Performance

Report

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| Name of service: | Estia Health Camden |
| Service address: | 78-82 Old Hume Highway CAMDEN NSW 2570 |
| Commission ID: | 2079 |
| Approved provider: | Estia Investments Pty Ltd |
| Activity type: | Site Audit |
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| Performance report date: | 12 June 2023 |

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 Estia Health Camden has been prepared by J Howard, 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 conducted from 3 April 2023 to 6 April 2023. 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 Approved Provider’s response to the site audit report, received on 17 May 2023.
* Other information and intelligence held by the Commission in relation to this service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Non-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 1(3)(a)* –Ensure each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* *Requirement 4(3)(a)*– Ensure each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.
* *Requirement 4(3)(f)* – Ensure where meals are provided, they are varied and of suitable quality and quantity.
* *Requirement 6(3)(a)*– Ensure consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.
* *Requirement 6(3)(d) –*Ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* *Requirement 7(3)(a)* – Ensure 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.
* *Requirement 8(3)(d)*– Ensure effective risk management systems and practices are in place, particularly concerning the management of high impact or high prevalence risks associated with the care of consumers and the management and prevention of incidents.

# Standard 1

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

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 1(3)(a).

*Requirement 1(3)(a):*

The Assessment Team considered the service did not demonstrate consumers were treated with dignity and respect. According to consumers’ feedback, their wishes were disregarded when contacting their representatives and their mail opened without their consent.

Representatives said consumers were left unattended when requiring assistance with toileting and continence care. Additionally, care staff reported there were insufficient staff to provide timely and respectful care to consumers. The Assessment Team witnessed incidents where consumers were attended by care staff with their door left open, and one incident where a consumer's private area was left exposed while lying in bed.

The Assessment Team identified the following issues:

* A consumer representative reported witnessing staff shouting at a consumer living with dementia, who was very distressed during their visit. This was fed back to management who stated they were unaware of the incident and therefore unable to provide comment.
* Several consumers reported their mail was opened by staff without their consent.
* The Assessment Team observed care staff attending to consumers in their rooms with the door open, and privacy curtains not being used.
* The Assessment Team was conducting an interview with a consumer when a care
* worker interrupted the interview to respond to questions asked of the consumer.
* The Assessment Team observed consumers being assisted for meals by staff who were standing, and sometimes assisting multiple consumers at once. They were not observed to be engaging with consumers or making any interactions whilst assisting them with their meal.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken. These included:

* Since the Site Audit, privacy and dignity education has been repeated at stop and watch meetings at change of shift handover and management are conducting observational rounds.
* Management identified the Client Service Officer, who shared the same name as the consumer, mistakenly opened a parcel thinking it was hers.
* Management have since apologised to consumers and representatives involved, and are confident they are isolated incidents.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies, at the time of the Site Audit, management at the service was unaware of staff lapses in treating consumers with dignity and respect, with their identity, culture and diversity valued, until it was notified by the Assessment Team. Furthermore, it will take time to ensure the service’s measures have taken effect. Therefore, I find the service was non-compliant with Requirement 1(3)(a) at the time of the site audit.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in this Standard.

Consumers said staff respected their culture, values, and diversity and supported them in practicing their beliefs. Staff were aware of consumers’ preferences.

Consumers were supported to exercise choice and independence, make decisions and maintain personal relationships. Staff described ways in which consumers are supported to maintain relationships of choice.

The service supported consumers to take risks to enable them to live the best lives they can. The organisation had documented policies for staff on managing risk and supporting consumers to take risks. Care planning documents included risk assessments and consent forms, and evidence of consumer and representative involvement in the decision making process.

Consumers were provided with information to assist them to make choices about their care and lifestyle, which included meal selections and activities of daily living. Staff described the various ways they provided information tailored to each consumer, which included sign language, printed material and interpretation services, and enabled them to exercise choice.

Most consumers advised their privacy was respected, and personal information was kept confidential. The organisation has documented policies and procedures on the collection, disclosure, security, storage and protection of personal information of consumers.

# Standard 2

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| Ongoing assessment and planning with consumers | | Compliant |
| 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

This Quality Standard is assessed as Compliant, as five of the five specific requirements were assessed as compliant.

