Performance

Report

**1800 951 822**

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| Name of service: | Fairway Rise |
| Service address: | 2 Toogood Drive LINDISFARNE TAS 7015 |
| Commission ID: | 8111 |
| Approved provider: | Southern Cross Care (Tas) Inc |
| Activity type: | Site Audit |
| Activity date: | 10 January 2023 to 12 January 2023 |
| Performance report date: | 22 February 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 Fairway Rise (**the service**) has been prepared by D.Fekonja, 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 on 7 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 | **Non-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)(b)

* Ensure medication is stored appropriately and administered as prescribed.
* Ensure medical directives are followed and the information is up to date in care planning documentation.
* Ensure incidents are reported within timeframes and staff are aware of the procedures for reporting and investigating incidents.

Requirement 3(3)(d)

* Ensure staff have been fully trained in the recognition and process to follow when a consumer presents with stroke-like symptoms.
* Ensure medical review is sought in a timely manner when consumers show signs of illness or deterioration.
* Ensure there is ongoing communication with representatives when a consumer deteriorates.

Requirement 4(3)(f)

* Ensure food is served to consumers in an appetising manner, at the correct temperature and at the time of their choosing.
* Ensure consumers are able to choose an alternative of their choice at all mealtimes.
* Ensure morning and afternoon tea is served to all consumers daily.
* Ensure the consumers have a say in the type and quality of the food that is served by the service.

Requirement 8(3)(d)

* Ensure incidents are identified and reported in legislated timeframes.
* Ensure all risks are identified and effectively mitigated and managed.

# 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

The service is treating consumers with dignity and respect and the staff understand consumer preferences and choices in care delivery. Care plans were individualised and reflected what was important to consumers including their values and goals. Consumers and their representatives said the service provides care and services that are culturally safe. The Charter of Aged Care rights is displayed in the service’s front foyer and the service has policies and procedures, including the cultural policy, to align with dignity and respect for the consumer.

Staff use keywords in consumers’ preferred language to help with communication, which are placed outside their doors. Consumers who identify as indigenous feel that staff are aware of and respect their culture.

Consumers and their representatives said the service supported the consumers to exercise choice and independence and decision-making about how care and services are delivered to meet their needs. Care planning documents and charts reflect the choices made by consumers are maintained.

Staff support consumers to connect inside and outside the service and maintain relationships with family and friends by encouraging and assisting the consumers in making these connections with people important to them.

Consumers interviewed by the Assessment Team were satisfied that the service supported their choices and preferences, however, the service has not ensured all risks are managed to prevent harm to consumers and staff. Consumers who warm up food in a microwave in their room did not have risk assessments completed to ensure food is safe to eat and the consumer is not at risk. Following this feedback, the service stated they would review all consumers with equipment in their rooms, and a risk assessment would be completed.

Consumers and their representatives are satisfied that the information they receive is current and accurate and communicated in a clear and timely manner. Information provided to consumers includes the menu, news regarding events occurring at the service and activities for the week through posters displayed on noticeboards. There are announcements over the public address system of activities occurring, and a notice handed to consumers each week of what is on offer at the service.

The service has policies and procedures regarding the confidentiality of personal information and disclosure of information. Consumers stated that staff respect their privacy by knocking on doors prior to entering and ensuring personal care is done behind closed doors. One consumer however said that staff don’t always wait to be invited in after knocking on the door and just enter the room. Observations of staff practice by the Assessment Team demonstrated that staff respected consumers’ privacy.

Although there were some gaps identified in relation to risk assessments these were rectified during the site audit by the service. Most consumers and their representatives were satisfied that their privacy was respected. One consumer stated that although staff knock on the door they do not wait to be invited to enter. Overall the Assessment Team observed good practice in relation to respecting consumer privacy.

I am satisfied the service is Compliant with all Requirements of this Quality Standard.

# 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

2(3)(a)

The Assessment team found this Requirement not met on the basis of the service not consistently identifying and assessing risk for restrictive practices for consumers subject to mechanical or chemical restraint.

