Performance

Report

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| Name of service: | Estia Health Wodonga |
| Service address: | 240 Felltimber Creek Road WODONGA VIC 3690 |
| Commission ID: | 3721 |
| Approved provider: | Estia Investments Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 6 December 2022 to 8 December 2022 |
| Performance report date: | 30 March 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 Wodonga (**the service**) has been prepared by Grace Hope-Simpson, 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 10 February 2023

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **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 3 (3)(a): The Approved Provider ensures wound care and monitoring is effective, that care staff monitoring of all pressure areas is in line with best practice and service policy, that wound care is documented and falls risk management and safety strategies are in place.
* Requirement 6 (3)(a): The Approved Provider ensures consumers are supported and encouraged to make complaints and provide feedback. The service monitors the effectiveness of complaints handling drawing on consumer voice and experience to do so.
* Requirement 6(3)(c): The Approved Provider ensures action is consistently taken in response to complaints and open disclosure practiced when things go wrong. The service ensures an effective complaints and feedback system is implemented, which supports best practice complaints management. The service ensures complainants are informed of the actions taken to respond to complaints and are engaged in the evaluation of any response, in line with best practice. The service ensure staff feedback and complaints are effectively documented and responded to.
* Requirement 7(3)(a): The Approved Provider ensures the number and mix of staff deployed enables the delivery and management of safe and quality care and services.
* Requirement 8(3)(c): The Approved Provider ensures the oversight and effective governance of complaints and feedback handling at the service, and that effective policies and procedures, as well as documentation systems, are in place to support same.

# Standard 1

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

Findings

Consumers and representatives said they felt valued by the service. Staff described consumers’ needs and preferences and how they treated them with respect. Care plans reflected how staff respected consumer’s individual identity and background. Staff were observed to be respectful and friendly to consumers throughout the service.

Consumers and representatives said care received was consistent with their cultural traditions. Staff described how they delivered care to meet specific cultural needs and preferences. Care plans reflected how cultural and spiritual information was captured upon admission by the service. Activity calendars evidenced cultural group meetings taking place twice a month.

Consumers and representatives said staff respected their choices about when care was provided. Staff described how they supported consumers to maintain relationships important to them. Care plans reflected consumers’ choices about who was involved in their care and how it was delivered. A consumer was observed enjoying a glass of wine before dinner, a choice supported by staff.

Consumers said they were encouraged to take risks by doing things of interest to them. Staff said they were aware of consumers who take risks and supported their right to make choices. Care planning documentation for 2 out of 3 sampled consumers reflected when and how consumers took risks.

Representatives said they received timely information about COVID-19 outbreaks or when incidents occurred. Staff and management described how they communicated information to consumers and representatives. Menus were displayed in different formats throughout the service.

Consumers said their privacy was respected by staff. Staff confirmed consumers’ personal information was kept confidential and not discussed in front of others. Care planning documentation was stored in the service’s electronic care management system (ECMS) which had access controls. Staff were guided by a privacy policy and procedure.

# Standard 2

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

Findings

The Assessment Team recommended Requirements 2(3)(c), 2(3)(d) and 2(3)(e) in this Standard were not met.

**Requirement 2(3)(c)**

The Assessment Team recommended Requirement 2(3)(c) not met, on the basis of consumer and representative feedback they had limited to no involvement in care planning. Consumers and representatives also gave feedback the assessment and planning process was generic and did not reflect individual needs, with document review confirming this. However, the Site Audit Report did not provide detailed examples of specific feedback, to support their ‘not met’ recommendation. Other evidence brought forward to support their recommendation was more relevant to other Requirements and remaining staff interview evidence reflected that the service was compliant with Requirement 2(3)(c).

The Approved Provider responded to the Site Audit Report on 12 February 2023 and disagreed with the report findings and recommendations. The response contained evidence to demonstrate ongoing partnership with consumers and their representatives, including evidence of care plan reviews conducted in partnership with consumers and their nominated representatives. Other evidence provided with the response showed two consumers named in the site audit report had received required input from relevant allied health professionals and evidence of the involvement and input of other representatives, prior to site audit. The response also highlighted inaccuracies in the site audit report and noted some gaps in the application of site audit methodology, which they considered influenced the findings in the site audit report.

Having had regard to the evidence in the site audit report and the response, I am persuaded by the evidence and arguments brought forward by the approved provider. I find insufficient evidence was brought forward to support the assessment team’s recommendation and most particularised evidence as more relevant to Requirement 2(3)(e), where is has instead been considered. I have also had regard to the evidence provided which shows assessment and planning occurs, with input from consumers (with capacity) and authorised representatives, as well as with involvement of relevant allied health and medical professionals. On balance, I am satisfied the service demonstrated ongoing partnership with consumers and others who ought to have been involved in assessment and planning processes. Therefore, I find the service is compliant with Requirement 2(3)(c).

**Requirement 2(3)(d)**

The Assessment Team recommended Requirement 2(3)(d) not met, on the basis of feedback from three representatives who said they were rarely advised of assessments or outcomes. However, the site audit report did not include sufficiently detailed evidence for two of the three representatives, who wished to remain anonymous. One anonymous representative raised concerns about referral to a podiatrist that was not made, and another raised concerns that their feedback about feeding support for a third consumer was not actioned, adding they had not ‘felt heard’ as a result. One named consumer’s representative considered the service updated them only when there were incidents, with little follow-up afterwards. Other negative feedback attributed to the representative was refuted with evidence in the approved provider’s response, and as a result, I have not considered it in reaching my decision. Other evidence relied on by the Assessment Team was also refuted, and as a result, I have not taken that evidence into account in reaching my decision. The site audit report also noted that most consumers and representatives interviewed were aware of care planning documentation, some had copies of care plans or had sighted care plans and others said staff explain things to them clearly and clarify clinical concerns.

The Approved Provider responded to the site audit report on 10 February 2023 and disagreed with the report’s findings and recommendations. The response also highlighted inaccuracies in the report and noted some gaps in the application of site audit methodology, which they considered influenced the findings. In response to feedback from the two anonymous representatives, the approved provider included supporting documentation to show the service had initiated podiatrist referrals for several consumers prior to the site audit, and it noted the assessment team had found the service adequately supported consumers with feeding during mealtimes. The response also noted their inability to respond to anonymous feedback. Finally, regarding the named consumer whose representative was concerned at lack of regular updates, the response confirmed the service had not been made aware by the consumer of their concerns prior to site audit and since receiving the site audit report, had arranged a weekly phone call to keep the representative more informed.

