),(b) and (c) based on the summarised evidence below.

The site audit report includes information the service:

* encourages and supports consumers and representatives to provide feedback/complaints through a variety of methods, including surveys, meetings and forms
* informs consumers/representatives of the processes available to them, including access to advocacy, language support services and other organisations for complaint referral and resolution
* ensures appropriate and timely action in response to most complaints utilising principles of open disclosure

The service demonstrates consumers and representatives are encouraged and supported to provide feedback and make complaints. Sampled consumers/representatives advised knowledge of meeting forums available and how they would raise issues of concern, expressing confidence action would be taken. Most consumers/representatives consider the service addresses concerns raised, including an apology if required, however one expressed dissatisfaction of not receiving an apology. Not all interviewed consumers expressed knowledge of external mechanisms and advocacy services available; most stating a preference to inform representatives if they were dissatisfied with responses received from the service.

Staff described how they respond to issues raised, including supporting consumers to access advocacy services. Documentation review and management staff described a recent improvement to menu selection as a result of consumer feedback. The assessment team observed information displayed throughout the environment relating to language services available if required to support consumers in communicating their concerns. Documentation provided to consumers details processes available. The organisational policy (albeit in draft format) outlines complaint processes including principles of open disclosure.

# 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I find the service is non-compliant in Standard 7. The non-compliance is in relation to requirements 7(3)(c),(d) and (e) and relates to the following.

Some aspects of these requirements were effectively demonstrated by the service. Documentation review detailed position descriptions outline responsibilities and scope of specific roles. A recruitment process includes value-based interview questions, reference and probity checks; an orientation process incorporating training and competency assessments. Management staff demonstrated monitoring processes to ensure currency of registrations/qualifications, completion of education and mandatory training requirements.

Interviewed staff advised of receiving training appropriate for their roles, advising requests for training would be considered by management. Management staff said consumer feedback, review of clinical indicators/incidents and staff reviews are methods utilised to identify training needs. Review of documentation detailed some topics relating to the Quality Standards, including Serious Incident Response Scheme and restrictive practices.

However, the assessment team bought forward evidence the services does not have effective systems to ensure a competent workforce with knowledge to effectively perform their roles, staff are trained, equipped and supported to deliver outcomes required by the Quality Standards. While monitoring and review of staff’s performance was demonstrated the assessment team bought forward evidence this process is not effective in identifying gaps in skills/knowledge and or additional training required.

Review of documentation, interview with members of management team and staff detailed the workforce does not demonstrate skills and knowledge to consistently meet consumers clinical care needs; which has resulted negatively for consumers and is considered in Standards 2 and 3. The assessment team bought forward evidence while the service’s policy is for an enrolled nurse to conduct wound care the service cannot demonstrate the method of determining and/or maintaining competency; pressure injury identification/classification is not being provided as per best practice; competency demonstrating recognition of deterioration of consumer’s health was not evident; staff do not consistently identify when consumers are experiencing pain; changes in consumers condition is not consistently recognised and responded to in a timely manner. Deficits in staff knowledge and practice were identified relating to complex clinical care, weight management, palliative and end of life care, incident reporting and restrictive practices

The approved provider did not offer evidence to negate/refute deficits bought forward by the assessment team. In their response, they acknowledged deficiencies in staff practice and consumer documentation resulting in lack of consumer care. They advised these deficits are to be addressed by the development of a comprehensive plan for continuous improvement (PCI) and implementation of staff training/competency assessments to commence early September 2022. I am satisfied it will take some time to fully implement the improvements outlined in the approved provider’s plan and to evaluate the effectiveness of those actions.

I am satisfied the evidence bought forward by the assessment team supports a finding the service does not have effective systems to demonstrate regular assessment, monitoring and review of the staff’s performance to ensure a competent workforce with knowledge, skills, training and organisational support to effectively perform their roles and provide care relevant to the Quality Standards and meet consumers clinical needs on an ongoing basis.

I find the service demonstrates compliance in requirements 7(3)(a) and (b) based on the summarised evidence below.