In relation to Requirement 2(3)(a) consumers and representatives provided generally positive feedback on their involvement in the assessment and care planning process. A review of 6 consumers’ care planning documentation reflected comprehensive assessment and care planning interventions that consider risks such as falls, skin integrity, pressure injury, and dietary intake.

However, in relation to restrictive practices, for one consumer who used an electric recliner chair during the day, staff were turning the power off regularly, which did not allow the consumer to use the controls. The service stated this was due to the consumer falling when raising the chair with the controller. The representative confirmed there were discussions with staff around their concerns with this mechanical restraint practice and another mechanical restraint practice used by staff in relation to a small table placed under the footrest of a previously used manual recliner chair, which prevented the consumer’s movement. The representative was also concerned it took a while to get bed and chair sensor equipment in place, even though the consumer was assessed as a high falls risk. The care file review on 10 January 2023 did not reflect authorised informed consent was obtained for this restrictive practice. No documented interventions directing staff to turn off the power to the recliner chair were viewed in the care plan on 10 January 2023.

Following an incident involving the consumer falling from the chair on the first day of the site audit, consultation with the consumer’s representative was held on the evening of 10 January 2023, resulting in authorisation for the initiation of mechanical restraint. The care plan was updated and reflected the restrictive practice for the consumer’s fall prevention strategies. The consumer also uses a low bed and bed mats due to falls from the bed and the Assessment Team observed sensor equipment on the chair and bed.

The service’s initial assessment and care planning process includes a consideration of risk. A range of clinical assessments are required on entry and a comprehensive suite of assessments is to be completed per a 28-day schedule.

The Approved Provider in their response provided evidence of physiotherapist assessments in relation to the trial and use of a variety of chair variations for the named consumer, as some were not compatible with the consumer’s transfer equipment. The Approved Provider does not consider turning off the power as mechanical restraint as it is done to ensure the safety of the consumer due to their mobility issues. Notwithstanding that, consent has been sought from the representative in relation to restrictive practices.

The Approved Provider was able to provide evidence that assessments that considered risk had been conducted in relation to this consumer and the service also disputes the consumer is subject to mechanical restraint, as the consumer has low mobility and the chair is used for therapeutic and comfort purposes. I am satisfied that the service now has all authorisations in place for use of this mechanical restraint and has conducted assessments regarding the use of the chair. I am also persuaded by the positive feedback provided by the majority of consumers and representatives.

I find the service Compliant with Requirement 2(3)(a) of the Quality Standard.

I’m satisfied the service is Compliant with the remaining Requirements under the Quality Standard as per the findings outlined below:

Assessment and care planning documentation reflected the consumers’ current needs and includes information on advance care plans. Consumers and representatives are satisfied that staff are aware of and provide care that is as per their preference, including when those needs and preferences change.

Care planning documentation reflected ongoing collaboration between the service, the consumers and their representatives, and other health professionals involved in their care. Consumers and their representatives are informed about the outcomes of assessments and care plans. Conversations take place and care plans are updated during the regular ‘care partnership record’ discussion or whenever changes to care to occur. Care plan documentation demonstrated the communication of care information to consumers and representatives.

The service conducts assessment and care planning reviews as per the monthly ‘Resident of the day’ schedule, with an evaluation of the planned care every 3 months and a complete review and update of the consumer’s care plan annually. Where consumers have a change in their condition, the care is reviewed in line with the changes, and assessments and care plan interventions were generally updated accordingly.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | 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**

Requirement 3(3)(b)

The Assessment Team found the service did not always demonstrate effective management of high impact risks including behaviour management, weight loss and medication management. Staff were not able to identify high-risk consumers or describe ways to mitigate the risks to consumers. Care planning documents did not always describe processes to manage risks to consumers. Incidents are not always logged or investigated thoroughly and there was no evidence that actions are implemented to minimise a recurrence.

An incident involving one consumer was not reported as required or followed up to prevent a recurrence at the time. The Assessment Team reported it was only due to their feedback in relation to the incident that resulted in the service submitting a report to the Serious Incident Response Scheme (SIRS), a referral to Dementia Services Australia and a case conference with the representative of the consumer. Although the incident report stated that all non-pharmacological interventions were trialled this was not supported by documentary evidence.