I have also had regard to evidence presented in other Requirements, concerning a consumer living with diabetes whose care planning documentation was reported to have no mention of their diabetes management requirements in it. As this evidence was refuted by the approved provider’s response, I am satisfied it did not reflect non-compliance with the Requirement.

Having regard to the site audit report findings and the response, I am persuaded by the evidence and arguments brought forward by the approved provider. The evidence from the site audit did not demonstrate the service failed to communicate the outcomes of assessment and planning to consumers, or to include them in care plans made available to consumers. The response contained evidence of regular consultation with consumers, and it refuted evidence from one representative, that they were not offered or provided care plans. Since the site audit, the service took appropriate steps to implement a phone call schedule to ensure the representative could be more regularly updated on care and services provided to their family member. Finally, the response contained numerous care plan examples reflecting the input of allied health and medical professionals, demonstrating the outcomes of assessment and planning were available to staff at the point care and services were provided. On balance, the evidence demonstrates the service is compliant with Requirement 2 (3)(d).

**Requirement 2(3)(e)**

The Assessment Team recommended Requirement 2(3)(e) not met, on the basis of documentation review evidence, which indicated that care plans had been reviewed according to service policy but did not contain accurate information for sampled consumers. Relevant summarised evidence brought forward across the site audit report included: 2 named consumers whose care plans listed them as being able to mobilise, when they could not. One of the named consumers also had documented malnutrition which the Team found had not been reviewed since August 2021. Consumers and representatives were reportedly not satisfied the service made sufficient changes to consumer care following incidents, however evidence to support this was limited to an anonymous representative who considered staff were at times reluctant to contact a GP. Lastly, the assessment team found limited evidence that behaviour support plans had been reviewed every three months but included no detailed examples to support this finding. Other evidence outlined in the report has either been considered in relation to earlier requirements or demonstrated that the service had embedded routine and as needed clinical review processes.

The Approved Provider’s response disagreed with the site audit report findings and contained supporting documentation to refute most evidence outlined in the report. The response also clarified inaccuracies in the report and included numerous examples of care plans which had been reviewed and updated in response to circumstances including weight loss, swallowing difficulties, changes in skin integrity and following allied health review. The approved provider outlined a number of consumers whose care plans had been reviewed by relevant allied health professionals and updated following weight loss, identified swallowing difficulties and changes in skin condition. The response refuted evidence that staff may be ‘reluctant’ to refer to a medical doctor when needed, with extensive evidence of GP referrals made prior to the site audit. Concerning the finding that Behaviour Support Plans had not been reviewed, the response contained evidence that the service had reviewed plans in the previous year. Lastly, the approved provider accepted there had been a documentation gap in relation to one named consumer’s mobility status, however contended this was an isolated occurrence which had not presented any risk to the consumer. The response included evidence to show other areas of the consumer’s care plan were updated and effective.

I have carefully considered the evidence in the site audit report and the response and was persuaded by the evidence and arguments brought forward by the approved provider. The response contained convincing documentary evidence to overturn the assessment team’s recommendations, demonstrating that care plans were reviewed for effectiveness following incidents or changes in circumstances, and that appropriate allied health and medical professionals had input to those reviews, as documented in care plans. I find that there was limited evidence of outdated or inaccurate care plans provided in the site audit report, demonstrating only gaps in documentation rather systemic failure to review care and services regularly or as needed. I have also had regard to refuted evidence presented in other requirements, in reaching my determination. Lastly, there was insufficient evidence to demonstrate any failure to refer to medical officers for review when necessary. For the reasons outlined above, I have reached a different decision than the assessment team, and instead find the service is compliant with Requirement 2(3)(e).

I am satisfied the service is compliant with the remaining 2 Requirements in the Standard.

Concerning the remaining requirements, most consumers and representatives said care plans were inclusive of their care needs and preferences. Staff demonstrated an understanding of what was important to consumers in relation to personal and clinical care provided and could describe how the service assesses, identifies, reviews and assesses consumers to ascertain their care needs. Care plans generally reflected documented strategies to manage identified consumer risks.

Consumers and representatives said they have discussed their care needs with the service, including advance care or end of life planning. Staff described how they involved consumers and representatives in assessment and planning. Management said consumers were provided with copies of advance care directives and encouraged to discuss their end-of-life preferences upon admission. Care planning documentation included completed advance care directives.

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

Findings

The Assessment Team recommended Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e) and 3(3)(f) were no met.

**Requirement 3(3)(a)**

The Assessment Team recommended Requirement 3(3)(a) not met, on the basis of detailed evidence concerning deficits in clinical and personal care for 3 named consumers. Relevant summarised evidence relied on by the Assessment Team is outlined below.

One named consumer’s wound documentation for a slow healing wound showed the service had missed 3 required documentation photos in the 6-day period prior to the site audit. However, the consumer had been referred to a wound specialist and the wound had been swabbed, in line with MO recommendations.

A second named consumer’s care plan summary required care staff check the consumer’s feet daily and they were seen by a podiatrist monthly, as specified in their care plan. The consumer lived with diabetes and was insulin-dependent. On 1 November 2022, the consumer had been seen by an allied health professional (APH), who discovered a wound of unknown cause. They dressed the wound and noted in progress notes it required dressing every 3 days. This was not documented in the consumer’s care plan. An incident report was not raised at that point. An incident was raised almost 3 weeks later, when the wound was found with the APH’s dressing still intact, demonstrating the wound had not been reviewed or dressings changed in that time. No incident report was located for the initial wound discovery. The site audit report noted clinical staff were not aware of the wound, information had not been handed over and the wound had deteriorated since it was discovered. Other evidence concerning the consumer’s diabetes management was refuted by the Approved Provider’s response and has not been considered.

A third named consumer was observed with an undressed wound in the middle of their shin and on their right and left big toes which was red and inflamed, with a toenail lifting. The consumer confirmed the wounds were all painful. The consumer said they had recently fallen in their room and could not reach the call bell. Other evidence brought forward concerning the consumer was either not relevant or was refuted by the response and has not been outlined here. Evidence concerning a dental referral for the consumer was more relevant to Requirement 3(3)(f) and has been considered there.

Other evidence brought forward in the site audit report was not relevant or was more relevant to other requirements.

