Performance

Report

**1800 951 822**

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| Name of service: | Greenhill Manor |
| Service address: | 190 Princes Highway FIGTREE NSW 2525 |
| Commission ID: | 1030 |
| Approved provider: | Greenhill Manor Pty Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 January 2023 to 18 January 2023 |
| Performance report date: | 22 February 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This Performance Report**

This Performance Report for Greenhill Manor (**the service**) has been prepared by M Buhagiar, 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 Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment conducted 16 January – 18 January 2022, 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 15 February 2023.
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Non-Compliance Notice dated 7 June 2022, Performance Report dated 1 April 2022 following Site Audit conducted 22 February – 25 February 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **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 1(3)(c)** The approved provider must ensure that consumers are supported to exercise choice and independence by providing independent interpreters for culturally and linguistically diverse consumers during admission and assessments to establish the decision-making pathways for their care and services. That consumers are provided personal care by staff of the gender that they choose, and that care planning is completed for all consumers in a timely manner.

**Requirement 3(3)(a)** The approved provider must ensure that consumers get safe and effective personal care, clinical care, or both personal care and clinical from staff that are knowledgeable of the consumers’ care needs and provide that appropriate care. Staff take time and demonstrate that they have time for consumers by engaging with them in activities. Staff are cognisant of where a consumer’s drink or call bell is, for easy reach. Consumers are attended to in a timely manner after using call bell.

# Other relevant matters:

This service was found non-compliant following a Site Audit from 22 February 2022 to 25 February 2022 in areas across all the Quality Standards. The organisation has implemented actions in response to the non-compliance identified at the Assessment Contact on 16 to 18 January 2023 which have been effective in some Standards, but non-compliance was still identified in Standards 1 and 3.

# Standard 1

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| Consumer dignity and choice | |  |
| 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. | Non-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 |

Findings

This Quality Standard has been assessed as non-compliant as one of the specific requirements was found to be non-compliant.

The following Requirement 1(3)(c); Requirement 1(3)(d) and Requirement 1(3)(e) were found to be non-compliant following a Site Audit conducted on 22 to 25 February 2022. The service could not demonstrate that consumers were supported to exercise choice and independence when making decisions or that each consumer is supported to take risks to enable them to live the best life they can. The service could not demonstrate that 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.

The organisation has implemented actions in response to the non-compliance which for Requirement 1(3)(c) has not been effective in meeting the Requirement.

The Assessment Team found that not all consumers are being supported to exercise choice about their own care, the way care and services are delivered, and to make decisions about when representatives should be involved in their care. Systems and processes have not been implemented effectively to address gaps identified during the Site Audit from 22 February to 25 February 2022 and the Performance Report dated 1 April 2022. The service has not provided independent interpreters for culturally and linguistically diverse consumers during admission and/or initial assessment to establish the decision-making pathways for their care and services, including when interpreters should be used, if consumers are to be supported in their decision making or if they have a substitute decision maker. It was also identified that personal care preferences were not adhered to by staff. Care planning documentation was found to be not completed for one of the sampled consumers.

The approved provider responded to the Assessment Team’s report and refuted the Assessment Team’s report, stating that the sampled consumers did not require interpreters as they could either understand or converse in English or that their family were able to translate for them. The provider did not provide evidence of care plans to support their response or information to state preferences for consumers were considered for personal care.

I have considered the providers response; however, without documentary evidence demonstrating that the consumer’s or their representatives (on their behalf) were exercising choice, I find that consumers are not supported to exercise choice and independence make decisions about their own care and the way care and services are delivered.

I find that the approved provider is non-compliant with this requirement.

The Assessment Team found that the organisation has implemented actions in response to the non-compliance in Requirements 1(3)(d) and 1(3)(e) identified at the Assessment Contact on 16 January to 18 January 2023 which have been effective and are therefore compliant.

The Assessment Team found through consumer and representative feedback, observations and document review, consumers are being supported to take risks and are provided information to exercise choice and have addressed the issues identified in the Site Audit report with processes sustainable to ensure consumers continue to be supported to take risks to enable them to live the best life they can.