Management and clinical staff described the assessment and planning process with consumers. Care plans are individualised and contain relevant information and assessments for potential risks to consumers’ health and wellbeing. The service had relevant policies and procedures concerning risk.

Consumers discussed their care needs, goals and preferences, including advanced care planning and end-of-life care. Care plans identified consumers’ goals and preferences.

Clinical staff engaged consumers and their representatives in the assessment and planning process. Care plans demonstrated consumers were consulted throughout the assessment and care planning process, and whenever required. Staff sought input from health professionals and allied services as required.

Care planning documents were readily available for staff delivering care. Care plans were updated when consumers’ circumstances changed, and consumers were notified of all changes to their care. Consumers confirmed outcomes of assessments and planning were communicated to them and they could access their care plans upon request.

Care plans contained evidence of regular reviews. Management, clinical staff and the physiotherapist described how and when consumer care plans were reviewed. Consumers and representatives said staff regularly discussed their care needs with them, and all changes were addressed in a timely manner. However, care planning documentation for one consumer who had a fall was not updated following their most recent fall.

# Standard 3

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

Findings

This Quality Standard is assessed as Compliant, as seven of seven specific requirements were assessed as compliant.

*Requirement 3(3)(b):*

The Assessment Team assessed this Requirement as Not Met, as it considered the service did not demonstrate compliance with clinical monitoring of risks associated with consumers’ care, wounds, continence care, chemically restrictive practice and falls. However, this was not the case and the Approved Provider’s response contained evidence which refuted the Assessment Team’s finding.

Having considered the evidence in the Site Audit report and the Approved Provider’s response, I reached a different conclusion and decided the service was compliant with this Requirement.

This requirement was found non-compliant following an Assessment Contact visit conducted from 8 February 2023 to 9 February 2023. During that visit, the service could not demonstrate clinical monitoring of risks associated with consumers’ care, wounds, continence care, chemically restrictive practice and falls.

The organisation implemented several actions in response to the non-compliance identified regarding wound management, which have proven effective. For example:

* The organisation reviewed all active wound charts and wound worklogs to ensure they were consistent with the prescribed wound regimes, which were completed on 24 March 2023.
* Weekly wound reviews including photographs of wounds.
* Consumers with high impact and high prevalent risks are discussed in weekly person-centred care committee meetings to ensure care strategies were appropriate and reflective of their care planning documentation.
* Implemented a ‘Hartmann’s Simply Wound’ care program and wound staging reference material in March 2023.
* Wound training delivered to all clinical staff with a focus on wound classification on 29 March 2023. Staff confirmed receiving training when interviewed.

During the Site Audit on 3 April 2023, care planning documentation for 3 consumers with pressure injuries was reviewed which showed wound management in line with best practice requirements. However, the Assessment Team considered the improvement actions undertaken were not sufficient nor effective in ensuring effective management of high-impact or high-prevalence risks associated with the care of each consumer. For example:

* In relation to oxygen management, the Assessment Team identified one consumer who lives with chronic lower respiratory disease including emphysema and asthma, as requiring continuous oxygen delivery through an oxygen concentrator, and oxygen saturation monitoring three times a day at 8:00 am, 4:00 pm, and 11:00 pm. Staff are to report to his MO if his oxygen saturations are below 91%. His care planning documentation identified whilst his oxygen saturations levels were above 91%, there were gaps in consistent monitoring and documentation of his oxygen saturations that were not completed three times a day as per his oxygen management directive.
* In relation to incident management such as falls, the Assessment Team observed that a consumer experienced four recorded falls in January 2023. The Assessment Team identified incident reports lacked contributing factors and triggers, as most were ticked as ‘unknown cause’, and lacked investigations for root causes. Whilst this consumer’s Fall Risk Assessment Tool (FRAT) and mobility care plans were reviewed after each fall in January 2023, they were not completed and updated after the most recent fall on 1 April 2023.
* In relation to restrictive practices, the Assessment Team identified that whilst consent was obtained from consumers and representatives for the use of psychotropic medications, including chemically restrictive practices, one representative said no information of risks was provided by management or staff to consumers and representatives. One representative of a consumer who has since passed away said the service did not explain side effects or what the medication was used for, except that the consumer was being aggressive.
* In relation to continence management and catheter care, a representatives said consumer received the continence care he needed, but staff take too long to attend to him. One representative said that the consumer smells even though he is showered every day, and that his continence aids needs to be changed more often.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of explanations and remedial actions being taken in response to the non-compliance identified.