The Approved Provider responded to the site audit report on 10 February 2023 and disagreed with the site audit report’s findings and recommendations. The response also highlighted inaccuracies in the report, provided additional context for consumer examples and included supporting evidence, as outlined below.

Concerning the first named consumer, the response provided additional context about the consumer’s condition, which impacted on the progress of the wound in question. Supporting evidence showed that one of the three wound photos had not been missed, however did not provide evidence the remaining two wound photos had been taken. On balance, I am satisfied monitoring of the wound was not optimised and that this example reflects non-compliance with Requirement 3(3)(a).

Concerning the second named consumer, the response took issue with documentation review findings, and stated that the APH had not specified a 3 daily dressing change for the consumer’s recently discovered wound. However, the response did not contain evidence of this. The response did not contain evidence the consumer’s wound had any review or dressing change for 19 days. The response accepted the consumer’s feet were not checked daily by care staff in that time however considered it was an isolated oversight. The approved provider acknowledged an incident report and wound chart had not been generated at the time the wound was discovered, to document the monitoring and evaluation of the wound, but provided examples of when incident reports had been created as required. The response contended the wound had not deteriorated or become infected in the time it was not reviewed, however no relevant evidence was offered to support this, so I was not persuaded on this point.

On balance, although the response noted the second named consumer’s wound had been reviewed and charted since the site audit, and was healing, I find the 19-day gap in any wound review for the named consumer reflects a pattern care not in line with this Quality Standard. On balance, I am satisfied this consumer’s wound care was not optimised, safe or effective, and the example reflects non-compliance with Requirement 3(3)(a).

Concerning the third named consumer, the approved provider disagreed with the Assessment Team’s direct observations, reported the consumer had no active wounds at the time of the site audit, had no history of wounds to the left leg, and gave additional contextual information about the consumer’s medical conditions, relevant to the team’s observations. Supporting evidence was provided, however it did not clearly support the approved provider’s position, nor did it displace the Assessment Team’s direct observations during the site audit.

Concerning falls management for the third named consumer, the approved provider supplied contextual information concerning the consumer’s average call bell response time. The response outlined steps being taken to trial a call bell pendant with the consumer, however it was not clear from the response what steps the service took to explore the fall reported by the consumer to the Assessment Team, to determine when it had occurred and whether a reassessment of their falls risk and prevention strategies might be necessary. For the reasons outlined here, I am satisfied the evidence outlined concerning the third named consumer reflects that their clinical care was not optimised, resulting in their pain and discomfort. I am also satisfied their falls risk and prevention measures were not optimised. As a result, I find that this example reflects non-compliance with Requirement 3(3)(a).

Having had regard to the evidence in the site audit report and the approved provider’s response, I find the service is non-compliant with Requirement 3(3(a) and there were deficits in care over a 19 day period, that resulted in a deteriorating wound for one consumer. Other consumers’ wound monitoring and evaluation was also not optimised, and issues with management of falls risks for two named consumers, including a consumer discussed in Requirement 3(3)(b) below, were also relevant to my decision. For the reasons outlined, I find the service is non-compliant with Requirement 3(3)(a).

**Requirement 3(3)(b)**

The Assessment team recommended the service did not meet this Requirement, however relevant and specified evidence of non-compliance was minimal and related to a consumer whose recommended falls prevention strategies for crash mats and lowered bed were observed to not be in place at the time of site audit. Other findings brought forward was an increase in wounds, falls and falls with injury in the month prior to site audit, however this information was not explored or accompanied by specific examples of sub-standard risk management for multiple named consumers. The assessment team also considered that staff had insufficient insight into causal factors underpinning the increased fall rate and considered the service did not demonstrate how they were using risk trending and monitoring data to promote risk minimisation strategies. Other evidence was either not relevant to this Requirement or was uncorroborated and as a result, has not been considered in reaching my decision.

In their response, the approved provider disagreed with the assessment team’s recommendation and provided additional contextual information concerning the assessment team’s observations of the named consumer’s room without falls safety strategies in place. However, the response did not clearly displace the assessment team’s observations. Regarding increased falls and pressure injury rates, the response emphasised the individual factors, such as cognition and medical conditions that were contributing to consumers’ falls. The approved provider also noted that several consumers were newly admitted to the service in the months prior to the site audit, with existing pressure injuries which skewed the data. Evidence of actions taken to manage consumers with pressures injuries or at risk of developing them was included in the response. The response also supplied evidence of engagement with a medical officers, allied health professionals and external services used to respond to identified risks, resulting in safety strategies being implemented for a number of named consumers.

Having had regard to the information in the site audit report, and the response, I am persuaded by the approved provider’s reasoning and evidence. While I did accept the assessment team’s findings that one named consumer’s falls prevention and risk mitigation strategies were not in place at the time of site audit, the remaining evidence brought forward to support their not met recommendation was either irrelevant or was refuted by the response. As a result, evidence concerning the one named consumer has been considered in Requirement 3(3)(a). On balance, the remaining evidence was insufficient to show the service’s management of high impact or high prevalence risks was ineffective. Therefore, I find the service is compliant with Requirement 3(3)(b).

**Requirement 3(3)(d)**

The Assessment Team recommended Requirement 3 (3)(d) was not met on the basis of the following relevant evidence. For the consumers sampled, care planning documentation and progress note entries record the identification of, but not the response to, deterioration or changes in their condition. However, there were limited specific examples to demonstrate these findings in the report. The ‘not met’ recommendation relied on findings relating to one named consumer whose foot wound was identified by an AHP in early November, but was then not monitored, or dressings changed for 19 days afterwards. Refer to Requirement 3(3)(a) for further details. Other evidence outlined in the report was not relevant or was refuted by the response and has not been considered in reaching my decision.

The Approved Provider’s response received on 10 February 2023 disagreed with the site audit findings and provided additional information and context to clarify perceived inaccuracies in the report concerning the named consumer with a foot wound. Refer to Requirement 3(3)(a) for detailed information about that aspect of the response. The response also outlined, with supporting evidence, ways the service has identified and responded to deterioration in consumers, including through timely hospital transfers, timely reviews by medical officers, speech pathologists, physiotherapists, palliative care teams, wound consultants and geriatricians in response to consumers’ deterioration and changes in condition.

