Performance

Report

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| Name: | Glaica House |
| Commission ID: | 0210 |
| Address: | 22 Flora Parade, TUNCURRY, New South Wales, 2428 |
| Activity type: | Site Audit |
| Activity date: | 10 April 2024 to 12 April 2024 |
| Performance report date: | 19 May 2024 |
| Service included in this assessment: | Provider: 1175 Great Lakes Aged & Invalid Care Association Ltd  Service: 226 Glaica House |

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 Glaica House (**the service**) has been prepared by Megha Kalra, 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 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 13 May 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 2(3)(a) – the Approved Provider ensures assessments are completed for all consumers or alternative solutions are identified through assessment or care planning consultation, especially where there may be a risk to consumer’s health and well-being.
* Requirement 3(3)(a) - the Approved Provider ensures each consumer gets safe and effective personal and clinical care, that is best practice, tailored to their needs and optimises their health and well-being, including for the use of restrictive practices.
* Requirement 3(3)(d) – the Approved Provider ensures 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.
* Requirement 7(3)(d) - the Approved Provider ensures training, learning and development needs of the workforce are regularly addressed and reviewed to ensure their practice is improving care outcomes for consumers.
* Requirement 8(3)(c) - the Approved Approver ensures effective governance systems supporting regulatory compliance, specifically in relation to restrictive practices.
* Requirement 8(3)(e) - the Approved Provider ensures where clinical care is provided, there are effective clinical governance systems in place that improve the outcomes for consumers.

# 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 was found non-compliant in Standard 1 in relation to requirement 1(3)(a) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented improvements to address the non-compliance and is now compliant with this requirement. Consumers and representatives interviewed said that consumers are treated with dignity and respect and that their identity, culture, and diversity is valued. Staff generally spoke about consumers in a respectful manner and demonstrated they are familiar with consumers’ individual backgrounds and preferences. Care planning documentation contained respectful language and reflected consumers’ identity, diversity, and specific cultural needs. Lifestyle calendars noted a variety of activities reflecting the cultural backgrounds of consumers and the consumer handbook outlined the right to be treated with dignity and respect.

Most consumers described how staff value consumers' background and provided care that is consistent with their cultural preferences. Consumers and representatives said that consumers are supported to maintain their relationships of choice, and their choices are respected by staff. Staff described how the consumers’ culture is acknowledged and maintained and were observed to demonstrate respect for consumers' diverse cultural backgrounds. Staff described how they support consumers to make choices, maintain their independence and engage in relationships of their choosing. Care planning documentation identified consumers’ individual choices pertaining to how and when care is delivered, who is involved in their care, and how the service supports them in maintaining the relationships that are important to them.

Consumers described how the service supports them to take risks, such as administering their own medications. Staff demonstrated they are aware of the risks taken by consumers, and said they support each consumer’s wishes to take risks but ensure risk mitigation strategies are in place. Care planning documentation for consumers evidenced a risk assessment or documentation of discussion risks prior to commencing the activity.

Consumers and representatives confirmed that they are kept informed through printed information and verbal reminders. Staff described how they provide information to consumers with sensory impairments and assist them to make choices by using visual aids, picture cards and allowing time to understand and respond. The service had systems and procedures in place to ensure that information regarding care and services is provided in a timely, clear, and easy to understand manner to enable consumers to make informed choices. Observations showed activities calendar and daily food menu was displayed throughout the service.

Consumers said their privacy was respected, and their personal information kept confidential. Staff practice was guided by a privacy policy and staff were observed knocking on doors prior to entering the consumers’ room. Staff explained all computer systems are kept secure with password protection to ensure consumer confidentiality is maintained.

# 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. | Not 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

I have found this Quality Standard as non-compliant as I am satisfied requirement 2(3)(a) is non-compliant.

* Regarding requirement 2(3)(a)

The service was found non-compliant in Standard 2 in relation to requirement 2(3)(a) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, these improvements have not been effective to rectify the non-compliance. I find the service non-compliant with this requirement.

I have summarised the relevant evidence below, and other evidence which was not relevant to the Requirement, or which was disproven by the Approved Provider’s response has not been outlined here.