* The organisation advised the consumer does not have a medical directive for his oxygen saturations to be monitored three times a day. His medical directive is for oxygen saturations levels below 88-92% to be reported to his General Practitioner. The dates referred to are consistent with the consumer being clinically well. The care plan has since been updated to make this direction clearer.
* Management acknowledged though strategies recorded on one consumer’s care plan are common falls and injury prevention strategies, they are relevant and effective for this consumer. The care plan is reflective of the consumer’s current goals of care, which is to remain as independent as possible. The slips from a chair are caused by a myriad of factors such as functional decline, impaired judgment and safety awareness and the consumer’s desire for independence. Management noted the Assessment Team also confirmed in Requirement 2(3)(c) that care planning documentation for this consumer evidenced input from his representative, Medical Officer, physiotherapist, and the geriatrician in relation to his recurrent fall incidents and this is evidence of a multi-disciplinary approach to care and services. Management stated the incidents were investigated for possible causative factors, ensuring that appropriate clinical management had occurred, and it was not always possible to identify contributing factors for each incident. The consumer’s FRAT was updated on 2 April 2023 following the fall on 1 April 2023. A copy of the completed FRAT chart dated 2 April 2023 was provided in response to the site audit report.
* Management said representatives were provided with explanations of the risks involved, and they physically signed consents. The Assessment Team sighted evidence of informed consent in sampled consumer files. In response to the representative who claimed to have been uninformed about side effects, the service stated an informed consent discussion with them occurred on 12 September 2022.
* Management acknowledged the comments of the consumer’s representative but were confident they were meeting the consumer’s needs and preferences.

Having considered the material provided by the Approved Provider in its response, I am satisfied that its actions are acceptable, and at the time of the site audit, it was compliant with Requirement 3(3)(b).

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 3.

Overall consumers and other representatives interviewed expressed satisfaction consumers received safe and effective care that was best practice, tailored to their needs, and optimised their health and well-being. The service had policies and procedures in place which supported the delivery of care provided. Care requirements were communicated between stakeholders in line with best practice guidelines and the needs, goals and preferences of consumers.

Clinical staff explained the changes made when consumers transition into end-of-life care. Management and clinical staff explained how they adjusted their care to support the end-of-life process. The service had an end-of-life policy in place. Family members were involved in palliative care decisions. Consumer files indicated an advanced care directive was in place.

Consumers said staff picked up any change in their condition and responded with appropriate actions. The service had policies, procedures and clinical protocols to guide staff in the management of deterioration. Care plans, and observations demonstrated that deterioration is recognised and responded to quickly.

Consumers and representatives believed staff worked together to meet consumer care needs and preferences. Clinical and care staff are kept informed about changing needs and preferences of consumers. Information about conditions, needs and preferences were documented and communicated with those responsible for providing care.

Consumers had access to a doctor or specialist when they needed it. Care plans demonstrated timely referrals to medical officers, allied health services and other providers of care and services. Effective information exchange occurred between the care and clinical teams, and other services where care was shared.

Management, clinical and care staff applied infection control practices effectively through antimicrobial stewardship. They minimised the need for antibiotics and ensured it was used appropriately. The Assessment Team reviewed policy and procedure documentation which guided staff practice.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 4(3)(a) and 4(3)(f).

*Requirement 4(3)(a):*

The Assessment Team recommended this Requirement was Not Met, as it considered the service could not demonstrate each consumer received safe and effective services and supports for daily living that met the consumer’s needs, goals and preferences and optimised their independence, health, well-being and quality of life. For example:

* Seven sampled consumers and representatives said they were not satisfied with the daily living supports provided to consumers living with dementia at the service. They also advised staff did not understand their care needs or goals, and consumers were not enjoying the lifestyle program. While lifestyle staff stated they documented consumer preferences and needs in their care plans to inform the lifestyle program, consumers and representatives felt there was a lack of activities for people with dementia. The Assessment Team observed consumers sitting in the common area without any activity, while other consumers were wandering around due to the lack of an activity during the course of the site audit.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken.

