Performance

Report

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| Name of service: | Eventide Lutheran Homes |
| Service address: | 72 Ballarat Road HAMILTON VIC 3300 |
| Commission ID: | 3285 |
| Approved provider: | Lutheran Church of Australia Victorian District |
| Activity type: | Site Audit |
| Activity date: | 16 May 2023 to 18 May 2023 |
| Performance report date: | 6 July 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 Eventide Lutheran Homes 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 16 May 2023 to

18 May 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.

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

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

# **Areas for improvement**

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

*Requirement 3(3)(g)*– Ensure minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection, as required by the Aged Care Quality and Safety Commission.

*Requirement 8(3)(d)*– Ensure the service consistently and appropriately identify, record and report incidents as required by the Aged Care Quality and Safety Commission.

# **Standard 1**

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| Consumer dignity and choice | | Compliant |
| 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

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

Staff treated consumers with dignity and respect and valued their identities and cultures. Care plans captured consumers’ details regarding their identity, background and cultural practices.

Consumers said staff respected their culture, values, and diversity and supported them in practicing their beliefs. Care plans included specific cultural needs, background and spiritual preferences. Staff described consumers with different culture and how they respected their cultural identity.

The service supported consumers to exercise choice and independence. Consumers were involved in, and supported to make decisions. The organisation ensured consumers and their representatives understood the choices available to them.

The Assessment Team confirmed the service supported consumers to take risks and enabled them to live the best lives possible. The organisation had documented policies on managing and supporting consumer to take risks.

Staff provided information to consumers promptly, which enabled them to exercise choice, and then assisted consumers to make choices about their care and lifestyle. Care plans indicated the different communication strategies required for each consumer.

Most consumers advised their privacy was respected, and personal information was kept confidential. Management and staff respected consumer privacy. Personal information was stored electronically with restricted access. The service’s privacy policy outlined how the service maintained and respected the privacy of consumer information.

# **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.

The service demonstrated assessment and planning informed the delivery of safe and effective care and service. Care plans contained relevant information and assessments for potential risks to consumers’ health and wellbeing. However, the Assessment Team found the service was unable to consistently identify through assessment, consumers potentially subject to environmental restraint. The service had policies and procedures on risk.

Assessment and planning identified and addressed each consumer’s 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. Consumer care documentation demonstrates involvement through routine contact and when changes occur to the health status of consumers. Care documentation demonstrates that other organisations and individuals are involved in the assessment and planning process for consumers as required. Consumers confirmed care assessment and planning outcomes were communicated to them and they could access their care plans upon request.

Care plans contained evidence of regular reviews, to minimise risk and implement improvements. Staff 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.

# **Standard 3**

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| Personal care and clinical care | | Non-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. | Non-compliant |

Findings

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

*Requirement 3(3)(a):*

The Assessment Team considered this Requirement as Not Met, as it considered the service did not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs, and optimises their health and well-being.

Having considered the evidence in the site audit report, and the Approved Provider’s response of 21 June 2023, I reached a different conclusion and decided the service was compliant with this Requirement.

The Assessment Team identified the following issues:

* Fifteen out of 16 consumers and representatives reported they were happy with the care and services received and consumers were receiving the care they need.
* On 16 May 2023, one consumer stated staff had taken away his walker approximately 2 weeks earlier. Both the Director Of Nursing (DON) and care staff did not perceive this to be a form of restrictive practice.
* The service did not have a process in place for monitoring and recording consumers receiving psychotropic medications. The DON was guided by the consumers’ Medical Officer (MO) and pharmacist on psychotropic medication management.
* A pharmacy consultant report recorded 9 of 12 consumers were prescribed and administered an antipsychotic medication, however, did not have a diagnosis indicating the need for an antipsychotic medication, with the DON accepting the consumers were chemically restrained. Care documentation reflects the antipsychotics were regularly reviewed by the consumer’s Medical Officer.
* During the entry meeting, management reported the service had one consumer subject to chemically restrictive practice, with no consumers subject to environmental or mechanical restrictive practice.
* In relation to environmental restrictive practices, the handover sheet records a ‘no exit’ alert for 8 consumers. Management did not consider this to be environmental restraint as the 8 consumers were allowed to leave with staff or family under supervision. Management acknowledged this was not in line with the Commission’s definition of a restraint.
* Staff confirmed they have not received training in restrictive practices.
* Management was unable to provide evidence of wound management training during the Site Audit.