The previous Site Audit report identified issues in relation to beverage and coffee making options. The Service is providing access to a café some days of the week and there is no charge to consumers. There is also instant coffee, tea and filtered water available at any time. Coffee and beverages are accessible to consumers in the Manor community. There is a beverage trolley with coffee available every morning tea and afternoon tea and consumers may use the call bell and ask for a staff member to get them a beverage or snack at any time. The service has also addressed the gaps in relation to the Dignity of Risk forms and demonstrates that processes are in place to support all consumers and their representatives to make dietary and other choices.

The Assessment Team reviewed minutes from monthly consumer meetings. Consumer meeting minutes dated 8 December 2022 demonstrate a variety of information about care and services. Twenty-eight consumers attended the meeting. Information was displayed in a number of ways including A3 poster size activity calendars throughout the service and in many of the consumers rooms, published meal menus were displayed throughout the service, evidence of direct response to consumers from staff and management and consumer information packs, handbooks, posters and pamphlets at receptions and on noticeboards throughout the community.

I find that Requirement 1(3)(c) is non-compliant and Requirements 1(3)(d) and 1(3)(e) are 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)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

This Quality Standard has not been assessed as not all of the Requirements have been assessed.

The following Requirements 2(3)(a); Requirement 2(3)(b); Requirement 2(3)(c) and Requirement 2(3)(e) were found to be non-compliant following a Site Audit from 22 to 25 February 2022. The service could not demonstrate assessment and planning, including consideration of risks to consumers' health and wellbeing, and informing the delivery of safe and effective care and services or that a consistent review of assessment and planning documentation to identify the consumer's current needs, and staff were unable to describe current care needs, goals and preferences was conducted. The service was unable to demonstrate consumer involvement in care, case conferences and care planning were consistently provided, representatives were not consistently involved when requested, and the consumer's social support services were not being accessed. The service was unable to demonstrate that care is reviewed regularly for effectiveness after falls and skin integrity incidents.

The organisation has implemented several actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023 which have been effective. These actions include the service contracting an independent aged care consultancy service to support staff to improve assessment and care planning for all consumers. The consultants have been at the service in a full-time capacity since March 2022. The consultants include nurse practitioners who have reviewed all consumer’s care plans including behaviour management strategies. The process for care planning and ‘resident of the day’ review has been more closely monitored. Compliance with processes in place are audited on a monthly basis. Education and training for all Registered Nurses on care planning and assessment has been provided on an on-going basis, in particular behaviour management.

The service manager showed the Assessment Team the schedule for regular care plan reviews and case conferencing and spoke about reviewing care plans regularly every 3 months and as needed, for example when a consumer is deteriorating and approaching the end of life. This schedule, the suite of consumer assessments in the electronic care planning system, and the case conferencing records show there are tools for assessing and understanding consumer needs, goals, and preferences. Consumer care plans capture the outcomes of assessment and the goals and preferences of the consumers.

Registered Nurses interviewed said the service provides a copy of the advance care directive to all representatives during the admission process.

The service manager said the service partners with consumers and others to be involved in planning and assessing care. The service has a process for care conferences. The service manager and Registered Nurses explained they meet or communicate regularly via phone calls with consumers and their representatives to discuss the consumers' care needs. Sampled consumers and representatives were asked about being partnered in care. They provided information about being involved in and having input into their relative's care and services via care planning.

Care planning documentation showed evidence of care conferences and involvement of a diverse range of external providers and services such as the Medical Officers, physiotherapists, speech pathologists and dietitian services in consumer care. Consumers could explain who was involved in their care and were confident that their care needs were being met.

Registered Nurses interviewed described the importance of the care planning process and said that it particularly helps to provide individualised person-centred care and explained how they initiate conversations around care planning with consumers and representatives face to face or over the telephone.

The Assessment Team found care and services for consumers are regularly reviewed for effectiveness and when circumstances change. The service manager outlined the process for consumer reassessment and care plan review, including when circumstances change, and incidents occur. Consumers sampled had regular care plan reviews attended. Review of incident reports also showed information was gathered to inform care and service review and for input into reassessment and care planning.

A review of the incident register shows that the service has a process of reporting falls and other incidents. Falls incident reports show investigation has occurred to determine the nature of the incidents leading to the incidents. A root cause analysis has been conducted, and appropriate strategies have been implemented to minimise the further occurrence.