* Management responded that this was not their recollection and did not agree with the statement that the current program did not cater for residents with dementia. They said all activities were inclusive and catered to residents with varying levels of cognition. In addition, various entertainment equipment had been upgraded and available, such as new magnetic communication boards and a range of sensory boxes and games.
* Management stated they continue to progress the quality activity program, and recent resident meetings indicated residents were satisfied with the program and were provided opportunity to offer suggestions and ideas. Management provided resident meeting minutes of March 2023, April 2023 and May 2023 in support of this. Further planned improvements include the implementation of a lifestyle shift in the afternoon.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies, at the time of the site audit, the Assessment Team’s observations were at odds with management’s explanations. Whilst inclusive activities that catered to residents with varying levels of cognition, and upgraded entertainment equipment were available, consumers were observed sitting in common rooms or wandering around uninvolved in any activity. Management at the service were unaware of staff lapses in management of safe and effective services and supports for daily living that met the consumer’s needs, goals and preferences, until it was notified of these issues by the Assessment Team.

While the service is now implementing remedial actions, it will take time for the remedial actions to be fully implemented and to be fully effective. Therefore, I find the service was non-compliant with Requirement 4(3)(a) at the time of the site audit.

*Requirement 4(3)(f):*

The Assessment Team recommended this Requirement as Not Met, as it considered the service could not demonstrate that, where meals were provided, they were varied and of suitable quality and quantity. For example:

* Twelve out of 15 sampled consumers and representatives did not provide positive feedback regarding the meals, citing concerns about the taste, portion size, and limited variety. They stated that the food was either overcooked or undercooked.
* The Assessment Team identified a recurring trend of complaints related to the meals, with no strategies for improvement noted.

In its response, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken.

* Management advised a quality initiative was commenced and involved the implementation of the organisation’s dining standards, which ensured residents had their meals in a relaxed, clean and inviting environment and were served by staff in a professional manner. They incorporate the dining environment (table placement, signage, décor, table settings, servery), comfort of the dining room (atmosphere, noise, movement), food delivery (temperature of the food, how food is served) and tray service. Menus offered both cold and hot options and residents could request other meals in accordance with their likes and dislikes. They identified through feedback in March 2023 that not all residents were aware of the menu choices and have since implemented a process whereby residents are provided a choice prior to the meals being cooked and served. Feedback about this initiative was positive. Management acknowledged the comments and will follow up.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies, the service is still implementing its remedial actions and it will take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 4(3)(f) at the time of the site audit.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 4.

Consumers said the service provided supports for daily living which promoted their emotional, spiritual and psychological well-being. Management and staff supported the religious, spiritual and psychological well-being of its consumers and demonstrated detailed knowledge of their preferences.

Consumers and representatives felt the service and staff assisted them to participate in their community, within and outside of the organisation's service environment, have social and personal relationships, and do things of interest to them. Care plans reflected the feedback provided by consumers and staff on this matter.

Consumers and representative indicated that consumer’s condition, needs and preferences were effectively communicated within the service and with others responsible for care. Care plans recorded information that supported effective and safe care for consumers.

Consumers and representatives were referred to individuals, other organisations and providers of other care and services satisfactorily. The Assessment Team sighted care plans which contained information on the process followed for these referrals to occur.

Staff had access to equipment that was safe, well maintained, and suitable for use. Consumers and representatives stated the equipment provided was safe, suitable for their needs, clean and well maintained.

# Standard 5

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

Findings

This Quality Standard is assessed as Compliant, as three of the three specific requirements were assessed as compliant.

Consumers felt at home at the service and the environment was easy to move around in. Representatives and other visitors felt welcomed. The Assessment Team observed adequate space for consumers, with clear signage to aid movement around the service.

Consumers and representatives stated the service was clean, well-maintained and comfortable. Clinical staff explained what they do when they identified a hazard or safety issue. The processes for cleaning, maintenance and laundry were explained by maintenance staff and management.

Clinical staff explained how shared equipment is cleaned and ensured equipment used for handling consumers was safe to use. The Assessment team reviewed maintenance registers, and confirmed consumer equipment were all cleaned regularly. Consumers indicated furniture and equipment were suitable, clean, well maintained and safe.