In its response of 21 June 2023, the Approved Provider acknowledged the assessment teams observations, and submitted the following:

* The consumer was a 97-year-old man admitted to the service in 2015. He sustained a fractured femur in a fall on 1 April 2022 and had corrective surgery. He had not ambulated since surgery despite his assertions he could walk with his four-wheeled walker (4WW). Due to his poor strength and dexterity, he could not hold the handles, or apply the brake. He falls backward pulling the frame over him. Staff did not believe they restricted his mobility as he was immobile. The physiotherapist review on the 2nd of May 2023 clearly stated that the consumer was unable to ambulate. The consumer had been assessed by an external Physiotherapist, to provide every opportunity for him to walk again. This physiotherapist also deemed him unable to ambulate.
* The home had a list of consumers on psychotropic medication which was provided to the pharmacists, who double check diagnosis with medication on admission and when changes occur. The service reported the number of residents on chemical restraint, confirmed by the team’s report at entry, and could not have done this without knowledge of residents on psychotropic medication. The home could not have provided the consultant Pharmacist with the list of residents on psychotropic medication to review if it did not monitor the residents on psychotropic use. As all residents on psychotropic medication had a diagnosed condition in accordance with their medication, management believed residents weren’t chemically restrained and reported this to the audit team.
* The data from the Consultant Pharmacist clearly showed that she reviewed the antipsychotic medication only as part of the data collection for the individual indicator question. She reported 9 of 12 residents did not have a diagnosis of psychosis for the collection period for purposes of the National Quality Indicator quarterly data. However, all 12 residents did have a diagnosed mental disorder, physical illness or physical condition recorded in their file at that time and administration of the psychotropic medication ordered by the GP was approved and suitable for their diagnosis and treatment. The service had in place a behaviour care plan for all appropriate consumers, however, it was not in the format the audit team member wanted.
* All consumers that had a “no exit” had a diagnosis of moderate to severe cognitive impairment. The home had an open memory support unit so residents could wander around the entire facility, including out to the numerous outdoor areas, and ensured the least restrictive practice were applied to consumers. There was a key coded exit from the home. One consumer provides the code to exit the building to visitors. Management have now displayed the code to the exit . All residents have been reviewed and the eight on the “no exit” list are now on the environmental restriction register.
* Management confirmed that staff had completed Restrictive Practises training online. Staff onsite were a mix of casual staff who do not work regularly.
* The Deputy Director of Nursing (DDON) manages wound care in conjunction with the nursing staff. Training records were in addition to the training in wound management that occurs during training for qualifications.

I have considered the information in the site audit report, and the material provided by the Approved Provider in its response on 21 June 2023. I am satisfied that its actions were acceptable, and, at the time of the site audit, it was compliant with Requirement 3(3)(a).

*Requirement 3(3)(g):*

The service did not ensure minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection, and an effective infection prevention and control program that was in line with national guidelines, recommendations, or advice. The service had a member of staff who was the Infection Prevention Control Lead (IPCL), but the staff member had been on leave for 3 months. The service did not have a replacement IPCL. All staff had received training in infection prevention and control. However, the service was unable to provide evidence of training records.

The Assessment Team identified the following issues:

* The Infection Prevention Control Lead (IPCL) was on leave. Management and the IPCL confirmed the service did not have a contingency plan to replace the IPCL whilst on leave.
* The service developed and implemented a COVID-19 management plan, which the IPCL confirmed was not in line with current guidelines and recommendations. The service has a generic outbreak plan for infectious diseases. The IPCL said they would ‘ad hoc’ additional infection prevention and control guidelines dependent on specific infectious outbreaks.
* The Assessment Team observed staff and visitors wearing masks incorrectly. Management said the IPCL was responsible for monitoring and ensuring staff comply with the infection prevention and control measures.
* The Assessment Team observed stocks of hand sanitisers on the PPE trolley had expired in November 2022.

