Performance

Report

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| Name of service: | Geoffrey Cutter Centre |
| Service address: | Kenny Street BALLARAT EAST VIC 3350 |
| Commission ID: | 3515 |
| Approved provider: | Grampians Health |
| Activity type: | Site Audit |
| Activity date: | 21 February 2023 to 23 February 2023 |
| Performance report date: | 4 April 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 Geoffrey Cutter Centre (**the service**) has been prepared by Stewart Brumm, 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 24 March 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 | **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 | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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 Assessment Team provided information that the Approved Provider demonstrated consumers’ cultural needs are respected and consumers can express their individuality without judgement. Staff could describe consumers’ cultural and spiritual needs that influences consumers’ delivery of care and services.

The Approved Provider was able to demonstrate how consumers are supported to exercise choice and independence about the way their care and services are delivered, and how consumers are supported to remain connected and maintain personal relationships. The service has person centred care policies to guide staff practice and Staff demonstrated knowledge and understanding of sampled consumers’ preferences and choices and described how each consumer is supported to make informed decisions about their care and services such as meals and leisure activities.

Most consumers said they are supported to take risks to enable them to live the best life they can through making their own decisions involving risk.

The Approved Provider was able to demonstrate how consumers’ privacy is respected by staff and how the organisation’s information management systems keep information confidential. Consumers/representatives interviewed confirmed consumers’ personal privacy is respected. They gave examples, such as staff knocking on doors and announcing themselves before being given consent to enter their rooms, staff allowing them privacy when praying or spending time with significant others, and staff keeping their personal information confidential except where the consumer had given permission for the information to be shared.

In relation to Requirement 1(3)(a) the Assessment Team provided information that the Approved Provider was unable to demonstrate staff consistently treat consumers with dignity and respect. Processes to monitor staff are treating consumers with dignity and respect have not been effective. Consumers are not consistently satisfied with the manner in which staff treat them. Staff did not demonstrate a shared understating of how to treat consumers with dignity and respect. Consumers’ care documentation did not consistently reflect respectful language.

At the time of the audit management acknowledged consumers were not being treated by staff consistently in a respectful and dignified manner. Staff dignity and respect training was completed during the site audit which 25 staff attended. Management advised the Assessment Team that consumer dignity and respect training would be ongoing over the calendar year and the training was added to the staff education calendar.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as education records and training material, consumer survey results, meeting minutes, photographs, case conference information and clinical records extracts.

Since the site audit, the Approved Provider has continued education for staff on dignity and respect, conducted surveys of consumer satisfaction, met with named consumers to address concerns raised, and has removed doors within the service to increase freedom of movement.

I note that increased level of satisfaction with the staff from the consumer survey conducted after the education on dignity and respect was provided. I note the positive consumer/representative feedback identified by audits, raised at consumer meetings, and captured during meetings with named consumers.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider, that has resulted in increased staff awareness of their roles and responsibilities and the improved overall consumer satisfaction identified through meetings and surveys.

Based on these improvements and the positive consumer/representative feedback, I find Requirement 1(3)(a) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# Standard 2

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

Findings

The Assessment Team provided information that the Approved Provider was able to demonstrate consumers’ care is planned to meet consumers’ care needs and preferences, with strategies to manage risk to consumers’ health and wellbeing. Consumers interviewed were satisfied with their care and Registered staff could describe the assessment and planning process for consumers care and service needs.

The Approved Provider was able to demonstrate consumers’ assessment and care planning processes include consideration of consumers’ current needs, goals and preferences, including end of life care. Staff could describe how they begin discussions with consumers/representatives regarding end of life planning on consumer entry to service and as consumers move towards end of life.

The Approved Provider was able to demonstrate consumers are involved with the planning of their care and services which includes their representative and other organisations when required. Registered staff could describe the referral processes to include other health care services involved in the care of the consumer. Consumers’ care and services plan is effectively communicated to consumers/representatives and documented and accessible for staff and visiting health care workers providing consumer care.

While the Approved Provider was able to demonstrate all sampled consumers’ care and services are evaluated monthly for effectiveness during the resident of the day review and when incidents occur; for consumers who have returned to or entered the service from hospital review of consumers care was not consistently effective.

I have considered the information presented by the Assessment Team, I note some inconsistency in review of consumers care needs following entry from or transfer from hospital, however I have considered the impact of this under Requirement 3(3)(a).