# Standard 6

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| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Non-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 have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirements 6(3)(a) and 6(3)(d).

*Requirement 6(3)(a):*

The Assessment Team recommended this Requirement was Not Met, as it considered the service could not demonstrate consumers and others were encouraged and supported to provide feedback and make complaints.

Consumers and representatives said their experience in providing feedback or complaints involved repeated unsuccessful attempts to engage with the service, related to internal communication issues, lengthy delays in service response times, non-availability of relevant personnel, and the manner in which they were treated. Consumers and representatives also expressed a reluctance to provide feedback or complain, due to fear of retribution. The service had a framework in place to enable the flow of feedback and complaints from consumers, their representatives, the workforce and others. Management and staff described the process and mechanisms for receiving feedback and complaints, including feedback forms, consultation directly with management, email, family conferencing, consumers, representatives and staff meetings. Staff interviews demonstrated a varying awareness of the process and mechanisms in place to provide feedback. For example:

* One representative was happy to provide feedback to the service. However, they were dissatisfied with the lack of response and difficulty in communicating with management. This representative advised they telephoned the service about 10 times with no response and said the best chance of being heard is to visit the service in person.
* One consumer provided information to the Assessment Team regarding a prior complaint; however, requested to remain anonymous for fear of retribution.
* Another consumer described an ongoing issue she had previously reported to management, that had not been addressed or rectified. Her shower recess floor was not draining effectively, and she had sustained a fall with significant bruising to her face, as a direct result of the slippery floor. She was concerned this issue presented an ongoing falls risk for her. She had been informed that management was intending to see her about this; however, she felt the response from management was dismissive.
* The Assessment Team observed approximately 60% of consumers completing the consumer feedback survey chose to remain anonymous.
* The Assessment Team provided information to management, regarding consumer reluctance to provide feedback out of an apparent fear of retribution.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken. These included:

* Management acknowledged the comments from representatives and advised it was working with them to resolve their concerns.
* The service reiterated the various ways to provide feedback, including providing the contact details of the Executive Director, and acknowledged people’s choice to remain anonymous.
* The service advised it promoted a safe environment that welcomed any form of feedback. Feedback was sought at meetings, case conferences, through feedback forms, and management traversed the home daily, conversing with residents. Avenues to raise feedback for those who preferred to be anonymous were also available, such as the organisation’s “See Something, Say Something” contact line, the service environment had information on display, which included the Charter of Rights, advocacy services, and details of the organisation’s national feedback process, as well as the commissions’ contact information. The service continued to promote awareness of these mechanisms.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies identified in the site audit report, the service is still implementing its remedial actions and it may take time for them to be fully effective, and to assess whether consumer’s feel happy with the service’s responsiveness to feedback and complaints.

Therefore, I find the service was non-compliant with Requirement 6(3)(a) at the time of the site audit.

*Requirement 6(3)(d):*

The Assessment Team recommended this Requirement was Not Met, as it considered the service could not demonstrate feedback and complaints were reviewed and used to improve the quality of care and services.

During the site audit, the Assessment Team identified that, overall, consumers and representatives did not feel responses to their feedback resulted in improvements to their care and services.

For example:

* One representative submitted a complaint relating to other consumers using their consumer’s bathroom as it was close to the dining room. This remains an ongoing concern.
* One representative requested for fresh fruit to be available. Consumers meeting minutes reflected consumer feedback to include fresh fruit and vegetables, endorsed by the service as an improvement. However, the consumer’s request for fresh fruit was denied.
* One consumer who requested anonymity said that any change in response to feedback is not sustained for long.
* One representative had complained about ongoing issues with missing clothing,
* Staff acknowledged missing clothing is an issue complained about by consumers frequently. Management responded to Assessment Team feedback by explaining it is considering an additional short shift for laundry staff that may help address the issue.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken.