In its response of 21 June 2023, the Approved Provider acknowledged the assessment teams observations, and provided the following response:

* The CEO and IPCL were on leave during the audit. A second staff member was qualified as an IPC resource, however the staff member was unavailable as they were not scheduled to work.
* The infectious diseases outbreak management plan was a whole-of-service plan, and encompassed all types of major outbreaks including COVID-19, Gastroenteritis and acute respiratory outbreaks. It was not a stand-alone plan. There was no requirement for separate plans. Management stated this was a privately run residential service and did not come under public sector guidelines. The IPC lead said she can modify these guidelines as required, not as as an “ad hoc” approach.
* Management monitor staff and resident practices as there was an infection control team, not just an IPC lead responsible for ensuring correct processes. Management sent a memo to staff reminding them of their responsibilities. The receptionist provided and instructed visitors on wearing masks, and the use of RAT kits.
* The home acknowledged this was an oversight. The trolleys were not utilised except for a Covid -19 outbreak, and were located in a storage unit referred to in the outbreak management plan. The IPC lead said the trolley would be checked prior to use in a Covid-19 outbreak, otherwise it stayed in the locked unit. The trolleys had been checked since the site audit and now had sanitisers with long expiry dates.

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 did not demonstrate full understanding of its obligations, and has not met its IPC responsibilities against the Aged Care Quality Standards, until it was notified by the Assessment Team. Therefore, I find the service was non-compliant with Requirement 3(3)(g) at the time of the site audit.

*The remaining Requirements:*

Care plans noted high impact or high prevalence risks were effectively identified and managed by the service. Staff described the strategies in place to manage those risks.

Care and clinical staff interviewed were able to articulate how to care for consumers nearing the terminal phase of life to ensure comfort is maximised and their dignity preserved. Management reported they would be guided by the MOs for involvement of the palliative care team.

Consumers care plans and progress notes reflected the identification of, and response to deterioration or changes in condition. Staff identified consumer changes and responded to these changes in a timely manner. The service had policies, procedures and clinical protocols to guide staff in the management of deterioration.

Consumers and representatives were satisfied 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 said the service had access to, and referred them to appropriate providers, organisations or individuals to meet their care needs. Referrals were prompt and the services provided was appropriate.

# **Standard 4**

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| Services and supports for daily living | | 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. | 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

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

Consumers and representatives were satisfied the service provided support for daily living which promoted their emotional, spiritual and psychological well-being. Lifestyle staff supported the religious, spiritual and psychological well-being of its consumers and demonstrated detailed knowledge of their preferences.

Consumers sampled reported their emotional, spiritual and psychological needs were supported, and they were supported to stay in touch with family or friends for comfort and emotional support.

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 consumers’ conditions, 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 observed a variety of resources available to support referral to external organisations.

Consumers and representatives expressed satisfaction with the quality, quantity and variety of the meals provided. Care plans included correct information regarding dietary requirements and preferences of consumers.

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 said the service environment was welcoming to their friends and family and encouraged a sense of belonging. The Assessment Team observed adequate space for consumers, with clear signage to freely access both levels at the service.

Consumers and representatives stated the service was clean, well-maintained and comfortable. The service had documented policies on maintenance of equipment and cleaning services. Cleaning schedules were in place with guidelines for staff on processes and frequencies of detailed cleans.

Shared equipment is regularly cleaned, and equipment used for handling consumers was safe to use. The service has documented policies in place for maintenance of equipment and stock management. The Assessment Team observed furniture and equipment to be clean and well maintained throughout the service.

# **Standard 6**

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| Feedback and complaints | | Compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

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

Consumers and representatives felt comfortable in providing feedback, and described multiple ways in which feedback could be provided. Staff were aware of the avenues available to consumers and representatives to provide feedback, and supported consumers to lodge complaints.