I am persuaded by the overall positive consumer feedback and staff knowledge of the systems and processes to meet the Requirements in this Standard.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# Standard 3

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

Findings

The Assessment Team provided information that the Approved Provider demonstrated effective processes to manage high impact or high prevalence risks associated with the care of each consumer.

End of life care preferences are documented in consumer’s care and service plans; registered staff could describe the service’s palliative care policy and end of life planning. Care staff can access community palliative care services to support end of life care.

The Approved Provider demonstrated staff recognise and respond to consumers’ deterioration in mental health and cognitive or physical function in a timely manner. Consumers said staff respond to their needs quickly and care documentation demonstrates staff recognise changes to the consumer’s condition and consumers/representatives said staff and other health professionals knew their care needs and health concerns.

The Approved Provider was able to demonstrate practices to minimise infection related risks and antimicrobial stewardship is promoted.

In relation to Requirement 3(3)(a) the Approved Provider was able to demonstrate most consumers receive effective clinical and personal care that is best practice, individualised and optimises consumers’ health and well-being. However, consumers who enter or return to the service from hospital were not consistently receiving effective clinical care due to the service not having a post hospital admission process to guide staff practice; and some consumers were subject to environmental restrictive practice without consent due to staff not having a shared understanding of the capacity of consumers to make decisions and consent to an environmental restrictive practice.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as education materials, apology letter, clinical records extracts, consumer feedback information, and dignity of risk forms and register.

Education on skin assessments have been completed by the clinical staff, additionally education on restrictive practice has been completed. I note that 12 consumers have been reviewed for risks associated with environmental restraint and where practical, dignity of risk has been discussed with the consumers, and the right to take risks acknowledge by the Approved Provider.

In regard to the named consumer and unmanaged weight loss, the Approved Provider has demonstrated the process followed for this consumer and the medical referrals and interventions that occurred. I am satisfied from this response that the consumers’ care needs, including weight were being managed with support from the medical officer.

In regard to the named consumer with mobility issues and potential restrictive practices. I note from the Approved Provider response that additional physiotherapist and medical officer reviews have occurred, as well as a case conference with the consumer and their representatives. I note the consumer has been provided the code to the front door, however I also note the medical advice about being unsafe to mobilise outside the service independently. I am satisfied with the Approved Providers actions and management in regard to this consumer.

In regard to the named consumer and potential restrictive practice, I note the consumer has again been provided the door code and the door code is displayed at the door. I also note the consumer has no independent mobility. I am satisfied with the Approved Providers actions and management in regard to this consumer.

In regard to the named consumers and potential restrictive practice, I note a case conference has been held with the consumers and the representative. It was decided at this case conference that the consumers would not be provided the door code, and they are subject to environmental restraint. However, I also note the representatives’ positive feedback on the removal on internal doors at the service, which has increased access around the service. I am satisfied with the Approved Providers actions and management in regard to these consumers.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider, that has resulted in education being provided to staff, management of risk for consumers, overall management of named consumers and consumer/representative positive feedback.

Based on these improvements and the positive consumer/representative feedback, I find Requirement 3(3)(a) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team provided information that the Approved Provider was able to demonstrate consumers are supported with safe and effective services to meet their daily living needs and remain independent. Consumers were able to describe how they are provided daily living supports to do the things they want to do. Staff were able to describe the assistance that consumers required to meet their daily living, and how the support they provide to consumers ensures they remain safe.

Consumers/representatives said the service acknowledges their cultural and religious practices and that they celebrate days that are meaningful to them. Staff were able to describe the cultural and spiritual needs of the consumers interviewed and how they have received training in recognising and responding to consumer’s diverse needs.

The Approved Provider was able to demonstrate that staff know consumer’s individual preferences and that they get what they need and do not have to repeat their requests. Consumers/representatives said staff know what they want and ensure their requests are communicated within the service and to other providers of care and services.

Consumers have timely and appropriate referrals to other individuals, organisations or providers and described how they collaborate to meet the diverse needs of consumers.

Most consumers/representatives said they are able to choose suitable and healthy meals, snacks and drinks and where required receive special dietary foods.

Equipment is safe, suitable, clean and if there are any concerns or issues reported, they are managed by maintenance staff in a timely manner.