Having had regard to the information in the site audit report, and the response, I am persuaded by the approved provider’s reasoning and evidence. The majority of evidence brought forward to support the ‘not met’ recommendation lacked specific detail or was refuted. The remaining evidence concerning the named consumer with a foot wound did reflect sub-optimal care, however on balance, it is not enough to prove the service consistently fails to recognise and respond to change or deterioration in consumers. The evidence concerning that named consumer is relevant to and has already been considered in Requirement 3(3)(a) and underpinned a finding of non-compliance with that Requirement. For these reasons, I find the service is compliant with Requirement 3(3)(d).

**Requirement 3(3)(e)**

The Assessment Team recommended Requirement 3(3)(e) was not met on the basis that reviewed care planning documentation, including progress notes and care and service plans, did not provide adequate information for staff and others, to support effective and safe shared care. However, the report did not bring forward within the Requirement specific examples of care plans with inadequate information within. Relevant, summarised evidence brought forward in the Requirement included interview evidence from one clinical staff member who considered changes were not communicated to all staff, and that recent clinical meetings relevant to their practice were not communicated to them. The staff member’s other evidence relating to complaints handling is considered in Standard 6(3)(c). The assessment team’s recommendation also relied on interview evidence from 2 anonymous and one unnamed consumer representatives, who expressed concerns over communication with the service, however this information was not corroborated through documentation review. Lastly, a care staff member advised the Assessment Team they relied on a handover sheet to understand consumer needs and did not have access to consumer care plans.

The approved provider’s response disagreed with the site audit findings and the ‘not met’ recommendation. The response contained evidence and examples of effective information sharing with visiting allied health professionals, hospital staff and medical officers and outlined the use of alerts and profile pages in the service’s electronic care managements system (ECMS) which supports effective sharing of information. The approved provider referred to the assessment team’s own observations of handover, which was described as effective and highlighted information in the report that found communication and information sharing with staff was effective. The approved provider responded to anonymous and unattributed representative evidence in general terms, as well as noting it was uncorroborated by the assessment team. I was persuaded by these aspects of the response. Concerning staff feedback, the response did not refute the clinical staff members’ concerns that they were not notified of relevant meetings. The response affirmed staff are provided a handover sheet at shift commencement, and were encouraged to seek clarification from a buddy, team leader or RN, however did not directly acknowledge or address the feedback that there was a lack of access to information and care plans for care staff. On balance, as concerns were raised by only two staff members, I find there is not sufficient in and of itself, to support the not met recommendation.

Having had regard to the evidence presented across the site audit report and the approved provider’s response to it, I find on balance, there is insufficient detailed evidence and examples to support the ‘not met’ recommendation. For this reason, I find the service is compliant with Requirement 3(3)(e).

**Requirement 3(3)(f)**

The Assessment Team recommended Requirement 3(3)(f) was not met on the basis of some anonymous representative feedback which has been previously outlined and assessed in Requirement 2(3)(d). The evidence was refuted and as such is not considered here. The not met recommendation was also based on information concerning a named consumer with an acute dental concern, which the assessment team found had not been attended to by the time of site audit.

The approved provider’s response disagreed with the Assessment Team’s recommendations and contained contextual information, examples and supporting evidence demonstrating the service recognises the need for referrals to other individuals and services, and initiates referrals accordingly. The response also clarified inaccuracies and provided additional context concerning the named consumer’s dental history and demonstrated that steps had been taken to address the named consumer’s dental concerns, before the site audit. Therefore, I am satisfied this evidence does not reflect non-compliance with Requirement 3(3)(f). As all evidence brought forward to support this not met recommendation was refuted, I find the service is compliant with Requirement 3(3)(f).

I am satisfied the service is compliant with the remaining 2 Requirements in the Standard.

Staff described how they changed care delivery for consumers nearing end of life and practical ways in which consumers’ comfort was maximised. Care planning documentation reflected advance care directives. However, some representatives said they have not seen any care plans or discussed advance care directives with the service.

Consumers and representatives said they were satisfied with the service’s infection control and COVID-19 outbreak practices. Staff were guided by infection control policies and an outbreak management plan. Staff demonstrated an understanding of hand hygiene and donning and doffing of personal protective equipment (PPE). Staff, visitors and contractors were observed following the service’s COVID-19 screening process.

However, observations showed some inconsistencies with PPE stations and only one type of N95 mask available for staff which was immediately rectified by management. Fit testing was not conducted at the service, however management advised staff were taught how to fit test their masks and it would be conducted soon.

# 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

Some consumers said they participated in activities of interest and consumers were observed engaged in group activities during the site audit. Staff explained what was important to consumers and what they liked to do. Care plans reflected consumers’ likes and dislikes. Consumers were observed engaging in various activities throughout the Site Audit.

A consumer interviewed described how staff supported her spiritual needs. Staff described how they facilitated connections with people important to consumers through technology. Care plans reflected consumers’ spiritual history. Activity calendars demonstrated church services were delivered every Thursday.

Consumers explained how they maintained relationships within the community and did things of interest. Lifestyle staff identified consumers who liked to go outside the service and participate in external activities. Care planning documentation reflected how staff supported consumers to engage with the community.

Care planning documentation in the ECMS was accessible by lifestyle staff and allied health professionals (AHPs). Staff explained they were informed of consumers’ needs through handovers, dietary folders and the ECMS. Care planning documentation identified which lifestyle programs consumers participated in.

Consumers said the service has offered to refer them to external providers. Staff described how consumers were referred to other providers and gave practical examples of this. Care planning documentation showed collaboration with external providers to supplement the care and services provided by the service.

Most consumers were satisfied with the quality, quantity and variety of the meals provided. Staff described alternative menu options and extra food available for consumers. The service’s drinks list reflected consumers’ dietary needs. No complaints about meals were reflected in the consumer meeting minutes.

However, some consumers said they did not get enough food, did not finish drinks provided as it was not aligned with their preferences or were unsatisfied with the quality of meals provided. Consumers were not aware of alternative options available at each meal. All meals on the menu were approved by a dietician employed by the organisation and on balance, the Assessment Team found Requirement 4(3)(f) was met.

Staff explained how consumers had access to equipment for private use. Maintenance staff confirmed minor equipment repairs were conducted. The maintenance schedule showed routine inspections undertaken on consumers’ equipment. Walkers and wheelchairs used by consumers were observed to be clean and well maintained.