Staff assisted consumers with cognitive impairment and communication difficulties to provide feedback. Advocacy and language service details are included in staff training, and in staff and consumer handbooks.

The service demonstrated it took appropriate action and used an open disclosure process in response to feedback or complaints. The organisation has documented policies on consumer feedback which guided staff practice on using an open disclosure process, recording actions taken, and receiving confirmation from consumers’ families that they were happy with the outcome of incidents. One representative said she was informed of a medication error whereby the consumer was inadvertently administered a double dose of methotrexate. The representative said the service apologised and explained what had occurred. The Assessment Team reviewed the incident report which identified the consumer was assessed and her wellbeing was monitored following the incident, and progress notes indicated management followed up with the staff member involved in the incident and provided education and counselling to the staff member.

Consumers and representatives confirmed the service used feedback and complaints received from them to improve care and services. Management demonstrated how it used feedback and complaints to improve the quality of care and services provided to consumers.

# **Standard 7**

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| Human resources | | 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. | 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

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

*Requirement 7(3)(d):*

The Assessment Team considered this Requirement as Not Met, as it considered the service did not demonstrate that the workforce was recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Having considered the evidence in the site audit report, and the Approved Provider’s response of 21 June 2023, I reached a different conclusion and decided the service was compliant with this Requirement.

The Assessment Team identified the following issues:

* Staff raised concerns regarding their ongoing training and support in their roles. Most said they were overdue for medication competencies, chemical safety and fire safety training.
* The maintenance officer was not provided a handover and was unfamiliar with the service’s electronic system for maintenance related activities.
* The chef manager said she received three days of training and handover and did not have a complete understanding of her role. She does not have visibility of her team’s training or competencies in food safety.
* The work health and safety (WHS) officer does not have a current duties list and has not attended a refresher training since 2019.
* Staff interviewed said they were not provided education on restrictive practices.
* The service could not demonstrate they provided staff training in the Quality Standards.
* The service was not able to demonstrate it monitors completion and currency of staff competencies. The service was not able to provide compliance rates for mandatory training and completion rates could not be determined.

In its response of 21 June 2023, the Approved Provider advised:

* Clinical staff who regularly administer medications have completed their medication competency written tests. Chemical safety, medication, and wound management competencies are not mandatory for all staff. Fire safety training was scheduled prior to the audit and has since been completed on 23 May 2023.
* The maintenance system is overseen by the CEO, who is the overall manager of the maintenance portfolio. The maintenance man has had orientation to his role and has a duty list, as well as directions from the CEO.
* The chef has had training in her field of work. The chef has a position description that she signed when she commenced her role, which clearly articulates the role and responsibilities of the chef manager.
* Staff are not permitted to work in the catering area without food handlers certificates. There have been no gastroenteritis outbreaks or cases in the past two years at the service. The team found catering staff to be wearing correct PPE for their area, and all records relating to infection control were in place.
* The WHS representative had completed the initial qualification and attended a refresher training day in February 2020. The WHS officer was booked to attend training in May 2022, however this was cancelled. Training was not possible in Victoria during 2021 and 2022 due to COVID lockdowns, and restrictions placed on aged care staff.
* Management refute staff did not have knowledge of restrictive practices, however acknowledge the registers could be improved and have since enhanced the documentation system and registers.
* The home integrated education across the 8 standards into all training onsite. The gaps identified in systems are about refining the documentation of systems and processes.
* The home uses online training resources to deliver and support onsite education. Management were unable to confirm staff compliance with mandatory training due to the absence of an admin assistant during the visit. Management said they could get the online education provider to retrieve records, but that it may take some time.

I acknowledge the Approved Provider was unable to provide some required training to staff when due, and unable to provide documented evidence of training records when requested. However, management have highlighted the difficulty in providing required training in Victoria during the COVID lockdown in 2021 and 2022. Management have also stated the maintenance officer has had orientation into his role, has a duty list to follow, and is directly supervised by the CEO on maintenance matters. The chef manager has signed a position description upon commencement with the service, which clearly articulates her job requirements.