The site audit report identified the service did not conduct relevant assessments, including consideration of risks to consumers’ health and well-being, to determine if the consumers residing in memory support units were subject to environmental restrictive practice due to keypad code required to enter and exit the memory support units. The service did not conduct relevant assessments for consumers who resided in the general wing of the service to determine if they are subject to environmental restrictive practice due to after-hours access to the service requiring pressing a green button to exit and pressing a call bell for staff assistance to enter the service. The site audit report brought forward examples of 4 named consumer care plans, which did not align with consumer preferences.

The Approved Provider responded on 13 May 2024, which included an action plan, education action plan and supporting clinical documentation. The response reiterated the employment of a dedicated registered nurse for assessment and care planning at the service. The response stated the restrictive practice register was not updated at the time of site audit and has since been maintained and monitored for currency and accuracy. The response noted only 4 consumers in the memory support units did not have their environmental restrictive practice assessment completed at the time of site audit, which has since been completed. The response stated consumers outside the memory support units who are not able to press the green button to exit the service can request staff assistance. However, the response did not address if relevant assessments, including consideration of risks and associated interventions, were conducted for consumers to identify if they were subject to environmental restrictive practice due to their inability to enter or exit the service independently after-hours.

I acknowledge the provider’s response reflects continuous improvement implemented in response to the issues identified in the site audit report. However, it is not evident that relevant assessments are completed for all consumers or alternative solutions are identified through assessment or care planning consultation, especially where there may be a risk to consumer’s health and well-being. As such, I find requirement 2(3)(a) is non-compliant.

* Regarding requirement 2(3)(e)

The service was found non-compliant in Standard 2 in relation to requirement 2(3)(e) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, the Assessment Team recommended requirement 2(3)(e) was not met. I have considered the Assessment Team’s findings; the evidence documented in the site audit report and the Approved Provider’s response and find the service compliant for requirement 2(3)(e).

The site audit report brought forward example of a named consumer whose challenging behaviours were not effectively managed and care planning documentation did not clearly describe the alternative interventions used to manage the consumer’s behaviour. I have considered and further discussed deficits relating to the named consumer under requirement 3(3)(a), where it is more relevant.

The site audit report brought forward example of another named consumer whose mobility and allied health assessments were not reviewed and updated after a fall incident. The provider’s response acknowledged fall management education is required for all staff. I consider this to be an isolated example and it does not reflect the service’s overall failure in reviewing care and services for effectiveness or when incidents occur. I acknowledge the provider’s response reflects continuous improvement implemented in response to the issues identified in the site audit report.

Overall, I consider care planning documentation were reviewed regularly and when consumers’ health status, preferences or circumstances changed, in accordance with the service's policies and procedures. Therefore, I find requirement 2(3)(e) is compliant.

Regarding the remaining requirements, consumers and representatives mostly said assessment and planning identifies and addresses the consumer’s current preferences and end of life wishes. Staff described how the service ensures that assessment and planning reflect consumers' current preferences and how they approach conversations around end-of-life care planning. Care planning documentation mostly identified and addressed consumers' current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wished. Policies and procedures informed staff practice on assessment and planning, including in relation to advance care planning. However, deficits were identified in relation to care planning and assessments not being completed consistently and not outlining consumer’s risks and associated interventions. These deficits have been further considered and discussed under requirement 2(3)(a).

Care planning documentation of sampled consumers evidenced that assessment and planning is based on an ongoing partnership, and involvement from a range of external health providers and services such as medical officers, allied health professionals, and specialists. Most consumers and representatives identified who was involved in consumer’s care, including internal and external healthcare providers. Where three consumer representatives expressed concerns about the process, management sent out a memorandum to consumers and representatives explaining the process for clinical referrals. Staff described, and the service’s procedures confirmed there is documented guidance ongoing care planning evaluation with consumers and representatives, and other healthcare services.

Most consumers and representatives expressed satisfaction with the service’s frequent and regular updates on care and services and said staff explain information about their clinical care in a simple manner, and that they have access to a copy of their care plan. Staff described the processes for effectively communicating assessment and planning to consumers and/or their representatives either in person, via telephone or email. Review of care planning documentation evidenced the outcomes of assessment and planning are effectively communicated to the consumer and their representatives and others who are involved in care.

# 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. | Not 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. | Not 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

I have found this Quality Standard as non-compliant as I am satisfied requirements 3(3)(a) and 3(3)(d) are non-compliant.