# Standard 5

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

Findings

Most consumers said the service environment felt like home. Individual rooms were decorated with consumers’ own personal furniture, fittings and decorations. The service environment was observed to be fresh and bright with clear signage and navigational aids. The service had a mix of communal areas and private spaces for consumers to enjoy.

The service environment was observed to be clean and well maintained. Staff described the cleaning procedure. Preventative maintenance records were complete and included call bell system checks and several types of water testing. Upstairs living area doors were unlocked and opened onto balconies.

However, some doors were found to be locked during the Site Audit and management provided evidence of upcoming installations of a push button to allow free movement. Fire exit doors were observed to be hidden by curtains. On the balance of evidence however, the Assessment Team recommended the Requirement was met by the service.

Consumers said, and observations confirmed, furniture, fittings and equipment were kept clean and safe for use. Furniture in the communal and outdoors areas was observed to be clean and in good condition.

# 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. | 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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Assessment Team recommended all requirements in this Quality Standard were not met.

**Requirement 6(3)(a)**

The Assessment Team recommended Requirement 6(3)(a) was not met on the basis of poor consumer and representative feedback. While consumers and representatives understood how to make a complaint and give feedback when they were not satisfied with their care and services, most interviewed reported they felt discouraged from raising complaints or providing feedback due to repeated lack of response and action to address their concerns. Some of the consumers and representatives interviewed stated they have made complaints either verbally or electronically, but the service does not respond or address them promptly. Some consumers said they have stopped providing feedback or making complaints because they considered they were not being heard or were being ignored. Documentation review showed those complaints had not been documented in a complaint register or log. The feedback and compliments folder supplied during the site audit had 1 compliment in it. The service did not provide a complaints and feedback log. Refer to Requirement 6(3)(c) for further detail.

Some consumers and representatives stated they do not feel safe making a complaint or would prefer to remain anonymous, and they had made complaints previously but have ceased in fear of negative consequences. One consumer interviewed said they had stopped giving feedback or making complaints about food. They said their concerns were not being heard or acted on. The named consumer was comfortable making complaints to management and staff, however felt they ‘get in in trouble’ as a result. The consumer listed several complaints made which were not documented in the service’s complaints handling system. The consumer had also stopped attending resident’s meetings, as they felt there was no point as their suggestions were not considered. This example is also considered in relation to Requirement 6(3)(c).

Staff interviews were also brought forward as evidence of non-compliance. While interviewed staff could describe a feedback and complaints process, they also reported they had not provided assistance to consumers to provide feedback and make complaints. Interviewed staff did not know what advocacy was. Staff said all feedback and complaints raised would be referred to management however management were unaware of several complaints’ consumers had raised with the assessment team. Other evidence brought forward by the Assessment Team was not relevant or was refuted by the response and has not been considered.

The approved provider’s response to the site audit report, received on 10 February 2023, disagreed with the site audit report findings. The approved provider drew attention to the service’s organisational documents, policies and procedures which were in place to guide service practice and considered it showed a service that actively seeks out and responds to feedback. The response reiterated advocacy information was on display throughout the service. The response asserted that advocacy information sessions had been run at the service on three occasions on the previous 18 months, however review of the documentation reflected these were webinars, and it was unclear how the sessions were advertised to consumers or how consumers might have been supported to attend. The response disagreed that staff stating they have not helped consumers to make complaints means they would not do so if asked, however I was not persuaded by this aspect of the response. The response considered staff who did not know what an advocate was reflected isolated knowledge gaps.

Regarding documentation review findings, the response explained that the service’s feedback register is stored electronically, and organisational comments, complaints and open disclosure policy allows for comments and complaints to be managed either on a feedback register or other forms of documentation such as progress notes or emails. The fact that the feedback was not on the register provided to the team, the approved provider asserted, was not evidence the service had not listened, acknowledged or actioned the feedback as required by the Standards. However, the response did not contain evidence of any documentation concerning the complaints outlined in the report to demonstrate they had been actioned and follow up evaluated with input from the consumer. Refer to Requirement 6(3)(c) for further detail.

Regarding the negative consumer and representative feedback, the response emphasised consumer feedback which showed consumers and representatives were aware of how to provide feedback and that most were comfortable to raise feedback directly with staff. The approved provider was disappointed to hear some consumers reported feeling unsafe in making complaints and/or preferring to remain anonymous and emphasised that information on lodging confidential complaints and external complaints avenues were displayed throughout the service. Regarding one anonymous representative who reported they had stopped complaining out of fear of negative consequences, the response confirmed the service was aware of the consumer in question and provided additional context and explanation of the situation.

In relation to the named consumer who felt they ‘get in trouble’ as a result of raising concerns, the approved provider’s response contained additional context concerning the consumer and outlined steps taken since the audit to meet with the consumer and understand their concerns. The response disagreed with the accuracy of statements made by the consumer directly to the Assessment Team. The response reported that the consumer had clarified several statements attributed to them in the site audit report when they met with them. The response did not overcome the consumer’s statement that they felt they ‘get in trouble’ as a result of raising concerns. More detailed account of the response to the named consumer is outlined in Requirement 6(3(c) where it is more relevant.

Having had regard to the evidence outlined in the site audit report and the approved provider’s response, on balance, I find the service is non-compliant with Requirement 6(3)(a). While consumers and representatives had been advised of complaints processes and knew how to make complaints and provide feedback, the weight of consumer and representative feedback showed some of those sampled had been discouraged from making further complaints as a result of lack of response or fear of negative consequences. I have given weight to the consumer and representative feedback provided directly to the Assessment Team that some were fearful of complaining and or preferred to remain anonymous in their feedback. I have given less weight to post-site audit clarifications or retractions of consumer feedback, reported in the approved provider’s response. For these reasons, as well as those outlined in relation to Requirement 6(3)(c), I find the service is not compliant with Requirement 6(3)(a).

**Requirement 6(3)(b)**

The Assessment Team found consumers were not made aware of and did not have access to advocacy, language services and other methods for raising and resolving complaints. Evidence brought forward in the site audit report included that although the service had made available information about advocacy and other methods for raising and resolving complaints, consumers were not aware of them. Interviewed staff did not know what an advocate was and said they had not received training on advocacy, and members of workforce were not aware of advocacy information displayed around the service. On the second day of the site audit, additional complaints process and advocacy posters were displayed in the service.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation and included a copy of the organisation’s feedback form, noted the organisation’s concerns and complaints poster was displayed throughout the service with directions for consumers and representatives to follow, to make a complaint. The response noted information on national advocacy services was displayed in the service and evidence provided indicated consumers had been offered the opportunity to participate in webinar’s run by a prominent advocacy service on 3 occasions. In response to evidence that staff were unaware of advocacy services, the response contended that staff were aware and that the availability of services was communicated to staff through information sessions and by management.