In relation to weight loss, one consumer’s weight loss was not recorded and only recorded when weight was gained. The service attributed this to the medical practitioner’s directive that it is to be reported only when the consumer’s weight is recorded as less than 70 kg. The dietitian recommended weekly weighs and fluid monitoring which did not occur.

In relation to medication management, one consumer did not have their medication stored appropriately, and the service at the time of the site audit notified staff of the correct medication management procedure and all ‘unpacked’ medications must be stored safely in the medication trolley.

The Approved Provider acknowledged that the medication was incorrectly stored and educated staff on the correct procedures that must be followed. In relation to the named consumer whose weight loss was not recorded the Approved Provider stated the service followed the directive given by the medical practitioner but acknowledge this was not recorded in the consumer’s care plan. They have updated their electronic system to ensure the information on each consumer’s care plan and assessments reflects all medical parameters.

In relation to the incident and behaviour management, the Approved Provider acknowledges that the incident that occurred in November 2022 was not reported when it occurred but that it was identified during an audit the day prior to the site audit and reported to the Commission on 10 January 2023. Actions were undertaken including ensuring referrals were made and open disclosure was practised with the representative. Further actions include ensuring all staff are educated on SIRS requirements and incidents are discussed at huddles. There was evidence submitted by the Approved Provider that the staff member that failed to ensure interventions were trialled prior to the administering of psychotropic medication, is no longer at the service.

Although the service has undertaken measures to improve its processes in relation to incident management and reporting, and medication management, this is not yet embedded in staff practice and training in SIRS has not yet been provided to staff as per the information in the action plan supplied.

I find the service Non-compliant with Requirement 3(3)(b) of the Quality Standard.

Requirement 3(3)(d)

The Assessment Team based on feedback from consumers and representatives found the service did not recognise and respond to deterioration in relation to a consumer who had suffered a medical episode, nor did it communicate another consumer’s further decline in health to their representative.

One consumer had to request medical intervention themselves when they experienced changes to their functional capacity and was found to have suffered a transient ischaemic attack. Vital signs and observations were completed and a telehealth consultation with a geriatrician was conducted 2 days after the consumer first experienced symptoms. The geriatrician referred the consumer for a medical review by a general medical practitioner. However, initially, it was only at the request of the consumer that medical examinations were conducted. The consumer stated there was no referral made to the medical practitioner and the consumer was only reviewed by the medical practitioner as they approached the medical practitioner when they came to the service 6 days after the first symptoms occurred.

Another consumer’s deterioration was recognised and responded to but the representative was not contacted following the recognition of the further decline of the consumer. This will be further explored in Requirement 3(3)(e).

The Approved Provider has already undertaken education in relation to the identification of transient ischaemic attack and stroke symptoms and presentation. There are also actions in the plan for continuous improvement on the identification of deterioration in consumers and concerns to be included in handover information.

Although the service failed to identify the consumer had suffered a transient ischaemic attack, observations were conducted and the consumer was monitored, however, a medical practitioner review was not requested or conducted at the time but 2 days later and at the request of the consumer.

I find that the service on the whole is identifying and responding to deterioration, however, there were deficits in the care of one consumer who had suffered a medical episode later identified as a transient ischaemic attack, which could have led to serious negative impacts for the consumer. Although the service has identified the deficits and has conducted training in relation to this incident the training is not yet fully embedded in the process.

I find the service is Non-compliant with Requirement 3(3)(d) of the Quality Standard.

Requirement 3(3)(a)

The Assessment Team found the service was not consistently able to demonstrate understanding and application of restrictive practices, including identifying and classifying the restraint, ongoing assessment for effectiveness and providing evidence of utilising non-pharmacological interventions prior to administration of ‘as required’ psychotropic medication. Staff interviewed could not explain interventions in place for one consumer subject to chemical restraint and their care file did not evidence the correct procedures were followed. Of 14 instances between October 2022 and January 2023, there was no evidence in documentation that indicated non-pharmacological interventions listed in the behaviour support plan were trialled prior to the administration of psychotropic medication for this consumer. Two instances of the use of ‘as required’ psychotropic medication were not documented at all and the reason for the administration of the medication was documented as ‘restless’ or ‘agitated’.