The service was found non-compliant in Standard 3 in relation to requirements 3(3)(a) and 3(3)(d) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, these improvements have not been effective to rectify the non-compliance. I find the service non-compliant with these requirements.

I have summarised the relevant evidence below, and other evidence which was not relevant to the requirement, or which was disproven by the Approved Provider’s response has not been outlined here.

* Regarding requirement 3(3)(a)

The site audit report brought forward examples of 4 named consumers’ care documentation, which did not follow the service’s pain management policy. The provider’s response included additional information for the named consumers, and outlined provider’s actions to address the deficits identified, including pain management toolbox education to staff, reviewing pain management policy, and purchasing of pain monitoring application.

The site audit report also brought forward examples of 4 named consumers whose wound documentation reflected wound measurements were not consistently taken to monitor wound progress. For one named consumer, their representative expressed concerns about lack of ongoing wound monitoring which led to wound deterioration. The provider’s response outlined comprehensive wound education will be provided to all staff and sufficient resources will be made available for measuring and recording of wounds.

The site audit report outlined deficits in relation to identification of environmental restrictive practice at the service, as discussed under requirement 2(3)(a). For one named consumer, as required chemical restrictive practice medication was administered without documenting the reason or if any non-pharmacological strategies were trialled prior to administration. The effectiveness of the medication was also not reviewed on 3 occasions and the consumer’s behaviour support plan was not individualised. Staff were unable to describe person-centred interventions for the consumer. The provider’s response stated the consumer’s behaviour support plan will be reviewed, and individual interventions and evaluations will be clearly documented.

I acknowledge the response provided additional information about the named consumers and the provider’s ongoing commitment and planned actions; however, I consider further improvements and time is required to demonstrate effectiveness of actions implemented. As such, I consider above examples demonstrate ineffective clinical care and lack of understanding and application of restrictive practices. Therefore, I find requirement 3(3)(a) is non-compliant.

* Regarding requirement 3(3)(d)

The site audit report brought forward examples of 4 named consumers’ care documentation and consumer or representative feedback, which demonstrated the service did not recognise or respond to consumer’s deterioration or change in condition in a timely manner. Two named consumer examples related to issues in recognising or responding to consumer’s weight loss, one named consumer example related to deterioration of a consumer wound, and one named consumer example reflected issues with complex care management.

Whilst the response provided some clarifying information for 2 named consumers, the response did not demonstrate if the service has effective processes in recognising and responding to deterioration or change in condition for all consumers. The response did not address deficits related to one named consumer and some consumer or representative feedback. The provider’s action plan included ongoing staff education and communication to health professionals.

I acknowledge the provider’s planned actions; however, further improvement and time is required to demonstrate effectiveness of these actions. Therefore, I find requirement 3(3)(d) is non-compliant.

* Regarding requirement 3(3)(b)

The service was found non-compliant in Standard 3 in relation to requirement 3(3)(b) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, the Assessment Team recommended requirement 3(3)(b) was not met. I have considered the Assessment Team’s findings; the evidence documented in the site audit report and the Approved Provider’s response and find the service compliant for requirement 3(3)(b).

The site audit report brought forward deficits in staff knowledge of person-centred behaviour support for consumers. One named consumer example was brought forward in the report, which has been outlined and discussed under requirement 3(3)(a). The provider response discussed further education & information sheets will be provided to staff. The report did not identify any further named consumer examples or associated impacts on care. As such, I do not consider this demonstrates ineffective management of high impact high prevalence risks for consumers.

The site audit report discussed one named consumer example where appropriate falls management pathway was not followed for the consumer. The response noted the incidents described in the report did not constitute a fall, however, the provider acknowledged staff education regarding falls is required. Since no further named consumer examples were brought forward regarding this issue, I consider this to be an isolated incident.

I am satisfied with the provider’s actions and due to lack of other named consumer examples, I consider the service overall effectively manages high impact high prevalence risks for consumers. Therefore, I find requirement 3(3)(b) is compliant.

Regarding remaining requirements, for the consumers sampled, care planning documentation included the needs goals and preferences of the consumer who received end of life care. Staff described how they provide end-of-life care to consumers, including spending extra one-to-one time with consumers, providing oral care, holding hands, and providing support to the family. The service has policies regarding the palliative approach to care and advance care planning which support staff to provide best practice care towards consumers' end of life.