In relation to Requirement 4(3)(c) the Assessment Team provided information that the Approved Provider is supporting consumers with social and personal relationships, however, were unable to demonstrate consumers participate within their service environment due to limited activities. Named consumers reported being bored, a lack of weekend activities, and a lack of choice of activities. Staff said consumers are often left with nothing to do as there are very limited activities for consumers to participate in.

At the time of the audit Management acknowledged to the Assessment Team that the service has limited activities for consumers to choose from and that the organisation’s activities coordinator will work with consumers to develop and plan a suitable activities program. A weekend calendar was developed and provided to the Assessment Team following feedback, for activities to be implemented on Friday, Saturday and Sunday commencing immediately.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as an action plan to support meaningful engagement, assessments, activity charts, care reviews, case conference records, feedback register, meaningful life activities program and a guide to providing individualise purposeful engagement within the memory support neighbourhood.

The Approved Provider has created a new position called a Meaningful Life Manager, to develop meaningful life programs at all the Approved Provider services, including Geoffrey Cutter Centre. The Meaningful Life Manager has provided education to staff on completing the new lifestyle assessment forms and has conducted feedback session to monitor the new activity attendance charting. I note the positive feedback from staff on these new processes.

Activities are being provided on Fridays and weekends and additional staff are being recruited to support this increase in activities. I note the positive consumer feedback about the increased and weekend activities. The Approved Provider is purchasing additional resources to support the improved activities program, increased “way finding” signage has been installed to assist consumers and education on managing dementia is planned.

In regard to named consumers, meaningful life engagement reviews have been completed. An additional 38 consumer case conferences have occurred with a schedule to complete a full review of all consumers. Case conferences with me be held bi-monthly or as needed in the future.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider, that has resulted in increased staffing, an increased activities program, improved consumer feedback on activities, as well as monitoring and sustainability processes established with the bi-monthly case conferences.

Based on these improvements and the positive consumer/representative feedback, I find Requirement 4(3)(a) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# 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

The Assessment Team provided information that all consumers/representatives sampled said the service environment is easy to understand and welcomes family. Staff said the service environment provides consumers with several areas to choose from including lounge/activity areas, communal areas and several outdoor seating areas.

All consumers/representatives said they are satisfied that the furniture, fittings and equipment are well maintained and kept clean. The Approved Provider demonstrated that furniture, fittings and equipment are fit for purpose and maintained, safe and clean. Staff were able to demonstrate options for fixing or replacing furniture, fittings or equipment that were unsuitable or broken, and were able to describe the process for raising maintenance requests.

In relation to Requirement 5(3)(b) the Assessment Team provided information that whilst the environment was observed to be clean, well maintained and comfortable, the Approved Provider was unable to demonstrate that consumers were able to move freely around the service environment, both indoors and outdoors as the doors adjoining other residential houses, and unsecured outdoor areas were secured with a keypad. The Assessment Team observed consumers subjected to intentional environmental restraint (with consent in place), as well as other consumers with unintentional environmental restraint, as they said they could not reach the keypad or remember the code.

At the time of the audit the Approved Provider opened the doors between houses and was obtaining quotes to remove the keypads. Management commenced a review of all consumers subject to environmental restraint.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as clinical records extracts, education records, case conference material, consumer feedback, survey results, and photographs.

In regard to the named consumer, who is reported to be subject to environmental restraint and cannot freely leave the premiss to smoke, the Approved Provider has identified this consumer does not smoke and does not seek to leave to smoke. As such I have placed no weight on this consumers reported experience.

In regard to the named consumer and potential restrictive practice, I note the consumer has again been provided the door code and the door code is displayed at the door. I also note the consumer has no independent mobility. I am satisfied with the Approved Providers actions and management in regard to this consumer.

In regard to the named consumers and potential restrictive practice, I note a case conference has been held with the consumers and the representative. It was decided at this case conference that the consumers would not be provided the door code, and they are subject to environmental restraint. However, I also note the representatives’ positive feedback on the removal on internal doors at the service, which has increased access around the service. I am satisfied with the Approved Providers actions and management in regard to these consumers.

I note that all consumers who wish to leave the service have been provided the door code again, however all door codes are labelled on the keypads to support consumers who are unable to recall the code.

All consumers with an environmental restraint have been reviewed by the medical officer for the need for ongoing restraint and the restrictive practices register has been updated.