* Management acknowledged the complaint relating to a particular consumer’s bathroom being used by others and were actively working with the consumer’s representatives to ensure their feedback is listened to and actioned. The feedback provided at the site audit had been worked through with the representatives previously; however, the service has re-engaged with them on 13 May 2023 about these issues to ensure they were resolved.
* Management referenced the provision of fresh fruit and vegetables being an example of how the service demonstrated the use of feedback leading to improvements. However, the response acknowledged feedback from the consumer’s representative, that a consumer was denied fresh fruit when requested.
* The service did not agree that missing clothing is a current issue. In 2022, there was a change in the laundry workflow which included the requirement for all consumers’ personal items to be laundered through the industrial washing machines situated in the nursing home, and while there was initial feedback regarding missing clothing, it is no longer a concern. Management will continue to seek feedback from residents and staff about these matters.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies identified in the site audit report, the response shows the service is still implementing its remedial actions and it may take time for them to be fully effective. Therefore, I find the service was non-compliant with Requirement 6(3)(d) at the time of the site audit.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 6.

Consumers were supported to provide feedback or make complaints through their communication preferences. Advocacy and language service details were included in staff training, and in staff and consumer handbooks.

The service demonstrated appropriate action was taken in response to feedback or complaints, and an open disclosure process was used. Management described the process used to respond to complaints, including speaking directly with the consumers and representatives, offering an apology upfront, and working together with them toward resolution. The service had feedback, complaints and open disclosure policies which provided guidance for staff.

# Standard 7

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| Human resources | | Non-compliant |
| 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. | Non-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

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 7(3)(a).

*Requirement 7(3)(a):*

The Assessment Team recommended this Requirement was Not Met, as it considered the service could not demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services.

Consumers and representatives reported inadequate staffing to provide the level of care they required to assist them to access the toilet and change continence aids when needed. Consumers provided feedback to management about their concerns. Staff reported shortages which impacted their ability to assist consumers. They reported this to management, but staff stated this did not result in any changes. Management said there have not been any reports of a shortage in staff, and they felt the service was sufficiently staffed to provide care. Consumers and representatives said staff often turned call bells off without assisting them. Staff reported turning call bells off as soon as possible, then prioritising their work. Management attributed the delay in call bell response to staff not turning them off, and faulty mat and bed sensors. However, there were no evidence of faulty sensors identified by the Assessment Team.

Examples included:

* The Assessment Team were provided call bell data for the previous few months, which identified at least one instance where a response took one hour and 14 minutes. Multiple instances of delayed call bell responses in excess of 10 minutes were observed. There was no documentation that identified causes or investigation of these long response times.
* One consumer has had a number of falls recently. Her file review showed that contributing factors included waiting for assistance to access the toilet. She reported waiting for more than an hour and a half for staff to respond to her call bell and take her to the toilet.
* Care workers said as a result of staff shortage, showers were often delayed by a day. Food was served late and served cold, and duties they were required to complete were often unfinished. They reported turning the call bells off as soon as possible and returning at a later time to assist the consumer.
* Cleaners said they had a duties list, which they were unable to complete, due to reduced number of cleaning staff. On completion of the shift, management were sent a report of what was not completed. They were unaware of what happened with the cleaning tasks they were unable to complete, but suspected they were not completed by anyone else, based on later observation of the areas they were unable to attend to.
* Management said shortages in staff have not been reported to them before. They said the service used a master roster which was staffed to provide care for full occupancy of 176 consumers, and at the time of the Site Audit, there were 152 occupied beds. In response to feedback from the Assessment Team regarding staff shortages, management said, ‘people have been used to higher levels of staffing’ and are ‘adjusting’.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken.

* The service acknowledged the feedback provided by consumers and their representatives, and the Assessment Team’s observations. Since the site audit, management have met with each consumer and representative to determine how staffing sufficiency is viewed.
* A new and improved call bell monitoring process is now in place to ensure ongoing compliance with the organisation’s call bell procedure. Additionally, the Regional Manager reviews the service’s call bell response to monitor staffing sufficiency at the service.

While I acknowledge the Approved Provided is now taking steps to remedy the deficiencies, the service is still implementing its remedial actions and it will take time for them to be fully implemented and to properly assess their effectiveness. Therefore, I find the service was non-compliant with Requirement 7(3)(a) at the time of the site audit.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 7.

Consumers and representatives felt staff were kind, caring, respectful and gentle when delivering care and services, and responsive to their needs. The organisation abided by their internal code of conduct which had been adapted to reflect recent changes in the National Disability Insurance Scheme (NDIS) and Code of Conduct for aged care.