A second consumer who is not listed as being subject to restrictive practice by the service has a floor line bed and mats on both sides. The consumer who prefers to self-transfer has a history of falls and is not confident mobilising. The consumer was told they have to wait for staff to assist them to get up even though they are able to mobilise. Their representative stated the consumer knows they need to wait for staff to get up. Their mobility plan states ‘please ensure my bed is on lo – lo and crash mats are on both sides’.

The Approved Provider in their response acknowledged the deficit in identifying the use of mechanical restraint in relation to the second consumer and ensured a risk enablement form has been completed to respect their choice of being able to mobilise freely and acknowledge the risk involved. A review has been carried out to identify all consumers subject to restrictive practices at the service.

In relation to chemical restraint, the Approved Provider has provided education to staff in relation to restrictive practices and the use of non-pharmacological strategies and interventions prior to the use of ‘as required’ psychotropic medication. Evidence was provided of staff utilising these strategies prior to the use of chemical restraint for consumers named in the site audit report in progress notes for dates following the site audit. Performance discussions were held with staff who were not following the correct process.

Consumers and their representatives expressed satisfaction that consumers’ personal care needs and preferences are being met. The service demonstrated that the service has effective pain and wound management and provides effective care for consumers with complex clinical care needs such as urinary catheter management and diabetes management.

Whilst the Assessment Team found this Requirement was Not Met, I have come to a different view based on the improvements made by the Approved Provider in relation to the effective management of restrictive practices.

I am satisfied the service is Compliant with Requirement 3(3)(a) of this Quality Standard.

Requirement 3(3)(e)

The Assessment Team observed staff communicating with allied health providers and exchanging information regarding consumers in huddles and handovers. Information in the electronic care documentation system provides a list of tasks to be completed as part of each staff member’s role. Wound management, reviews and charting tasks are assigned to each rostered clinical/care staff member. Allied health providers generally document information directly into consumers’ electronic care files

The Assessment Team found this Requirement Not Met based on feedback from consumers and representatives. There was mixed feedback from consumers and representatives regarding the level of communication provided by staff and management in relation to the consumers’ condition, and changes in care and services. Representatives wanted better communication in relation to relevant and updated consumer information. Some stated they are only contacted after an incident and others would like better communication when the consumer is seen by allied health professionals.

One consumer had deteriorated on 4 December 2022 and the consumer’s representative was contacted by the service when the initial deterioration was identified. The representative was not satisfied that there was no daily communication of the consumer’s condition and communication was only received when the consumer’s condition had deteriorated further on 8 December 2022. There was ongoing communication by the service from 8 December 2022 with the family of the consumer until the consumer passed away on 11 December 2022. The representative said they expected a daily update on the consumer’s condition following an urgent medical review occurring on 5 December 2022.

The service included improvements to be made in relation to this feedback on its plan for continuous improvement with training to be conducted on 23 January 2023.

The Approved Provider in its response acknowledged improvement in communication with consumers and representatives is required. They were able to provide information that refuted some of the claims made by representatives in relation to the lack of communication.

Based on the evidence provided in its response and the evidence of effective communication between the service and others involved in the care of the consumers, I am satisfied that the service is Compliant with Requirement 3(3)(e) of the Quality Standard.

I’m satisfied the service is Compliant with the remaining Requirements 3 under this Quality Standard as per the findings outlined below:

Consumers and representatives confirmed that staff consult with them in relation to the consumer's needs, goals and preferences when nearing the end of life. Consumer information is reflected in the advanced care plan regarding their goals and wishes related to end of life care. Staff demonstrated an understanding of the needs of consumers nearing the end of life.

Consumers and their representatives said they are satisfied they have access to a general practitioner and other health professionals when required. Care planning documentation reflects timely and appropriate referrals and specialist recommendations are reflected in the consumers’ care documentation.