I also note that certain internal doors have been removed to improve consumer movement around the inside of the service. I note the positive feedback provided by representatives on this improvement.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider, that has resulted in the removal on internal doors to increase free movement of consumers within the service, as well as the review of environmental restraints to ensure the ongoing need for this restrictive practice. I note the positive consumer and representative feedback provided.

Based on these improvements and the positive consumer/representative feedback, I find Requirement 5(3)(b) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# 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

The Assessment Team provided information that consumers and representatives said they are supported to give feedback or make a complaint and said they feel comfortable doing so. Most consumers and representatives interviewed said they are comfortable to voice their concerns and on occasion, are provided with opportunities such as surveys. Management and staff said they openly encourage and support feedback and complaints, and the assessment team reviewed the service’s complaint policy which includes a clear process for all levels of complaints directed to any staff member.

Consumers/representatives sampled are confident management will address and resolve concerns which are escalated and are invited to be involved in solutions. Staff described the principles of open disclosure stating they will apologise and explain to consumers/representatives what went wrong and how they will fix it.

Management described the processes in place to escalate complaints, and how complaints are used to improve the care and services available to consumers.

In relation to Requirement 6(3)(b) the Assessment Team provided information that whilst information about advocates, language services and other methods for raising and resolving complaints is provided to consumers on entry and are available at the service, processes to monitor consumer awareness of the system has not been effective. Consumers reported not being aware of advocates, language services, nor other methods for raising and resolving complaints. Staff could not articulate how they would effectively assist consumers who may have barriers in raising complaints. No consumers/representatives sampled were able to articulate how they would make a complaint to an external body where the service has been unable to resolve their concerns. No consumers/representatives sampled were aware that they could make a complaint to the Aged Care Quality and Safety Commission.

At the time of the audit the Approved Provider created a complaints pack which included information on the various ways to make a complaint, an internal complaints and feedback form, and a brochure for advocacy services. The pack was placed in each consumer’s room and sent out to all representatives.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as a how to provide feedback bundle, feedback and complaints information, survey results, and case conference information.

I note that both the Assessment Team and the Approved Provider response indicate that consumers are provided with on entry and have ongoing access to complaints and advocacy information. I also note that all consumers and representatives have been provided with a how to make a complaint bundle, that includes information on raising a complaint and accessing advocacy. All staff have received training on supporting complaints and feedback.

The Approved Provider has continued to receive feedback and complaints from consumers/representatives since the site audit.

I also note the bi-monthly case conference process that has commenced and will be used as an additional avenue to provide feedback and discuss complaints. These case conferences should ensure sustainability of access to raised complaints.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

Based on these improvements and the ongoing receipt of feedback and complaints by the Approved Provider, I find Requirement 6(3)(b) compliant.

In relation to Requirement 6(3)(d) the Assessment Team provided whilst the Approved Provider has a documented complaints policy and process in place, actions to monitor compliance with the policy have not been effective. Staff are not trained in managing feedback and concerns raised verbally by consumers. These concerns are not captured, recorded, or analysed to identify trends in feedback/complaints or to ensure resolution of the complaint, as the systems put in place by the organisation have failed in monitoring and analysing consumer feedback. Six consumers/representatives interviewed said that concerns raised directly with staff were not always addressed.

Staff were unable to describe a process for capturing and reviewing unsolicited feedback or concerns raised which they believed did not require escalation; contrary to the service’s complaints policy which outlines the documentation and escalation process. Management was unable to describe how the organisation records, analyses and acts on feedback and concerns raised directly with care/registered staff.

At the time of the audit the management acknowledged it was not collecting unsolicited feedback from consumers where the concerns were not escalated. Education was planned for staff on the complaints process. Management contacted named consumers to follow up on concerns and survey results will be discussed with consumers to establish context to the survey results.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as feedback and complaints information, survey results, meeting minutes, clinical records extracts, photographs and case conference information.

I note all staff have received training in feedback and complaints processes.

In regard to the named consumer with mobility issues and desire to leave the service. I note from the Approved Provider response that additional physiotherapist and medical officer reviews have occurred, as well as a case conference with the consumer and their representatives. I note the consumer has been provided the code to the front door, however I also note the medical advice about being unsafe to mobilise outside the service independently. I am satisfied with the Approved Providers actions and management in regard to this consumer.