I have considered the evidence in the site audit report, and the material provided by the Approved Provider in its response of 21 June 2023. I am satisfied its actions are acceptable, and, at the time of the site audit, the service was compliant with Requirement 7(3)(d).

*The remaining Requirements:*

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

Consumers and representatives said there were enough staff at the service. Call bells were answered within an acceptable timeframe, and staff gave them the care they need. Management said vacancies on the roster were offered to the services staff before assistance is sought from nursing agencies. Management provided evidence of strategies in place to address any impacts on staff availability.

Consumers and representatives felt staff were kind, caring, respectful and gentle when delivering care and services, and responsive to their needs. Staff were respectful of consumers’ identities and diversity and understood their backgrounds and cultural preferences. The service had policies which clearly documented behaviours expected of staff.

Management detailed processes which ensured the workforce was competent and had the qualifications or knowledge to effectively perform their roles. Consumers and representatives felt confident staff were sufficiently skilled to meet their care needs.

Management regularly undertook assessment, monitoring and review of the performance of staff members. The service had a formal process for annual performance appraisals. Management informally reviewed performance through observation, surveys, monitoring of feedback and complaints and supervision of staff practice.

# **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)(c):*

The Assessment Team considered this Requirement as Not Met, as it considered the service service does not ensure effective organisation wide governance systems.

Having considered the evidence in the site audit report and in the Approved Provider’s response of 21 June 2023, I reached a different conclusion and decided the service was compliant with this Requirement.

The Assessment Team identified the following issues:

In relation to information management.

* The ECMS is accessible to all staff, and access is provided according to scope of practice. Not all staff are trained to use the system effectively leading to staff not accessing important information relating to changes in consumer care, and monitoring and recording preventative and reactive maintenance.
* The restrictive practices policy was not aligned with current legislation and had errors in definition.
* The service’s dignity of risk form provided minimal information and did not include a consumer/representative’s signature confirming that risks associated with consumer's choices were discussed and accepted.
* Review of the incident register identified not all incidents are captured, recorded and investigated in line with the organisation's incident management policy.

In relation to feedback and complaints:

* The service did not maintain a feedback register. Feedback was provided either through meeting forums, in person or via surveys.

In relation to continuous improvement:

* The Continuous Improvement Plan (CIP) did not include items relating to results from surveys and audits, incident reporting, data and trend analysis, and feedback from consumers and representatives.

In relation to regulatory compliance:

* The service was unable to demonstrate compliance with regulations regarding restrictive practices.

In relation to workforce governance.

* The service had not supported staff to maintain their currency in mandatory training related to fire safety and medication competencies.
* The service was not able to demonstrate it monitored staff compliance with training requirements.
* The service was not able to demonstrate consumers receiving chemical restraint medications had BSPs in place.

In its response of 21 June 2023, the Approved Provider gave the following information.

In relation to information management:

* The ECMS is accessible for staff; however, differing security levels do not allow all staff to input or read information which is not part of their role. Management have deemed it inappropriate to provide access for staff who don’t have the training authority or scope to input information into the system. The maintenance officer does not need access to the ECMS, as he does not manage the preventative maintenance register.
* The home identified the issue with policy and procedure updates and have contracted an external provider for assistance with regulatory compliance.
* Every consumer who chose to pursue a risky activity had full knowledge off the risk, all assessments and conversations regarding the risks were articulated by staff, and consumers confirmed their satisfaction to the audit team.
* Management stated they would retrospectively review consumer incidents as identified during the Site Audit and investigate, record and report on those incidents internally and externally as appropriate.

In relation to feedback and complaints:

* Feedback is entered into the ECMS platform. Consumer feedback is captured through residents meeting where it is a standing agenda item and feedback forms are provided with admission packs and available throughout the service. Consumer surveys are conducted on a regular basis and have included the dining experience, menu review, sleep environment and the homes response to COVID outbreaks. The audit team was supplied with a copy of all resident surveys conducted in the previous 12 months.