On balance, having had regard to the evidence in the site audit report and the response, I find the service took satisfactory steps to inform consumers of the presence of advocates and other ways to make complaints. I have taken into consideration the lack of named consumer examples to support the Assessment Team’s finding that ‘most consumers’ were not aware of advocacy services, and find as a result, there is insufficient evidence to support that the majority of consumers were not aware of the availability of advocates. I have also had regard to evidence the service had publicised, on the lifestyle calendar, advocacy service webinars on occasions prior to the site audit. Lastly, I have taken into account the lack of consumers who do not speak English at the service. On balance, I find the service is compliant with Requirement 6(3)(b) and the service had taken steps to make consumers and representatives aware of alternative means to raise complaints.

**Requirement 6(3)(c)**

The Assessment Team found the service did not demonstrate appropriate action is taken in response to concerns raised by complaints. Evidence relied on included that some staff did not know what open disclosure was or had a limited understanding of the concept. Interviewed staff reported that during mealtimes consumers would complain about their food and these complaints were not appropriately actioned and catering staff were not approachable. Three specific consumer complaints were reported by staff. However, the site audit report did not contain specific, attributed examples of this staff feedback, to support their conclusions such that it was unclear how many staff members gave the feedback. When the matter was raised with management, they reported being unaware of such complaints from the three consumers named by staff. The assessment team did not confirm the complaints with the named consumers.

Other evidence relevant to this Requirement was instead brought forward in Requirement 6(3)(a), including feedback from 2 named consumers about several complaints they had made previously, which were not addressed by the service. One named consumer’s representatives had sent emails regarding personal care needs not being met, delays in administering medication and issues with the consumer’s room being unclean. When raised with management, they were not aware of the complaints or emails, and the Assessment Team found no record of the complaints in the service’s complaints folder.

A second named consumer (previously discussed in Requirement 6(3)(a)) had raised concerns about meals being cold, not being delivered to their room, food not matching their preferences, care staff being rushed in provision of care, slow call bell response times, referrals, agency staff being unaware of how to use equipment and access to wheelchair. The consumer specified an instance when the service had made a mistake in scheduling their medical officer appointment and the service did not practice open disclosure in response. The consumer had stopped making complaints and attending resident meetings as they felt it was pointless to continue doing so. The Assessment Team found no documented record of any of the consumer’s complaints.

The service’s complaints register/feedback logs contained some feedback forms and a compliment only, and requests for a detailed complaint and feedback log were not met. Other evidence included in the report was not relevant and has not been considered here.

In their response received 10 February 2023, the Approved Provider disagreed with the site audit report findings and provided additional context and information about the service’s handling of complaints and open disclosure. The response stated that staff would have varied understanding of open disclosure depending on their role, with care staff trained to escalate concerns, cooperate in investigations and apologise for mistakes. The response noted the limited specific examples of staff feedback made it difficult for them to respond to evidence in the site audit report but drew attention to findings that there had been 100% completion of open disclosure training. In the response, the approved provider reported being unaware of previous complaints lodged by staff on behalf of consumers with concerns about meals and noted the assessment team did not corroborate concerns with the named consumers. Regarding one named consumer, the response stated the service had addressed a historical food concern. As a result, I have not taken this example into consideration.

The response confirmed the service does not have a practice of recording complaints from email to the feedback register, as per organisational policy, which allows for staff to manage complaints through progress notes or just through emails. The Approved Provider took the position that such feedback not being recorded on a register does not evidence the service had not responded to the feedback.

Regarding the first named consumer, the Approved Provider stated that complaints raised by the representative, about late medication times, had been raised just prior to the site audit however documentary evidence was not provided to support this. The response showed that the service had responded to some of other emails, but no evidence the service had evaluated the follow-up action in consultation with the representative was provided. I have considered the service’s repose but am not persuaded by it. No evidence of the service’s handling of the complaints regarding late medication was provided, and no evidence that the service had evaluated the effectiveness of follow up to earlier complaints about personal care. I have given weight the representatives clear evidence their concerns had not been resolved and I find this consumer example reflects non-compliance with Requirement 6 (3)(c).

Regarding the second named consumer, the approved provider’s response has been outlined previously in Requirement 6(3)(a), where I noted it contained additional context concerning the consumer’s health and outlined steps taken since the audit to meet with the consumer and understand their concerns. The named consumer had reportedly retracted a number of the complaints they had raised with the Assessment Team, but it did not overcome the consumer’s statement that they felt they ‘get in trouble’ as a result of raising concerns. Having had regard to the evidence in the site audit report and the response, on balance, I find this example reflects the service had not responded to complaints the consumer had made. I have given weight to the interview evidence provided by the consumer directly to the Assessment Team, over any reported clarifications issued since the site audit, to management or staff of the service.

Having had regard to the evidence in the site audit report and the response, I find, on the balance, the service did not demonstrate they have an effective and functioning complaints and feedback handling processes in place. Based on the weight of staff and consumer feedback, I find complaints, follow-up actions, and open disclosure use were not consistently applied and documentation reviewed tended to confirm this. The response did not contain sufficient documentary evidence to show listed complaints were documented, follow up actions taken, open disclosure applied and complainant satisfaction was evaluated, as is best practice. Services are expected to acknowledge when things have gone wrong and to encourage and support people to identify and report negative events. Consumer, representative and staff feedback, as well as document reviewed, indicated consensus that complaints were not managed or responded to in a consistent manner and some consumers had ceased to raise concerns at all, as a result. Therefore, I find the service is not compliant with Requirement 6(3)(c).