The service was found non-compliant in Standard 3 in relation to requirement 3(3)(e) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented improvements to address the non-compliance and is now compliant with this requirement. The service mostly demonstrated that progress notes and care plans provide information to support effective and safe sharing of consumer’s information to support care. Staff described how information on consumer needs, conditions, and preferences are documented and communicated within the service and others where clinical care is shared, including staff handovers. However, some consumers and representatives reported that information about the consumer’s condition and needs were not effectively communicated within the service. This has been further discussed and considered under requirements 2(3)(a) and 3(3)(a).

Most consumers and representatives interviewed said that timely and appropriate referrals occur and that consumers have access to relevant health supports. Care planning documentation generally reflected input of other health professionals where needed, including consultation from specialist dementia services, medical officers, speech pathologists and physiotherapists. Clinical staff described the processes in place to refer consumers to external services, such as specialist wound care services, palliative care services, specialist dementia advisory services, dietitians, and nutrition specialists.

Consumers and representatives said they were satisfied with the service’s management of COVID-19 precautions and other infection control practices. Management confirmed that the service has a current Infection Prevention and Control (IPC) lead who had completed the IPC Course. Clinical staff advised that antibiotics were commenced following a confirmed pathology result. Staff were observed following infection control procedures, including the COVID-19 screening procedure in place at the service. However, clinical staff reported that they were not required to undertake antimicrobial stewardship training and the current IPC lead advised that they had not actively worked in their role due to staff shortages at the service. Deficits relating to staffing levels and staff training are further discussed under requirements 7(3)(a) and 7(3)(d) respectively.

# 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

Consumers interviewed said they feel supported to pursue activities of interest to them and are supported to do so. Management and lifestyle staff described how the service partners with the consumer or their representative to conduct assessments which identify the consumer's individual preferences including their likes, dislikes, leisure interests, social, emotional, cultural, or spiritual needs, and any traditions important to them. Staff interviewed described what is important to specific consumers and what they enjoy, and this aligned with information contained in the consumer’s care planning documentation. Review of documentation showed a robust lifestyle program informed by consumer interest.

Consumers and representatives said they are supported when they are feeling low, and described how the service promotes their emotional, spiritual, and psychological well-being. Care planning documentation included information on consumers' well-being needs, goals, and preferences. Staff described how they recognise changes in consumer’s well-being and advised that the consumer’s emotional, social, and psychological needs can be supported by facilitating connections with people important to them, and by delivering religious services.

Consumers said they are satisfied with the variety of activities provided at the service and that they can participate in activities based on their preferences. Consumers and representatives said consumers are supported to participate within and outside the service, keep in touch with people who are important to them and do things of interest to them. Staff described how consumers are participating in their community within and outside the service environment. Care planning documents of interviewed consumers aligned with the information provided by consumers, representatives, and staff regarding their continued involvement in their community and maintaining personal and social relationships.

Consumers said information about the consumer's conditions, needs and preferences are communicated within the organisation and with others where responsibility for care is shared. Staff said that they communicate and document changes in the electronic documentation system and staff handovers. Overall, care planning documentation for consumers sampled provided adequate information to support safe and effective care related to services and supports for daily living. Information about consumer’s dietary needs were observed to be accessible to hospitality staff in the central kitchen.

Consumers and representatives said they are supported by other organisations, support services and providers of other care and services. Staff described, and care documentation showed timely referrals to other organisations and services. Management explained they engage a range of external services, such as community services, visiting musicians and performers, pet therapy, visiting religious services and volunteers, to broaden the lifestyle services and supports delivered to consumers.

Most consumers expressed overall satisfaction with the quality, quantity and variety of meals provided at the service and said that they can provide feedback and comments on the food which are acted upon. Staff described how they ensure that consumer choices are supported and arrange alternatives if the consumer wishes. Documentation was available that described the dietary needs and preferences of consumers. The service has feedback mechanisms, such as food focus groups, which allow consumers to provide feedback on meals and dining experience.

Consumers reported having access to equipment, including mobility aids to assist them with their daily living activities. Staff described how equipment is kept safe, clean, and well maintained. Management advised that staff have undergone training in appropriate manual handling. Observations throughout the site audit confirmed equipment was clean and well-maintained.