I find that Requirements 2(3)(a), 2(3)(b), 2(3)(c) and 2(3)(e) are 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(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 |

Findings

This Quality Standard has been assessed as non-compliant as one of the specific requirements was found to be non-compliant.

The following Requirements 3(3)(a), 3(3)(b) and 3(3)(e) were found to be non-compliant following a Site Audit conducted on 22 to 25 February 2022. The service could not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs; and optimises their health and well-being or that there was effective management of high impact or high prevalence risks associated with the care of each consumer and that 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.

The organisation has implemented several actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023, however the Assessment Team found that this was not always effective for Requirement 3(3)(a).

The Assessment Team reviewed assessment and planning documentation which could not demonstrate that each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and wellbeing. While most consumers and representatives interviewed provided positive feedback about care delivery, some had concerns in relation to care delivery and personalised care tailored to the needs of the consumer.

The Assessment Team reviewed documentation, spoke with consumers and representatives and interviewed staff. It was identified by the Assessment Team that some care staff had limited knowledge of consumers’ care needs what care the consumers receives. Representative feedback included that staff do not have time for consumers, whether to engage with them and/or involve them in activities.

The Assessment Team interviewed representatives who provided feedback that personal care and clinical care was not optimum with one consumer not having their protein supplement drink left within close proximity and care staff for another consumer with fluid restrictions not aware of the consumer’s condition. Further feedback from representatives included where a consumer used their buzzer and was told to wait, however no one returned to provide care until the distressed consumer called the representative who contacted the service, the representative advised that the consumer has previously mentioned to staff when they are in pain and that the staff will follow up with the clinical staff, however it does not happen. The Assessment Team also identified a consumer whose personal care preferences were not being adhered to despite information in care planning documentation recording the preference.

The approved provider responded to the Assessment Team’s report and provided further information advising that some consumers care plans had been updated to reflect their compliance with this requirement. The provider advised that it was not a requirement for care staff to know of a consumer’s condition as this was known by clinical staff, however it is a requirement for staff to know of care needs. The provider noted some discrepancies in the Assessment Team’s report.

I have considered the providers response and the improvements that the Assessment Team have detailed, however the provider has not demonstrated that all staff understand the care needs and personal preferences of consumers to provide safe and effective personal care and clinical care that is best practice; and is tailored to their needs; and optimises their health and well-being. I find that the approved provider is non-compliant with Requirement 3(3)(a).

The Assessment Team found that the organisation has implemented actions in response to the non-compliance in Requirements 3(3)(b) and 3(3)(e) identified at the Assessment Contact on 16 January to 18 January 2023 which have been effective and are therefore compliant.

During the Assessment Contact held on 16 January to 18 January 2023, the Assessment Team reviewed assessment and planning documentation which demonstrates that the service identified high impact and high prevalence risks for the consumers. These are effectively recorded and managed through regular clinical data monitoring, trending and implementing suitable risk mitigation strategies for individual consumers. Management and staff described the high impact and high prevalence risks for consumers at the service. Consumers and representatives said the service adequately manages risks to consumers' health, particularly for falls, weight loss, clinical deterioration and behaviour management. The Assessment Team reviewed risk assessments which showed that they were thorough and identified risks, and corresponding strategies to mitigate the risks.

The service manager said information about the consumer's condition, needs and preferences are documented and communicated with those involved in the care of consumers. The Assessment Team reviewed care planning documentation which demonstrated progress notes and care, and service plans provide adequate information to support effective and safe sharing of the consumer's information to support care.

The Assessment Team interviewed consumers and representatives who said the consumer's care needs and preferences are effectively communicated between staff and the care they receive. Registered Nurses and care staff were able to describe how information is shared when changes occur through staff meetings and handover and how changes are documented in progress notes and the handover sheet.

I find that Requirement 3(3)(a) is non-compliant and Requirements 3(3)(b) and 3(3)(e) are 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 |

Findings

This Quality Standard has not been assessed as not all of the Requirements have been assessed.