The service demonstrated clinical oversight of antimicrobial use, adherence to therapeutic guidelines and confirmation of pathogen sensitivity through pathology testing. The clinical care coordinator is the appointed infection prevention and control lead who conducts regular daily spot checks, and monthly auditing of the service’s preparedness for outbreaks and the service’s registered nurses assist in the assessment of staff competencies in hand hygiene and PPE usage.

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

Findings

Requirement 4(3)(f)

The Assessment Team stated the service operates a cook-chill food production service for 3 of the organisation’s service sites. The Assessment Team found the service Not Met in this Requirement based on feedback from consumers and representatives. Ten of 12 consumers were critical of the meals offered at the service stating they were overcooked, lacking in flavour, not presented in an appetising manner and they were not offered alternatives.

One consumer stated they are consistently fed meals they cannot eat due to their medical condition. Their family provides frozen home-cooked meals they heat up in their microwave oven. They once requested an alternative of a cheese and tomato toasted sandwich but did not receive what they requested as the service did not have tomatoes.

Most consumers complained that the menu had been discussed with them one week in advance, and they find this hard to remember. They stated that if they request other options, such as sandwiches on the day, the staff do not provide them because they did not order them in advance. Consumers who prefer their meals served to their rooms, said meals do not arrive until 1:15 pm at lunchtime and 6:00 pm at dinner time. These consumers stated that when meals arrive the food is cold, and 4 consumers said they need to warm up their meals in the microwave ovens in their rooms. The Assessment Team observed morning tea being served at 11.15 am and staff stated this was due to staff shortages and on occasion morning or afternoon tea is not served to consumers. Catering staff stated there were limited numbers of alternative meals and therefore some consumers remain hungry. One consumer provided a photo of their meal and it consisted of one scoop of mashed potato and two small sausages. Another consumer stated the service doesn’t serve them enough food and they feel they have lost weight, which was confirmed by fluctuations in the consumer’s weight as per their care file.

The Approved Provider in its response stated food is freshly cooked in their production kitchen and is not a cook-chill production as documented by the Assessment Team. The food is cooked and transported using electric boxes which are heated to a temperature of 80 degrees and taken to the main servery. A review of the catering options was undertaken in May 2022 in response to consumer feedback and food focus groups also provided input. All menus are reviewed by a dietitian and are seasonal and served on a four-week cycle with the option of two cold and two hot options for each of the three meals served daily. There was a food focus group on 9 January 2023 and there were 11 consumers involved. Although there were no real complaints raised at this meeting there were a number of suggestions in relation to the vegetables and desserts served.

The food temperature records show that there can be a fluctuation of up to 7 degrees between the first meal served and the last but these are within acceptable service parameters when measured at the servery. There can be a difference of up to 2 hours from the first meal served to the last, especially at breakfast and dinner times. There was no evidence as to the time taken to serve the last meal from the servery to the consumer and the temperature may fluctuate further. There is also a change of texture and quality of food when served in ‘thermos’ plates and covers. As there is only one trolley to serve morning and afternoon tea for each wing and this can take an hour to complete.

I find the available evidence including negative consumer feedback and the plan for continuous improvement submitted by the Approved Provider demonstrates that food has been an ongoing concern at the service. Although the service has made some adjustments to ensure that food is available and served consistently this is not always occurring. The use of ‘thermos’ plates affects the quality of the food, thus impacting the consumer enjoyment of the food and reheated food also loses quality according to some of the consumers.

I find the service is Non-compliant with Requirement 4(3)(f) of the Quality Standard.

I’m satisfied the service is Compliant with the remaining Requirements under this Quality Standard as per the findings outlined below:

Consumers and their representatives described how they were supported to engage in what they wanted to do and how their individual preferences are respected. Staff described how the service supported consumers to maximise their independence, well-being and quality of life. Care planning documentation identified consumers’ choices and provided information about the services and supports needed to help them do what they like.