# Standard 5

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

Findings

Consumers and representatives said they find the service environment to be welcoming and easy to understand with clear signage. Management described that the service environment fosters a welcoming environment for consumers and representatives through the layout of furniture in common areas to encourage social engagement. Observations confirmed the service environment to be welcoming, with sufficient lighting, handrails for consumers to move around, and clear signage throughout the service for room numbers. Consumer rooms were decorated with their personal photos, furniture, and decorations.

Most consumers and representatives said the service environment is safe, clean, and well-maintained and allowed them to move around freely. Staff described the service has a clear procedure to report and record hazards or maintenance concerns. Consumers were observed to be independently moving between communal areas throughout the site audit. However, the service did not conduct appropriate assessments or followed restrictive practice legislative requirements to determine if the consumers residing in memory support units were subject to environmental restrictive practice. Access to the service after hours required pressing a green button to exit the service and pressing a call bell for staff to open the door to enter the service. While consumers in the general wing did not raise concerns in relation to this practice, the service did not conduct appropriate assessments or followed restrictive practice legislative requirements to determine if any consumers in the general wing were subject to restrictive practice. As this deficit mainly relates to assessment and governance areas, this is further considered and discussed under requirements 2(3)(a), 3(3)(a), 8(3)(c) and 8(3)(e).

Observations showed, and most consumers and representatives confirmed, that equipment and fittings were cleaned and maintained regularly. Staff described how they frequently conduct environmental audits to ensure the service environment, furniture, fittings, and equipment are safe, clean, well-maintained and are suitable for all consumers in the service. Staff said the reactive and preventative maintenance schedule is regularly checked by them to ensure adherence to schedules.

# 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 recommended requirement 6(3)(d) was not met. I have considered the Assessment Team’s findings; the evidence documented in the site audit report and the Approved Provider’s response and find the service compliant for requirement 6(3)(d).

The site audit report stated the service’s continuous improvement plan for the last 3 months did not have any activities resulting from consumer or representative feedback. However, the site audit report only brought forward one example where one medication incident was not reported to the Commission’s Serious Incident Response Scheme (SIRS). The consumer representative expressed satisfaction with the service’s open disclosure process relating to the incident. I have considered this example under Requirement 8(3)(c) where it is more relevant, as it relates to the service’s regulatory obligations. Overall, the site audit report stated consumers and representatives said their feedback is reviewed and used to improve the quality of care and services.

The provider’s response outlined planned actions, which included staff education on trending of complaints and complaint trends to be an agenda item on the continuous improvement and clinical governance meeting. I am satisfied with the provider’s response and since no other examples were outlined in the site audit report, I consider feedback and complaints are reviewed and used to improve the quality of care and services. Therefore, I find requirement 6(3)(d) is compliant.

Regarding remaining requirements, consumers and representatives said they understand how to give feedback or make a complaint, they feel comfortable doing so and described the different ways in which they were able to provide feedback and make complaints. Staff described the feedback and complaints procedure which includes notifying the senior staff member on shift and management of the feedback and lodging the feedback or complaint in the service’s electronic system. Information about the service’s feedback and complaints mechanisms was observed in the consumer handbook, staff handbook, minutes of consumer meetings, and displayed throughout the service.

Most consumers and representatives said they are aware of and have access to language services, advocates, and other methods for raising and resolving complaints but preferred to raise concerns within the service. Management described the advocacy services and external language services available to consumers, and advocacy material was observed to be readily available to consumers and representatives throughout the service. However, staff could not describe the advocacy services available to consumers and representatives, which is considered under requirement 7(3)(d).

Consumers and representatives said the service responds to and resolves their complaints or concerns when they are raised and described how the service practiced open disclosure. Management and staff demonstrated an understanding of open disclosure, explaining how they would act in response to a complaint by acknowledging the issue, apologising to the consumer and their representative, and by keeping them informed throughout the investigation process. Review of service documentation evidenced that the service responds to feedback and complaints in a timely and appropriate manner.

# 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

I have found this Quality Standard as non-compliant as I am satisfied requirement 7(3)(d) is non-compliant.

* Regarding requirement 7(3)(d)

The site audit report identified staff did not demonstrate a clear understanding of different restrictive practices and associated requirements, antimicrobial stewardship, open disclosure, and advocacy services. Staff were unable to describe person-centred interventions to support a consumer who exhibits responsive behaviours. Some staff were also overdue for their mandatory training.