The Requirements 4(3)(a), 4(3)(b), 4(3)(c) and 4(3)(d) were found to be non-compliant following a Site Audit from 22 February 2022 to 25 February 2022. At the time of the Site Audit the service could not demonstrate that consumers get safe and effective services and supports for daily living to optimise the independence, health, well-being and quality of life. The service could not demonstrate that supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. The service could not demonstrate that the service supports daily living to participate in their community and do things of interest to them and the service could not demonstrate that information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

The organisation has implemented actions in response to the non-compliance, identified at the Assessment Contact on 16 January to 18 January 2023.

The Assessment Team found that not all consumers are receiving safe and effective services and support for daily living that meet their needs, goals and preferences and optimise their health, well-being and quality of life. The Assessment Team identified that the lifestyle team do not have leisure and lifestyle qualifications and have not been trained in the electronic care planning system resulting in some consumer’s leisure and lifestyle care planning not being updated when the consumer’s condition changed. Lifestyle participation records have not been updated for consumers who are less mobile and unable to participate in group activities and do not demonstrate one to one activities or consideration of an increased risk of isolation due to an increased decline to attend activities.

The Assessment Team identified that not all consumers are receiving effective services and supports that promote each consumer’s emotional spiritual and psychological well-being. Documentation was reviewed and interviews with consumers and representatives demonstrated that leisure and lifestyle plans are generic and spiritual and emotional well-being care plans are brief and do not address increased needs for emotional support and interaction. Other representative feedback included that staffing on the weekends is restricted and that consumers are often left in their rooms without any meaningful activities.

The Assessment Team found that not all consumers are receiving effective services and supports that support them to participate in their community and do things of interest to them. The Assessment Team observed many consumers not being supported to engage in activities. Staff feedback indicated there are not enough staff to encourage or assist consumers to do things of interest to them. Systems and processes have not been implemented effectively to address gaps identified in the site audit report and performance report.

The Assessment Team observed that lifestyle staff were often rushing and not supported to assist consumers to group activities. The Assessment Team observed many consumers not being supported to engage in activities particularly at times in the memory support unit. The Assessment Team found that there are not enough activities in each of the communities and the activities are shared across all of the communities. For example, if there is an activity in the Lodge community it is difficult and discouraging for other consumers residing in the other communities to attend, particularly for many consumers that are not independent with their mobility or requiring assistance from staff. Consumers who are at risk of isolation are not receiving regularly planned scheduled one to one care.

Some consumers are not having accurate information shared within the service in relation to their condition, needs and preferences. The Assessment Team received feedback from consumers and representatives and reviewed documentation which showed that information was not shared when consumers were consistently declining activities, and no other strategies were put in place to meet the consumer’s needs. The Assessment Team spoke with consumers about their preferences for meals and received feedback that regardless of preferences, the consumer ‘can’t eat’ many of the meals because they are of very poor quality and many other consumers in the service think the same.

The approved provider responded to the Assessment Teams report and advised that the Lifestyle Officers have enrolled in Certificate IV in Disability Services which has modules covering Leisure and Lifestyle and that they are also supported by a qualified Lifestyle Officer. The provider also advised that there is a schedule of one-to-one activities in the Lifestyle office. Care planning documentation has been updated in consultation with consumers that are at risk of isolation by reminding, prompting and encouraging consumers to attend activities. The provider also advised that some activities from external providers were ceased due to outbreaks, however at present there is exercise each morning following breakfast and bus trips in the morning and afternoon twice a week, consumers also have access to puzzles, cards, interactive games and mini golf. The Assessment Team found Requirements 4(3)(a), 4(3)(b), 4(3)(c) and 4(3)(d) to be not met, however the provider’s response to this report and actions that they have taken have persuaded me of their compliance with these Requirements.

I have considered the feedback received from the provider and recognise that the provider has taken actions with ensuring lifestyle staff have the qualifications and support to undertake their roles and further actions are required, however acknowledge that feedback from consumers and representatives has been actioned with care plans updated to meet their preferences and care needs.

I find that Requirements 4(3)(a), 4(3)(b), 4(3)(c) and 4(3)(d) are compliant.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

This Quality Standard has not been assessed as not all of the Requirements have been assessed.