Consumers and their representatives said the consumers’ emotional, spiritual, and psychological well-being is supported. A range of in-house religious services are offered, and consumers are assisted to attend the service of their choice. The service demonstrates that information about consumers’ conditions, needs and preferences is communicated within the organisation and with others where responsibility for care is shared.

The service offers the consumers services that enable them to participate in the community, have relationships and do things of interest to them. Staff described how they support consumers to do the things of interest to them, participate within and outside the service environment and have social relationships. Care planning documentation contained information on individual consumers’ interests and identified the people important to them.

Timely and appropriate referrals are made to other organisations, individuals and providers of other care and services. Consumer care planning documentation reflects that the service collaborates with external providers to support the diverse needs of consumers.

Consumers and staff were satisfied with access to suitable and well-maintained equipment. Equipment was observed to be clean, well-maintained and available to meet the needs of consumers.

# 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

Consumers said they feel comfortable and at home at the service. They feel they belong in the service and can easily move around. They said that their visitors are made to feel welcome. Staff said that they do their best to make the consumers feel at home and comfortable and support them to be as independent as possible by allowing them to do as much for themselves as possible while supervising them as necessary.

The Assessment Team observed staff interacting with consumers in a friendly and comforting way and assisting them to be independent. The Assessment Team also observed that the service was well-lit and easy to navigate with ample signage and that the corridors were wide and clear of clutter. The indoor and outdoor areas of the service were clean and maintained. The floors, carpets and windows were clean.

Maintenance programs include essential services, preventative maintenance schedules, reactive maintenance processes and the use of external contractors when required. Consumers and their representatives commented positively on how the rooms, communal areas and outdoor areas are maintained.

Preventative and essential services maintenance is scheduled with documents viewed confirming regular preventative maintenance occurs with oversight of the organisation. Reactive maintenance is documented on logs and maintenance signs off when issues are resolved. The Assessment Team noted that a timely resolution occurred.

The Assessment Team observed a range of equipment available to meet consumers’ care and clinical needs. Staff effectively demonstrated the maintenance process in the event equipment was required to repair and were aware of the need to keep sanitiser wipes nearby and clean shared equipment before and after use.

I am satisfied the service is Compliant with this Quality Standard.

# Standard 6

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

Findings

Advocacy, feedback, and the Commission complaint brochures are displayed at the service entrance as well as on notice boards throughout the service, however, not all consumers and representatives were aware of how to access these services. Staff were not able to describe other methods of raising and resolving complaints. This feedback was provided to the service who then sent emails describing all methods of making a complaint and included a copy of the consumer handbook. The Assessment Team viewed the service’s documentation of consumers and representative complaints made to the Commission.

Consumers and their representatives said that they felt comfortable providing feedback and making complaints. Staff described assisting consumers and their representatives to raise concerns. Documentation including ‘Resident and Representative’ meeting minutes and feedback systems demonstrated the service encourages and supports feedback.

Most consumers and their representatives who had provided feedback or raised a complaint were satisfied with the resolutions. Evidence provided by the Approved Provider showed that the service uses open disclosure and apologises when things go wrong. All staff interviewed by the Assessment Team were able to describe open disclosure principles in handling complaints and when informing family members about incidents.

Not all consumers were satisfied that complaints resulted in improvements to the service. However, the Assessment Team viewed the plan for continuous improvement and the complaints raised were used as the basis in most cases for improvements to be made. For example, there has been numerous feedback from consumers in relation to food. One action item listed in the plan for continuous improvement is based on feedback from consumers requesting enough prepared sandwiches available as an alternative to meals at all times.

I am satisfied the service is Compliant with this Quality Standard.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Although consumers and representatives expressed concern that there were not enough staff at the service to meet their needs, the Assessment Team found that the roster showed minimal unfilled shifts. Consumers felt call bell response times were lengthy but this was not reflected in the call bell report data. The Assessment Team observed sufficient staff working in each unit and service delivery areas across the 3 days of the site audit. There were some catering staff shortages that affected morning and afternoon tea on occasion, but the Approved Provider in response to Standard 4 Requirement 4(3)(f) has outlined that staff have been added to prevent this from occurring in the future.