The provider’s response stated a new clinical nurse educator commenced at the service on 2 May 2024. The provider also submitted their education plan and planned education topics, as outlined in other requirements.

I acknowledge the ongoing support and planned training for staff at the service. However, issues relating to staff’s understanding in different areas have also been identified in other requirements, including requirements 2(3)(a), 3(3)(a) and 3(3)(d). I consider planned actions require time to demonstrate effectiveness to ensure learning and development needs of the workforce are addressed and reviewed regularly. Therefore, I find requirement 7(3)(d) is non-compliant.

* Regarding requirement 7(3)(a)

The Assessment Team recommended requirement 7(3)(a) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit Report and the Approved Provider’s response and find the service compliant for requirement 7(3)(a).

During the site audit, 14 consumers and representatives expressed satisfaction with the number of staff and the speed at which consumer’s care needs were responded to. However, the site audit report outlined 5 consumers or representatives who stated they sometimes felt there were not enough staff at the service. The feedback did not always identify if there was a deficit in meeting consumer’s needs or delivering safe and quality care and services to consumers.

The provider’s response outlined clarifying and additional information relating to the feedback, including call bell reports, discussion with one named consumer representative, staffing allocation, care minutes data, current agency, and recruitment contracts.

I am persuaded with the response as it demonstrates the service has a system to work out workforce numbers and the range of skills they need to meet consumers’ needs and deliver quality care. Therefore, I find requirement 7(3)(a) is compliant.

* Regarding requirement 7(3)(e)

The Assessment Team recommended requirement 7(3)(e) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit Report and the Approved Provider’s response and find the service compliant for requirement 7(3)(e).

The site audit report outlined the service has appropriate performance management processes in place and a suite of policies and procedures that inform regular assessment, monitoring, and review of staff performance. However, some staff’s performance reviews were not conducted in 2023. This issue was identified by management in January 2024 and staff were distributed self-assessment form for completion. No adverse outcomes or incidents as a result of staff performance were outlined in the site audit report. Where deficits in staff knowledge and training were identified, they have been considered under requirement 7(3)(d).

The provider’s response reiterated they have now created a spreadsheet to track staff performance reviews. As this issue was identified by the service prior to the site audit and the service has put appropriate measures in place that demonstrate ongoing improvement, I am satisfied with the response and find the service compliant with requirement 7(3)(e).

Regarding remaining requirements, consumers and representatives indicated that staff are kind, caring, respectful and gentle. Staff described how they treat consumers in a kind and respectful manner. Overall staff were observed to be interacting with consumers respectfully during the site audit. Service documentation, such as policies, position descriptions and staff handbook, outlined the service’s organisational values and expectations of staff in delivery of person-centred care that was respectful of everyone’s identity, culture and diversity.

Consumers and representatives said they consider staff to be skilled and competent in their roles. Management described how the service ensures staff are competent and capable to perform their functions through orientation and key competencies outlined in their relevant position descriptions. Position descriptions for various staff roles described the knowledge, experience, qualifications, key competencies, and responsibilities required for each position. Staff reported that they are confident the training provided has equipped them with the knowledge to carry out care and services for consumers. However, deficits in relation to staff training were identified, which have been discussed under requirement 7(3)(d).

# 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. | Not 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. | Not Compliant |

Findings

I have found this Quality Standard as non-compliant as I am satisfied requirements 8(3)(c) and 8(3)(e) are non-compliant.

* Regarding requirement 8(3)(c)

While the service has functional governance systems in place for information management and financial governance, the site audit report brought forward deficits relating to continuous improvement, workforce governance, regulatory compliance and feedback and complaints governance systems. I have found this requirement non-compliant due to deficits relating to only regulatory compliance governance systems. Relevant evidence has been summarised below.

Regarding continuous improvement and feedback and complaints governance systems, the site audit report stated the service’s continuous improvement plan for the last 3 months did not have any activities resulting from consumer or representative feedback, as discussed under requirement 6(3)(d). The report brought forward one example where one medication incident was not reported to the Commission’s SIRS program. I consider this example is relevant to the regulatory compliance governance systems. Due to lack of any further examples, I do not consider these deficits demonstrate organisation wide governance failure. Therefore, I find the organisation has effective continuous improvement and feedback and complaints governance systems as evidenced through consumer feedback, policies and processes outlined in the site audit report.