In regard to the named consumer and lack of a suitable smoking area, I note the Approved Provider has completed the new smoking area and this consumer has free access to the area. I am satisfied with the Approved Providers actions and management in regard to this consumer.

In regard to the named consumer and voiced concerns about the standard of care, I note a case conference has occurred and the representative is satisfied with the actions taken by the Approved Provider. I am satisfied with the Approved Providers actions and management in regard to this consumer.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider that feedback and complaints are reviewed and used to improve the quality of care and services. I note all staff have been provided education on the complaints process. I also note the actions taken in response to complaints raised by the named consumers in the Assessment Team report.

Based on these improvements and the ongoing receipt of feedback and complaints by the Approved Provider, I find Requirement 6(3)(d) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# 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

The Assessment Team provided information that most consumers/representatives interviewed indicated satisfaction with the care and services consumers were receiving. Staff said there were appropriate levels of staff coverage within the service to provide care and services to satisfy consumers’ needs and preferences. The Approved Provider was able to demonstrate that it was operating with sufficient staffing levels, employing a workforce provided with sufficient time to undertake assigned tasks and responsibilities, and aligning with legislated state staffing ratios for publicly run aged care services.

Consumers/representatives provided positive feedback in relation to workforce interactions and confirmed most staff are kind and caring and treat consumers well. Staff demonstrated an understanding of sampled consumers, including their identity, culture, needs, and preferences.

Consumers/representatives sampled described how staff know what they are doing and believe staff have the knowledge and skills to provide safe and quality care and services that meet consumers’ needs and preferences.

Consumers/representatives say the staff do their job well. Staff interviewed confirm they undergo regular performance appraisals, and the Approved Provider is ensuring performance reviews are occurring and staff performance is being monitored.

In relation to Requirements 7(3)(d) the Assessment Team provided information that despite an established mandatory training policy, review of records provided by the Approved Provider demonstrate significant noncompliance in mandatory training by most of the staff employed by the service. The Assessment Team found the service did not have an adequate system to ensure staff are trained, including effective monitoring of compliance with training. Most staff interviewed stated they had not received training in restricted practices, the serious incident response scheme, or the Aged Care Quality Standards.

At the time of the audit the Approved Provider was arranging additional training for staff and add to the plan for continuous improvement actions to develop a tool to monitor completion of education.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as an education records.

The Approved Provider has provided context to the challenges of presenting information regarding this requirement at the time of the site audit. I accept that due to the amalgamation of five services into one larger group of services, and information being on different platforms prior to the amalgamation, the information was challenging to present to the assessment team. I note that the supplied education records and Approved Provider response indicated staff have completed mandatory training to a high percentage of completion, with many being a 100% completion result. Staff who have not completed mandatory training are on/or have been on leave. I also note all staff have completed training on the serious incident response scheme.

I also note ongoing education is being provided around dementia essentials and meaningful life engagement.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the information provided by the Approved Provider to indicate staff have completed mandatory training. I am satisfied the Approved Provider has a process to monitor training, post amalgamation of services.

Based on these improvements and the ongoing receipt of feedback and complaints by the Approved Provider, I find Requirement 7(3)(d) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

# 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. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The Assessment Team provided information that consumers/representatives advised they considered the service to be well run and they can provide feedback and suggestions about care and service delivery to staff directly which, if required, can be escalated to management within the organisation. Management described various ways consumers are supported to be engaged in the development, delivery, and evaluation of care and services.

Consumers reported the service provides culturally safe care in accordance with their preferences. Management demonstrated how the organisation’s governing body promotes a culture of safe, inclusive, and quality care and oversees strategic direction for delivering care against the Quality Standards, and management model expected behaviours.

In relation to Requirement 8(3)(c) the Assessment Team provided information that whilst management and staff could describe the systems and processes of organisational wide governance, the service was not able to demonstrate organisation wide governance systems for information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints are effective. Processes to monitor compliance with organisational policies and procedures have not been effective.

The Approved Provider was unable to demonstrate that it has an effective system in place to monitor staff education, and as such mandatory training in legislative amendments over 2022 in topics such as the serious incident response scheme and restrictive practices have not been completed.

The Approved Provider had not identified a range of deficiencies identified by the Assessment Team during the audit and was unable to demonstrate regulatory compliance relating to the identification and reporting of incidents under the serious incident response scheme nor in minimising the use of restrictive practices.