This Requirement was found non-compliant following a Site Audit from 22 February 2022 to 25 February 2022. The service could not demonstrate that consumers could move freely, both indoors and outdoors.

The organisation has implemented actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023 which have been effective. The improvements that the provider has implemented include that consumers rooms are cleaned to the satisfaction of the consumers and their representatives. Consumers have access to exit the building during the day without assistance from staff (a green button has been installed by the front door) and consumers have access to outdoor courtyards. A booking system to the ‘Rose Garden’ courtyard which is a smaller area enables consumers to enjoy the area, maintaining social distancing protocol and allows easy monitoring by the service manager who can oversee the area from his office and ensure it is being maximised by consumers and their representatives.

The Assessment Team observed the service environment to be clean on each day of the Assessment Contact. The environment is very spacious in all communities with lounge and other areas offering a variety of settings for consumers to enjoy including a cafe. The lift does not have a keycode device and consumers who are independent can access each of the communities (except the Lodge), the café, the foyer area and the front door which has a green button to allow consumers to exit. There is one consumer that wishes to access activities in the Lodge community. This is not environmental restraint as the consumer requires assistance with mobility and staff can access the Lodge with the keycode as they are assisting the consumer to the Lodge.

I find Requirement 4(3)(b) to be 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)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

This Quality Standard has not been assessed as not all of the Requirements have been assessed.

The Requirements 6(3)(a), 6(3)(c) and 6(3)(d) were found to be non-compliant following a Site Audit from 22 February 2022 to 25 February 2022 as the service could not demonstrate that consumers, their family, carers and others are encouraged and supported to provide feedback and make complaints. The service could not demonstrate that appropriate action was taken in response to complaints and an open disclosure process is used when things go wrong at all times. The service could not demonstrate that feedback and complaints were reviewed and used to improve the quality of care and services.

The organisation has implemented actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023 which have been effective.

The Assessment Team identified that consumers are actively encouraged to provide feedback at monthly consumer meetings. Attendance at these meetings has improved. The last meeting on 8 December 2022 had 28 consumers in attendance. Consumers are reminded about advocacy services and interpreter services that are available to them at each meeting. The organisation arranged a ‘meet and greet’ with consumers representatives at a local racetrack to build and foster relationships. The executive team and board members attended the event. This was well received by consumers representatives.

Consumers and representatives confirmed that they understand how to give feedback or make a complaint and said that they feel confident that management would address and respond to them appropriately and in a timely manner. Management and staff demonstrated a sound knowledge of the processes in place to encourage and support feedback and complaints.

The Assessment Team interviewed consumers and representatives who were confident that action would be taken if they made a complaint. All recent complainants were interviewed by the Assessment Team and satisfied with the outcome of their complaint.

Consumers and representatives confirmed that management acknowledge and respond to concerns raised in an appropriate manner. Staff demonstrated a sound understanding of open disclosure and explained how they would apologise to a consumer in the event of an error made impacting on consumers. Management described the process of how staff are guided by their policy and procedures on open disclosure and complaints management. The documented procedures are in alignment with best practice guidelines and the Quality Standards.

The Assessment Team interviewed consumers and representatives confirmed their feedback is used to improve care and services. Management described processes in place to escalate complaints and how they are used to improve the care and services available to consumers. Staff were able to describe improvements which were driven by consumer feedback. However, during the Assessment Contact it was identified that some feedback from consumers is not always formally documented and incorporated into the electronic feedback system. Therefore, managerial oversight of comments and complaints received is not clearly documented. Trending of feedback cannot be correctly tracked and reviewed. However, consumers/representatives confirmed that their feedback is addressed, and management displayed a proactive approach to managing consumers’ feedback. For this reason, I find that the approved provider is compliant with the Requirements.

I find that Requirements 6(3)(a), 6(3)(c) and 6(3)(d) are 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

This Quality Standard has not been assessed as not all of the Requirements have been assessed.

The Requirements 7(3)(a) and 7(3)(d) were found non-compliant following a Site Audit from 22 February 2022 to 25 February 2022 as the service was unable to sufficiently demonstrate that 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. Most consumers and representatives interviewed during the Site Audit were not satisfied with the staffing levels and response times to care needs. The service was unable to sufficiently demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required under the Quality Standards.