In relation to continuous improvement:

* The service has a CIP which records improvement initiatives under the Quality Standards and contains 35 initiatives, of which 33 were added in the previous 5 months.

In relation to regulatory compliance:

* Management read, and have familiarised themselves with the Commission’s guidance material on restrictive practices. Management refute staff did not have knowledge of restrictive practices, however acknowledged the registers could be improved and have since enhanced the documentation system and registers.

In relation to workforce governance:

* Training was not possible in Victoria during 2021 and 2022 due to COVID lockdowns, and restrictions placed on aged care staff. The home used online training resources to deliver and support onsite education. Fire safety training was scheduled prior to the audit and had since been completed on 23 May 2023. Clinical staff who regularly administed medications had completed their medication competency written tests.
* Management were unable to confirm staff compliance with mandatory training due to the absence of an admin assistant during the visit. Management said they could get the online education provider to retrieve records, but that it may take some time.
* The service had in place a behaviour care plan for all appropriate residents however, it was not in the format the team member wanted.

I considered the evidence in the site audit report, and the material provided by the Approved Provider in its response on 21 June 2023. I am satisfied that its actions are acceptable, and, at the time of the site audit, the service was compliant with Requirement 8(3)(c).

*Requirement 8(3)(d)*

The Assessment Team considered this Requirement as Not Met, as it considered the service does not consistently and appropriately identify, record or report incidents when these occurred.

The Assessment Team identified the following issues:

* The service did not always identify the affected consumer, and record interventions for their safety and wellbeing. One consumer was involved in 2 incidents of verbal aggression where he was identified as the alleged aggressor. He was verbally aggressive to another consumer. The Assessment Team identified whilst the service had recorded an incident within the service’s IMS under the first consumer, and reported the incident to police, it had not recorded the incident in either the service’s IMS or assess the incident for reporting via the SIRS portal for the second consumer. Management confirmed the incident had not been recorded for the second consumer, including no record in his progress notes of any safety or wellbeing follow up to be carried out, and no SIRS report made.
* A review of consumer pressure injuries and wounds identified staff did not always complete incident forms for wounds as required by organisational policy, nor could the service demonstrate wound management training was completed for care staff undertaking simple wound dressings.

The service provided the following information in its response of 21 June 2023:

* There was no report to the police on this occasion for this incident. The second consumer did not require physical or emotional support following the incident, only the first consumer was distressed. There was no SIRS report as the second consumer did not require any medical or psychological treatment as a result of the verbal outburst. Next of kin for both parties were notified. The DON or DDON reviewed incidents daily or as reported on weekends, and said this didn’t meet the criteria or situation of Serious Incident Reporting.
* There is evidence all incidents are reported monthly to the Board. Incidents are reviewed and evidence is available of analysis by the DON. The DON is notified of any SIRS or potential SIRS immediately. Staff had been requested to tease out further details as a result of the audit, however the home refutes incidents are not managed appropriately.
* The DDON acknowledged the discrepancy in policy, however in the case of the stage one pressure point cited in the report, there was no wound and no injury, thus no incident report. The site report confirms preventative care by staff with the support of pressure relieving aids resulted in no wound or injury, therefore no need to register an incident. The wound policy is being reviewed currently.

I acknowledge the Approved Provider’s response; however, I note its actions were not in accordance with the requirements for a reportable incident as defined by the Aged Care Quality and Safety Commission.

Management at the service did not demonstrate a full understanding of its obligations, and the service has not met its reporting responsibilities against the Aged Care Quality Standards. Therefore, I find the service was non-compliant with Requirement 8(3)(d) at the time of the site audit.

*The remaining Requirements:*

Consumers assisted the organisation in the development, delivery and evaluation of care and services provided. Management confirmed this. The service involved consumers and their representatives in the development of service delivery.

The organisation’s governing body promoted a culture of safe and inclusive care, and was accountable for the delivery of safe, quality care and services. Consumers and representatives felt safe, and lived in an inclusive environment with access to quality care and services.

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)