Management ensured the workforce was competent and had the qualifications or knowledge to effectively perform their roles. Management described their process to ensure staff were sufficiently skilled to meet consumer care needs.

Management, staff and training records demonstrated staff were trained, equipped and supported to deliver care and services that met consumer’s needs and preferences. Records showed high levels of engagement from the workforce which management attributed to incentives they provided, and a fostering a culture of learning and development.

Management described the service’s performance assessment process. Staff records and documentation pertaining to staff performance further supported this process.

# Standard 8

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

Findings

I have assessed this Quality Standard as Non-compliant, as I am satisfied the service is non-compliant with Requirement 8(3)(d).

*Requirement 8(3)(d):*

The Assessment Team recommended this Requirement was Not Met, as it considered the service could not demonstrate it possessed effective risk management systems and practices.

The organisation has a Board Subcommittee dedicated to risk, a risk register for high prevalence and high impact risks, training for the identification and responding to abuse and neglect of consumers; however, the site audit report identified gaps in the way the service responded to and mitigated risks. The report noted the investigation of incidents was not always comprehensive in determining root causes and did not always include strategies to reduce further instances. Incidents reported to staff did not always follow the correct process for mandatory reporting requirements. Risks reported to staff were not always appropriately and promptly responded to.

For example:

* On 20 October 2022, medication for one consumer was incorrectly administered to another consumer. The error was recognised immediately by the registered nurse administering it, who begun taking observations, and upon hearing an irregular heartbeat, called an ambulance. This was reported as a priority one SIRS incident; however, it was not reported until 17 November 2022, 28 days later.
* On 27 February 2023, one consumer reported that another consumer had punched her in the face. This was reported as a priority one SIRS incident; however, it was not reported until 29 March 2023, 30 days later. Notes on the SIRS incident form indicate the nature of the injuries was made known to the service on the night the incident occurred.
* One consumer raised concerns regarding the drainage in her bathroom with management, feared slipping on the floor and reported a previous fall due to this. She was told the bathroom had undergone renovations and that there would be no immediate changes. The consumer reported she felt like the service treated her like a ‘2-year-old’ when she raised her concerns on this matter.

In its response of 17 May 2023, the Approved Provider acknowledged the Assessment Team’s observations, and submitted details of remedial actions being taken.

* In its response to the site audit report, the service acknowledged the SIRS incident dated 20 October 2022 was submitted 28 days after the event. This delay was caused by the sudden departure of the Executive Director responsible for submitting the report. This was an isolated incident rather than a failure of the system or lack of understanding of reporting responsibilities.
* Management responded that the incident on 27 February 2023 did not fit the reporting criteria of a Priority 1 SIRS. Management acknowledged that it was lodged late, but this was due to a technology failure and not a lack of understanding of the SIRS requirements.
* Management responded that this complaint regarding the consumer’s bathroom had been actioned, and the complainant was happy with the outcome. Management said they would revisit the issue.

While I acknowledge the Approved Provider has provided reasons for not always following mandatory reporting requirements, or satisfactory complaints resolution, it did not provide any solutions or improvements to its process, in taking steps to remedy the deficiencies. Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the site audit.

*The remaining Requirements:*

I am satisfied the service is compliant with the remaining Requirements in Standard 8.

Consumers said they assisted the organisation in the development, delivery and evaluation of care and services provided. Management and staff described the various ways the service involved consumers and their representatives in the development of service delivery.

Consumers felt safe and received the care they needed. Senior management were informed of all clinical and operational activity through systematic reporting processes, which enabled them to oversight performance and areas of concern, and provided the basis of developing strategies to address them.

The service had secure information management systems and guidance material for staff on accessing, storing, protecting and archiving information relating to consumers and operational resources. Continuous improvement register was populated with items following audit findings, feedback and legislative changes. Internal organisational specialists, including the chief financial officer, chief counsel, and the head of people and culture, provided support for financial, regulatory compliance and workforce governance. The service had effective workforce governance systems in place with responsibilities and accountabilities clearly outlined in position descriptions.

* The organisation’s clinical governance framework ensured the delivery of safe and effective clinical care across areas which included antimicrobial stewardship, minimising the use of restrictive practice, and the use of open disclosure. Staff demonstrated understanding and practical applications of these policies.

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)