The organisation has implemented actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023 which the Assessment Team did not feel had taken full effect to ensure compliance with the Quality Standards.

The Assessment Team found that the service was unable to demonstrate staffing allocations adequately meet all consumers needs and ensure the delivery of safe and quality care and services. Not all consumers felt they were very well cared for by the staff and some provided negative feedback to the Assessment Team on the provision of care. The service is unable to ensure staff allocations are adequately meeting changing consumer needs and preferences.

The Assessment Team interviewed representatives who stated that they have observed a notable improvement in human resource management however there could be further improvements to meet consumer’s needs. There were gaps in personal and clinical care that were identified and found to be non-compliant in Requirement 3(3)(a). The service has increased staffing hours to meet consumers care needs. An additional eight-hour shift has been added to the roster on the morning shift and afternoon shift in Sorensen and a morning and afternoon shift has been extended from 4 hours to 8 hours in Hoskins. The number of consumers residing at the service has reduced from 98 to 86 since the Site Audit in February 2022. Despite the decrease in consumers at the service these additional hours have been retained.

The service has introduced an additional managerial role. The care manager has been appointed in a full-time capacity to assist management with increasing workloads and delegations of duties to improve care delivered to consumers. An additional clinical leader role has been recruited at the service. The clinical leader commenced their role on the first day of the Assessment Contact. The clinical leader will work in a full-time capacity Thursday to Monday to provide support to staff and improve management of consumers care and services over the weekend.

The Assessment Team interviewed care staff who confirmed that there has been a notable improvement in regard to staffing and management of the service over the last six or more months. They expressed satisfaction with their workplace and human resource management.

The service has introduced a new procedure to investigate any call bell response over 10 minutes. The facility manager receives a call bell report daily and reviews it as a matter of priority. Call bell response times over 10 minutes has consistently reduced by nearly half since November 2022.

The approved provider responded to the Assessment Team’s report and detailed information about consumer care for sampled consumers. The provider also advised that their average care minutes is above the average recommended by the Department of Health and Aged Care. The provider added that consumers and their representatives often feel that staff are always busy and there are not enough staff, however, are confident that the consumer’ needs are met. The provider will continue to educate and advise consumers and representatives of the staffing numbers at the service and the review of staffing hours/ratios and appointment of key personnel and have added this to the Continuous Improvement Plan.

I have considered the providers response and the many actions that they have taken and continue to take to address the previous non-compliance and have found that the provider has demonstrated compliance with Requirement 7(3)(a).

The Assessment Team found the service demonstrated the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. Staff complete training on a regular basis and the training program is well attended with 100% compliance in mandatory training. Most staff at the service had appropriate skills and knowledge to perform their roles. The organisation has processes to ensure training is well attended and staff complete mandatory training within an appropriate timeframe.

The Assessment Team interviewed consumers and representatives and found that the majority expressed their satisfaction in the way care and services were delivered by staff at the service, with one consumer stating that the staff “excellent’ and meet all their needs”. The consumer did not feel that staff were lacking in any area.

The organisation has contracted an external, experienced educator to provide training on behaviour management and consumers with dementia. This education focuses on person centred care and the importance of staff engagement in aged care. Education records confirmed that all rostered staff had completed mandatory training.

Other training has been well attended and includes antimicrobial stewardship, bed making, behaviour management documentation, medication management, bowel check, consumer choice and dignity, partnership with care, environmental cleaning, delirium, dementia care, dietary needs, dignity of risk, falls management, falls prevention, handover, handwashing, heat packs, housekeeping, medication storage and an overview of the Commission’s Site Audit report.

I find the approved provider is compliant with Requirements 7(3)(a) and 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. | 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

This Quality Standard has been assessed as compliant as all of the specific requirements was found to be compliant.

Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) were found non-compliant following a Site Audit from 22 February to 25 February 2022 as the service was unable to sufficiently demonstrate that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The organisation’s governing body did not demonstrate a culture of safe, inclusive and quality care and services and was accountable for their delivery. There were not effective organisation wide governance systems relating to information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance or feedback and complaints. The organisation did not have effective risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system. The organisation could not demonstrate a clinical governance framework, including but not limited to antimicrobial stewardship; minimising the use of restraint; and open disclosure.