The Assessment Team identified not all feedback and complaints had been recorded as staff are not trained in or not following the policy, and the service does not have an effective complaints management monitoring system.

At the time of the audit the Approved Provider advised it will implement a performance development review tool, they also lodged the outstanding serious incident response scheme reports and provided evidence of submission to the Assessment Team. Staff education in relation to the identification and accurate submission of reportable incidents was being arranged. As well as additional education for staff in recording feedback and complaints is being arranged.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as education records, case conference information, plan for continuous improvement, restrictive practice information, flowchart, feedback and complaints information and consumer survey results.

In regard to information management, I am satisfied the Approved Provider has a system to monitor staff mandatory education and was able to demonstrate staff have completed the mandatory training, I also note education has been provided on complaints handling and the serious incident response scheme.

I note the Approved Provider maintains a plan for continuous improvements and has demonstrated improvements are completed in relation to identified deficits.

I note any outstanding serious incident response scheme notifications have occurred and all staff have been educated on the serious incident response scheme.

I note consumers/representatives are informed of and have access to a feedback and complaints system, I also note the staff training that has occurred in relation to managing feedback and complaints.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the information provided by the Approved Provider that there are effective organisation wide governance systems.

Based on these improvements and the ongoing receipt of feedback and complaints by the Approved Provider, I find Requirement 8(3)(c) compliant.

In relation to Requirement 8(3)(d) the Assessment Team provided information that whilst processes are in place to manage high impact or high prevalence risks, including through the use of an effective incident management system, some incidents identified in the service’s management system relating to consumer abuse and neglect had not been reported to the serious incident response scheme as there is a lack of understanding around reportable incidents and up to date serious incident response scheme training has not been undertaken by most staff. Additionally, consumers are not always supported to live their best life as the service does not have an effective system to determine the appropriate decision maker.

At the time of the audit, the Approved Provider commenced arranging additional education on the serious incident response scheme for staff.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as education records, mandatory reporting register, and clinical records extracts.

The Approved Provider acknowledged that not all incidents had been reported to the serious incident response scheme as required. A full audit of all incidents was undertaken and with additional incidents reported as required. Education on the serious incident response scheme has been provided to all staff and to ensure sustainability senior clinical staff monitor all incidents daily.

In regard to supporting consumers to live the best life they can, I note the Approved Provider has reviewed all consumers subject to environment restraint to ensure the restraint is necessary and staff have been provided education on restrictive practice. I also note the appointment of the meaningful engagement manager and the additional resources being provided to support consumers in activities and meaningful engagement.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the information provided by the Approved Provider that there are effective risk management systems and practices. I am also pursued by the additional monitoring and sustainability processes implemented included bi-monthly case conferences and daily review of incidents by senior clinical staff.

Based on these improvements and implemented monitoring and sustainability processes find Requirement 8(3)(d) compliant.

In relation to Requirement 8(3)(e) the Assessment Team provided information that the clinical governance framework is not effective in relation to minimising the use of restrictive practices, and consumers were subjected to environmental restrain without appropriate consent. However, understanding and practices by staff in relation to antimicrobial stewardship and open disclosure was demonstrated.

The Approved Provider provided a response that included clarifying information to the Assessment Team report as well as a restrictive practice registers and consents, education records, and clinical records extracts.

I note the deficiencies identified by the Assessment Team related to the use restrictive practice. The Approved Provider has provided education on restrictive practice. I note that 12 consumers have been reviewed for risks associated with environmental restraint and where practical, dignity of risk has been discussed with the consumers, and the right to take risks acknowledge by the Approved Provider. Consents are documented for all consumers subject to restrictive practice and behaviour support plans are established. I also note the introduction of bi-monthly case conference to monitor consumer care delivery, including the use of restraint is needed.

In regard to named consumers in the Assessment Team report and restrictive practice, I am satisfied with the Approved Providers actions and management in regard to these consumers.

I have considered the Assessment Team report as well as the Approved Provider response and I am persuaded by the improvement actions taken by the Approved Provider, that has resulted in education being provided to staff, management of risk for consumers, overall management of named consumers restrictive practice and consumer/representative positive feedback.

Based on these improvements and the positive consumer/representative feedback, I find Requirement 8(3)(e) compliant.

I find all Requirements in this Standard to be compliant and as such the overall rating for the Standard is compliant.

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)