The site audit report includes information the service:

* demonstrated the workforce is planned and the number/mix of staff members enables the delivery and management of safe and quality care and services
* care and services are delivered by staff in a kind, caring respectful manner demonstrating awareness of consumer’s identity, culture and diversity

Most interviewed consumers/representatives were complimentary of staff; feedback included staff being available when needed; consistently checking on consumers’ needs, friendly, gently and respectful staff. Effective systems ensure replacement of staff when unplanned leave occurs; monitoring of staff numbers for continuity of care delivery and monitoring of staff responsiveness to consumers’ requests for assistance.

The assessment team observed mostly respectful, kind and caring interactions between staff and consumers, including demonstration of respecting consumer’s choice/wishes and consideration of identity, culture and diversity.

# 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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | 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. | Compliant |

Findings

I find the service is non-compliant in Standard 8. The non-compliance relates to requirements 8(3)(b),(c) and (d) and relates to the following.

The site audit report includes information the service does not demonstrate:

* effective systems to demonstrate the governing body promotes a culture of safe, inclusive and quality care and services. The service is non-compliant in 5 of the 8 Quality Standards
* an effective clinical governance framework ensuring consumers clinical care needs are met in line with best practice guidelines
* effective governance systems in key areas of information systems, all aspects of regulatory compliance, workforce governance and feedback and compliance
* effectively identifying and implementing minimisation processes relating to high-impact, high-prevalence risks, including incident management
* effective implementation of policies and procedures as a component of governance framework. Organisational policies and procedures are being updated – not all are completed, some are in draft form and not available for staff access.

The assessment team bought forward evidence relating to the role of the governing body, detailing an organisational body comprising of sub-committees reporting to the board, and board involvement was demonstrated. However, the service did not demonstrate effectiveness in relation to the governing body’s overarching monitoring processes to ensure a culture of safe, inclusive quality care. While a clinical governance framework is evident, it is not effective at a service level in ensuring consumers clinical needs are appropriately addressed. The service is in the process of implementing an electronic organisational governance system, not all policies/procedures to guide staff have been completed and staff have not been provided with training on changes. The self-monitoring systems lack effectiveness in ensuring compliance with all requirements and Standards of the Aged Care Quality Standards; the service is non-compliant in 5 of the 8 Quality Standards.

While the service demonstrates some aspects of governance systems relating to financial, information management, feedback and complaints and regulatory compliance, the service did not demonstrate an effective clinical governance framework, workforce accountability and some aspects of information management. The assessment team noted the service did not provide appropriate complex care provisions for one consumer. Management staff said they were unaware of this deficit and committed to ensure immediate reimbursement of costs and ongoing future supply.

Organisational systems relating to workforce governance, and effectively managing high impact/high prevalence risks is not effective at the service level to support consumers to live their best life. The service did not demonstrate staff sufficiency to meet consumers’ needs, nor an effective system to monitor staff competency/skills to undertake clinical care provision, and ensure staff are trained and supported to deliver outcomes required by the Quality Standards. While the approved provider has refuted some evidence within the site audit report it has failed to persuade me the organisation meets its responsibilities under all requirements within this Standard.

In their response, they advised the organisational goal to ensure effective governing systems are readily accessible and recognised recent implementation of some new systems remain incomplete and therefore not effective. They advised of intentions to review systems to ensure effectiveness in promoting a culture of safe, inclusive and quality care and ensure escalation/reporting to the board. I am satisfied it will take some time to fully implement the improvements outlined and to evaluate the effectiveness and sustainability of these actions. I am satisfied the evidence within the site audit report supports a finding the service does not have effective governance systems in all aspects of this Standard. I find requirements 8(3)(b),(c) and (d) are non-compliant.

I find the service does demonstrate compliance in requirements 8(3)(a) and (e) based on the summarised evidence below.

The site audit report includes information the service:

* engaging consumers in the development, delivery and evaluation of care and services including supporting consumer/representative forums
* effective organisation wide systems relating to financial governance
* effective frameworks relating to some aspects of antimicrobial stewardship and open disclosure practices

The service demonstrated how consumers and representatives are supported to provide feedback and engage in improvement processes. Sampled consumers and representatives consider the organisation is well run, they can partner in improving delivery of care and services through active participation of a variety of methods. A plan for continuous improvement (PCI) identifies improvement opportunities via consumer feedback and evidence of recent improvement examples. Staff demonstrate knowledge of the complaint/continuous improvement, information management, and some regulatory responsibilities. They demonstrated knowledge of open disclosure processes; minimising restraint use, reporting and management of most incidents.

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)