The organisation has implemented actions in response to the non-compliance identified at the Assessment Contact on 16 January to 18 January 2023, which have been effective with all Quality Standard 8 Requirements.

The Assessment Team found that the service was able to demonstrate it supports consumers and representatives to be involved in the development, delivery and evaluation of care and services. Management provided examples of different ways the service incorporates consumer feedback and suggestions into changes implemented to care and services at the service and organisational level. This included involving consumers in a review of the menu and in improvements to the meal service and dining experience, consulting consumers about the leisure activity programs and outings. Consumers are engaged to participate in advanced care planning, and various aspects of how their care and services are delivered.

Management said consumers are encouraged to engage in the development, delivery, and evaluation of care services through different means, for example, through meetings, focus groups, verbally and surveys. The managing director was observed engaging with consumers throughout the visit and was clearly very familiar with individual consumers.

The governing body has various avenues to ensure they are informed and accountable for the delivery of safe and quality care and services. The board meets up to 10 times a year and regularly receives reports on consumer safety, consumer quality outcomes, the implementation of the strategic plan, key policy decisions, stakeholder engagement, and research activities and outcomes. The governing body receives information from the service about COVID-19 outbreaks, serious incidents including SIRS notifications, and complaints. The CEO attends all continuous quality improvement committee meetings. During this meeting the facility manager’s report is discussed including adverse incidents, complaints, COVID-19 updates, SIRS, clinical indicators, amendments to policies and procedures.

An executive management meeting is held weekly with directors of the board, general manager, operational manager and facility managers. Any high-risk consumers identified are discussed amongst the executive team. The board is subsequently fully informed about any clinical issues and any actions taking place to rectify an area requiring improvement.

The Assessment Team reviewed of documentation during the Assessment Contact visit demonstrated that documentation was current, detailed and easily accessible. The Assessment Team reviewed the service’s continuous improvement plan and affiliated documentation and found it to be current, and informative and action has taken place within an appropriate timeframe. Dates of when improvements are scheduled to be closed off are incorporated into the plan. The service’s continuous improvement plan demonstrates the service identifies, and actions areas for improvement on an ongoing basis, and areas for improvement are identified from a variety of sources. This includes feedback from internal audits, feedback and corrective action required resulting from the Commission, the organisation’s clinical governance team, consumer experience surveys, staff surveys and complaint trends.

The board has oversight of investment and acquisition activities. Programs are in place for the maintenance and renewal of the service, including restoration, repair, replacement, extension and renovation of the facilities.

There is a hierarchy of approval from the facility manager to the CEO and to the board. There is an online ordering system that the directors have oversight of. The organisation has an accountant that works in a full-time capacity to support financial governance.

The organisation effectively monitors workforce governance at the executive level. This includes monitoring staffing numbers, agency staff use, overtime and staff turnover. Workforce governance has effectively recruited new staff to meet rostered requirements and reduce overtime and use of agency staff. The CEO and managing director explained how the organisation manage the roster and ensure that there is sufficient staffing to meet consumers’ needs and that the staff are competent.

Mandatory incident management and SIRS education has been provided to all staff. It is part of the orientation program and is a mandatory annual education session. Staff demonstrated a sound understanding of incident management and their responsibilities under the legislation.

The service demonstrated feedback and complaints inform continuous improvement, and complaint trends are monitored at the executive management level with relevant information provided to the governing body.

The service has effectively implemented the organisation’s risk management systems and practices. The organisation has oversight of the risk management at the service through monthly quality monitoring reports. These reports include information on high impact/high prevalence risks such as falls, behavioural incidents, restrictive practices, pressure injuries, and SIRS reports. These risks are monitored with issues identified and action taken in response, such as education provided.

The organisation has a clinical governance framework that includes antimicrobial stewardship, minimising the use of restraint and open disclosure. Education in these areas has been provided to staff and on an ongoing basis.

I find that the approved provider is compliant with Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

1. The preparation of the performance report is in accordance with section 68A– Assessment Contact, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)