Regarding workforce governance systems, the report outlined deficits in relation to staffing levels, staff training and staff performance reviews. As outlined under Standard 7, I have only found the service non-compliant for requirement 7(3)(d). I do not consider this deficiency alone demonstrates ineffective workforce governance systems.

Deficits were identified in governance systems supporting regulatory compliance with the *Quality of Care Principles 2014* (the principes), specifically in relation to restrictive practices. The service did not conduct appropriate assessments to determine whether consumers were subject to environmental restrictive practice, as discussed under Standard 2 and 3. Appropriate assessments were not completed, consultation had not occurred, non-pharmacological strategies were not always documented to be trialled before the use of restrictive practices, regular monitoring or review of the restrictive practice was not undertaken, and behaviour support plans meeting the regulatory requirements were not always implemented. The provider’s response is detailed under Standards 2 and 3. A medication incident for a named consumer was not reported to the Commission’s SIRS program as per regulatory requirements. I find this demonstrates ineffective regulatory compliance systems. Therefore, I find requirement 8(3)(c) is non-compliant.

* Regarding requirement 8(3)(e)

The service was found non-compliant in Standard 8 in relation to requirement 8(3)(e) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, these improvements have not been effective to rectify the non-compliance. I find the service non-compliant with this requirement.

While clinical governance systems were in place, they were not effective to provide quality care to consumers. The service did not demonstrate it minimised the use of restrictive practices as the service did not correctly identify the number of consumers subject to environmental restrictive practice or provide an accurate chemical restrictive practice information. Documentation showed restrictive practice was not always used as a last resort. The provider’s response is noted under relevant standards.

Overall, the service did not demonstrate effective clinical governance, safety, and quality systems. These systems did not maintain and improve the safety and quality of clinical care, or improved outcomes for consumers. Consumers were negatively impacted as a result of the deficits identified in the delivery of clinical care, as evidenced by non-compliance in Standards 2 and 3. Therefore, I find requirement 8(3)(e) is non-compliant.

* Regarding requirement 8(3)(d)

The service was found non-compliant in Standard 8 in relation to requirement 8(3)(d) following an Assessment Contact in October 2023. Evidence in the site audit report dated 10 to 12 April 2024 supports that the service has implemented some improvements to address the non-compliance. However, the Assessment Team recommended requirement 8(3)(d) was not met. I have considered the Assessment Team’s findings; the evidence documented in the site audit report and the Approved Provider’s response and find the service compliant for requirement 8(3)(d).

The site audit report brought forward deficits relating to clinical care and management of high impact high prevalence risks for named consumers, as discussed under Standard 3. The provider’s response is also outlined under Standard 3. The site audit report did not clearly identify on how these deficits demonstrated a failure in organisation’s risk management systems and practices.

As evidenced in the site audit report, the service has implemented a risk register to monitor risks for consumers, conducts regular internal audits, and has a suite of policies and procedures related to management of high impact high prevalence risks. I do not consider deficits pertaining to individual consumers demonstrate ineffective risk management systems. I acknowledge the provider’s ongoing commitment to demonstrate continuous improvement in relation to this requirement. Therefore, I find requirement 8(3)(d) is compliant.

Regarding remaining requirements, consumers and representatives expressed satisfaction in the management of the service, said they feel they are involved in their own care, and are supported to be a partner in their own care via various processes such as the 3-monthly consumer and representative meetings, the feedback and complaints process, and 3-monthly care planning evaluations and processes. Management confirmed consumers and representatives are actively engaged in the development, delivery and evaluation of care and services through a variety of mechanisms. Documentation showed the service provided consumers and their representatives the opportunity to form consumer advisory bodies at a minimum of every 12 months.

Management described the role of the governing body in ensuring that safe and quality care is delivered, including communication processes from the Board and Chief Executive Officer (CEO) to the service management. Meeting minutes showed the Board members and the CEO attend monthly continuous improvement and clinical governance meetings. The organisation has a reporting mechanism to inform Board members of service performance, including conducting regular internal audits, developing monthly clinical reports for the Board, feedback and complaints avenues, and clinical governance meetings.

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