**Requirement 6(3)(d)**

Regarding Requirement 6(3)(d), the Assessment Team considered the service did not review feedback and complaints information to improve the quality of care and services. However, the relevant evidence brought forward in the Requirement did not clearly support their recommendation. Relevant evidence brought forward included representative interviews that showed a theme of complaints about falls and medication incidents at the service. Members of the organisation’s executive quality workforce demonstrated how they use feedback reports from each of the organisation’s services to address ongoing concerns and complaints. While they also reported delays in the implementation of proposed system/s for improvement, there were strategies in place to reduce the number of falls and to increase staff numbers. Documentation reviewed by the Assessment Team demonstrated the service had been conducting an ongoing recruitment drive to address staffing concerns. Interviews with management and staff confirmed the service was taking action to address falls and medication errors through strategies such as ‘Stop and Watch’ and staggered hand-over for staff members, as well as medication competency training, education counselling and reflective practices for staff administering medication. Other evidence brought froward, including examples of consumer complaints about staffing and call bell response time, were more relevant to Requirement 7(3)(a), or was demonstrated to be inaccurate by the approved provider’s response.

In the response received 10 February 2023, the Approved Provider disagreed with the site audit report findings and outlined the monitoring processes in place at the service, including feedback avenues to measure satisfaction levels such as feedback forms, meetings and consumer experience interviews. The response noted falls and medication incidents had decreased significantly following implementation of strategies outlined. The response outlined in more detail the measures being taken to address staffing issues, and it clarified inaccuracies in the site audit report findings. I accept those clarifications and have not considered that evidence in reaching my decision.

Having had regard to the evidence in the site audit report and the response, I find the service was taking account of complaints and feedback, to improve care and services. Evidence brought forward in the site audit report itself showed strategies and feedback measures used to this end, and evidence brought forward by the Assessment Team to indicate that these strategies were not successful was clarified in the response. While there appear to be ongoing concerns held by consumers regarding staffing, this is more relevant to Standard 7 and will be considered there. On balance of evidence, the service demonstrated feedback and complaints were sought and used to inform organisation wide improvement strategies and staffing efforts. I am therefore satisfied the service is compliant with Requirement 6(3)(d).

# 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. | 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

**Requirement 7(3)(a)**

Regarding Requirement 7(3)(a), the Assessment Team recommended not met due to consumer and representative evidence the service is short-staffed, resulting in extended call bell wait times, in particular for personal care. Relevant evidence brought forward in the site audit report is outlined below. Other evidence brought forward was either irrelevant or clarified by the Approved Provider’s response and has not been outlined here.

Consumers said while staff were friendly, caring and familiar with their needs, some were not knowledgeable. Evidence from 2 named consumers and 3 named representatives, presented throughout the report, reflected concerns about short-staffing resulting in long call bell response times, rushed care, difficulty finding staff when needed and deficits in personal and continence care. One representative specified detrimental impact to consumer dignity as a result. A representative wishing to remain anonymous considered staff were not always able to trial non-pharmacological strategies with one consumer, due to staffing issues. In relation to lifestyle Standards, consumers said staff did not spend one on one time with them because they were understaffed and too busy, which was confirmed by staff. Observations showed consumers repeatedly calling out for staff and interactions with consumers only taking place during activities or in walkways.

Staff interviews reflected ongoing problems with insufficient personnel numbers to meet consumer need. Interviewed staff confirmed they were “always understaffed” and sometimes had 4 staff to look after 80 consumers. A clinical staff member reported delays in attending personal care duties in a timely manner due to understaffing. A care staff member confirmed they had, by themselves, assisted consumers requiring two-person assist when consumers required urgent assistance and other staff were unavailable to assist. A clinical staff member reported being overworked owing to repeated requests from management to extend shifts or work additional shifts. The staff member had raised concerns with management which had not been resolved. A second clinical staff member said poor staffing impacts upon all aspects of care within the service, stating sometimes staff were not replaced when they went on leave and the service had lost a lot of staff throughout the year.

In their response to the site audit report received 10 February 2023, the Approved Provider disagreed with the site audit report findings and raised concerns about the application of the site audit methodology. The response also clarified inaccurate information in the report, which I have not considered in reaching my decision, as a result.

The response acknowledged there were workforce challenges at present, particularly in regional areas, but contended the organisation had implemented a robust response to address the matter. The response disagreed the staff shortages had compromised service delivery citing no significant increase in clinical measures. The response outlined the governing body’s Victorian regional workforce strategy to attract staff with organisational level recruitment strategies. The response also outlined service-level workforce strategies used, including adjusting shift times to make them more attractive to casual and agency staff, block bookings of agency staff and additional monetary incentives including paid accommodation and travel. The response stated that 30 new staff had commenced at the service in the 5 months prior to the site audit, however no documentary evidence of this was included in the response. It was also unclear how many employees had exited employment in that time.

The response stated there had never been only four staff in attendance on any morning or afternoon shift, confirming that where there are shift vacancies, management staff who are registered nurses fill the shifts. The response questioned the accuracy of a clinical staff statement that there were delays in attending to personal care duties as a result of understaffing. I was not persuaded by this aspect of the response as I consider clinical staff are in a position to observe whether personal care is delivered to consumers in a timely manner or not.

The response affirmed all staff received manual handling training and a minimum of two staff are required for all transfers. The response stated that the service was unaware of any staff completing transfers solo, and that if they became aware of this, disciplinary action would result. I was not persuaded by this aspect of the response, as it does not displace the direct interview evidence provided by the staff member to the Assessment Team at the time of site audit.

The response acknowledged staff are fatigued but emphasised that extra or extended shifts are offered via an app and it is voluntary whether staff pick up the shifts or not. The response emphasised the service’s efforts to address fatigue through staff engagement surveys. While I acknowledge efforts to address staff fatigue, I have given weight to the clear interview evidence of staff, describing their experience of staffing levels at the service.

The response disagreed with quantitative evidence presented in the site audit report, about the number of consumers and representatives who presented negative feedback about staffing. I have taken those clarifications into account.

The response stated the average call bell response times for the service in the months prior to site audit were all below 6 minutes, and well below the service’s performance indicator of 10 minutes. However, this was not supported by documentary evidence, such as the call bell reports themselves. Call bell reports were provided for 3 named consumers who complained of extended wait times. Of those provided, one was illegible and two indicated several extended waits of more than 20 minutes, though averages for those three consumers were below 10 minutes. On balance, however, I find that call bell evidence before me tended to confirm the poor consumer and staff feedback about extended wait times.

Lastly, the response responded to individual consumer and representative interview evidence, providing additional information about the concerns raised with the assessment team. While I acknowledge the context, this information did not displace the consumer experience as described by those consumers and representatives themselves. The response did not address direct observations reported by the assessment team in the context of Standard 4, lifestyle.