Consumers and their representatives said that most staff are kind, respectful and caring and observations by the Assessment Team confirmed this. All staff showed that they know their consumers, their choices, needs and preferences.

Consumers and their representatives said staff perform their roles effectively, and are confident staff are skilled to meet their care needs. All staff are required to complete mandatory training as well as regular refresher training. All clinical and care staff said the service provides mandatory and additional training to support them to provide quality care. Care staff said that they had been supported to complete additional training in the Montessori program.

Staff training needs are identified through feedback from consumers, representatives, and staff, through performance appraisals, observations, audits and incidents. The service recently conducted staff training for all clinical and care staff in relation to the deteriorating resident and transient ischemic attack and stroke as a result of a consumer’s unrecognised transient ischemic attack.

The training is monitored and followed up by management at the service as required. Position descriptions specify roles and responsibilities to their particular role and staff are required to have relevant qualifications and registrations. The Assessment Team reviewed education documentation which identified staff have the knowledge and skills to meet consumer needs, preferences, and organisational processes.

Performance reviews are conducted annually for all staff and after an initial probation period for new staff. The Assessment Team reviewed the performance review schedule and noted that all performance reviews are currently up-to-date.

I am satisfied the service is Compliant with this Quality Standard.

# Standard 8

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

Requirement 8(3)(d)

The Assessment Team found this Requirement Not Met based on the service not consistently identifying and reporting risk as per the service’s processes. The Assessment Team identified 4 consumers who were not risk assessed in relation to the use of restrictive practices. Two consumers were subject to mechanical restraint, with the equipment employed for their safety. Two consumers did not have current authorisations in place for chemical restraint, with one consumer’s progress notes not reflecting the service’s process was followed when the ‘as required’ medication was administered for their escalating behaviour.

There was also a risk that was not identified with consumers using microwaves in their rooms to heat food prepared in the service or provided by others outside of the service. The service ensured that risk enablement assessments were conducted when it was provided with this feedback during the site audit.

An external consultant completed an audit of the service’s care documents to assist in identifying risk, which resulted in 9 incidents reported out of the recommended time frame to SIRS. A reportable incident that occurred in November 2022, involving unreasonable use of force between two consumers was not reported or identified until an audit was conducted in January 2023.

Although the Assessment Team reported the incident was only identified following their feedback, the Approved Provider was able to provide evidence it was identified the day prior to the commencement of the site audit and reported to the Commission on the day the site audit commenced. The service conducted an investigation and referred one consumer for review by a specialist dementia provider.

Although the Approved Provider has taken steps to make improvements in the way they identify risk in relation to restrictive practice and reportable incidents, I am not satisfied the processes are fully embedded in the service’s practice and they are not effectively identifying risk.

I find the service is Non-compliant with Requirement 8(3)(d) of the Quality Standard.

I’m satisfied the service is Compliant with the remaining Requirements under this Quality Standard as per the findings outlined below:

Consumers and their representatives are engaged in the development, delivery, and evaluation of services. All consumers felt empowered to provide feedback to staff and management about their care and services. One consumer has been selected to be the consumers’ representative and it is their role to ensure the consumers’ voice is heard in ‘Residents meetings”.

Consumers and their representatives said they feel safe and are living in an inclusive environment providing quality care and services. The Approved Provider consulted with staff, consumers and their representatives about the proposed implementation of a new model of care but some consumers and staff did not always feel they were able to voice their concerns freely in relation to this topic. However, this is in contrast to the feedback provided to the Assessment Team in Requirement 6(3)(a) where consumers and representatives stated they felt comfortable providing feedback and making complaints.

There are processes and mechanisms in place for effective organisation-wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, feedback and complaints. The service’s plan for continuous improvement incorporates information obtained from mechanisms such as consumer, representative and staff feedback, observations, incidents, and internal audits.

The organisation’s clinical governance framework includes policies and practices for antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff have received training in these clinical governance areas and were able to explain the principles outlined in the policies. Documentation was not always completed as per the organisation’s policies and procedures in relation to restrictive practices. This has been covered more specifically in Requirement 3(3)(a).

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)