On balance, having regard in particular to the strong negative interview sentiments expressed by service personnel, consumers and representatives, I find the service has not ensured sufficient number and mix of staff are deployed to ensure the delivery and management of safe and quality care and services. Impacts on personal care, in particular, were identified. I have also had regard to my decision in Requirement 3(3)(a), concerning the extended, 19-day failure of care staff to check a diabetic consumer’s foot wound and I find this likely reflects an insufficient number of care staff deployed. Based on strong negative consumer, representative and staff feedback during the site audit, and based on the identified impact in Requirement 3(3)(a), I am satisfied the service is not compliant with Requirement 7(3)(a).

**Requirement 7(3)(c)**

The Assessment Team found that most members of the workforce had the knowledge to effectively perform their roles, however recommended this Requirement was not met as a result of evidence a list of IPC Leads contained a management staff member without a relevant qualification. Other evidence concerning medication incidents was more relevant to other requirements, where is has been considered.

The approved provider’s response, received 10 February 2023, disagreed with the assessment team’s recommendation and pointed to excerpts from the site audit report specifying relevant knowledge and training of staff. They acknowledged the error that resulted in incorrect information being displayed in the IPC Lead lists.

On balance, I find there is insufficient evidence to support the assessment team’s recommendation. Information brought forward was either relevant to other Requirements or was insufficient to demonstrate systemic shortfalls in training. Concerns related to adequacy of wound care and medication incident trends, have been considered in Requirement 3(3)(a), where they are more relevant. As there was insufficient remaining evidence to support the not met recommendation, I instead find the service is compliant with Requirement 7(3)(c).

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

Consumers and representatives said some staff were nice and friendly. Staff described how they treated consumers respectfully, including using their preferred name. Staff were observed assisting consumers with their meals in a dignified, calm, and gentle fashion. However, some consumers said some staff could be ‘rough’ or ‘rude’ when they rushed during personal care delivery.

Staff said they had access to ongoing online and face-to-face training modules. Training records showed 100% completion for legislated mandatory training modules. However, some staff said they felt unsupported by management. Attendance records indicated restrictive practices training was not completed by all staff. Upon inquiry, staff were unable to demonstrate an understanding of restrictive practices or advocacy.

The service was guided by a performance management policy. Staff confirmed they have completed annual performance reviews with management. Staff said they were able to communicate their training needs to management.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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. | 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

The Assessment Team recommended Requirements 8(3)(a), 8(3)(c) and 8(3)(d) were not met

**Requirement 8(3)(a)**

Regarding Requirement 8(3)(a), the Assessment Team recommended not met on the basis of evidence that was largely relevant to other Requirements. Evidence included a consumer’s feedback their request for equipment had been ignored, which has been considered and refuted by the approved provider’s response, in Standard 6. Other evidence relied on related to catering staff not using feedback forms to evaluate meals.

The Approved Provider’s response queried the relevance of most evidence brought forward in the Requirement and provided examples of ways the service engages consumers in design and evaluation of services. The response affirmed information already outlined in Standard 6, that the service seeks out the consumer voice. The response identified examples of specific changes made at the service level, as the result of consumer participation in service design and evaluation.

On the balance of evidence, I am satisfied the service engages consumers in design, evaluation and delivery of services. Evidence brought forward to the support the not met recommendation as either not relevant or was refuted. As a result, I find the service is compliant with Requirement 8(3)(a).

**Requirement 8(3)(c)**

Regarding Requirement 8(3)(c), the Assessment Team considered there were deficits in the organisation-wide governance systems for workforce governance and feedback and complaints.

Regarding workforce government, the team relied on evidence from interviewed staff who reported not being informed of or engaged by members of the governing body, committees, the Chief Executive, Managing Directors or other senior executives. Other evidence was refuted by the response or was more relevant to Standard 7 and has not been outlined.

Regarding feedback and complaints governance systems, refer to evidence previously outlined in Standard 6.

In their response, received 10 February 2023, the approved provider disagreed with the assessment team’s recommendation. The response emphasised inconsistencies in the information included in the report, and cited extracts of the report which contradicted the Assessment Team’s recommendations. The response acknowledged staff feedback concerning lack of engagement from key organisation personnel but provided a list of recent engagement by key organisation team members at the home in recent times. The response also outlined workplace communication channels used to deliver key messages to staff, including email and SMS, as well as all employee calls. I was persuaded by this aspect of the response and consider the response refutes evidence cited as evidence of deficits in workforce management. I have considered the finding of non-compliance in Standard 7, staffing, however consider the evidence does not clearly reflect organisation wide governance issues.

Regarding feedback and complaints, the response has been outlined previously in Standard 6, where I also outlined my reasons for finding the service did not encourage and support consumers and representatives to make complaints and provide feedback, or provide timely and systematic response to address complaints raised. I consider the service’s processes for handling complaints without a central complaints log or register does not reflect best practice and does not support the evaluation of actions taken in response. As the organisation’s existing governance arrangements did not identify and address shortfalls in complaints handling at the service, and given the lack of alignment with best practice complaints handling principles, I find the service is not compliant with Requirement 8(3)(c).

**Requirement 8(3)(d)**

The Assessment Team considered Requirement 8(3)(d) was not met, relying on was either relevant to other Requirements or was clarified or refuted by the response. The Site Audit Report also referred to a fall for a consumer, which was not referred to SIRS. Other evidence brought forward reflected compliance with the Requirement.

In the response, the approved provider disagreed with the Assessment Team’s findings and provided additional detail about the service’s quality and risk frameworks, the overarching governance structure of the organisation. The response drew attention to other parts of the report which contradicted the recommendation, and described in detail the effective nature of risk governance at the service. The response reiterated errors in falls and medication incident data relied on by the Assessment Team and demonstrated decreases in falls and medication incidents in recent months, as a result of steps taken by the service. Lastly, the response gave additional context concerning the incident, which clarified the incident may not have been reportable. As evidence brought forward to support the not met recommendation was overturned by the response was or was not relevant, I am satisfied the service is compliant with Requirement 8(3)(d).

The service’s compliance and regulatory requirements was overseen by several board committees. A clinical governance framework was used to identify improvement opportunities based on clinical indicators and management reports. Executive staff said policy changes adhered to regulatory reforms. Reports were generated by management for Board and senior leadership team review.

The clinical governance framework was overseen by the quality team based on a range of clinical indicators. Staff confirmed they were guided by policies, about antimicrobial stewardship, open disclosure and minimising the use of restrictive practices.

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