Performance

Report

**1800 951 822**

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| Name of service: | Halls Creek Peoples Church Frail Aged Hostel |
| Service address: | 440 Neighbour Street HALLS CREEK WA 6770 |
| Commission ID: | 7178 |
| Approved provider: | Halls Creek Peoples Church Incorporated |
| Activity type: | Site Audit |
| Activity date: | 29 November 2022 to 1 December 2022 |
| Performance report date: | 27 January 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 Halls Creek Peoples Church Frail Aged Hostel (**the service**) has been prepared by J Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the Infection control monitoring checklist dated 30 November 2022;
* the provider’s response to the Assessment Team’s report and Infection control monitoring checklist, received on 23 December 2022 and 25 January 2023 respectively;
* the performance report dated 14 October 2021 for the Site Audit undertaken from 17 August 2021 to 19 August 2021; and
* the Risk escalation brief – COVID-19 dated 5 April 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **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.

Standard 1 Requirement (3)(b)

* Ensure consumers are provided care and services in a way which ensures their cultural identity is supported.
* Ensure effective measures are implemented to ensure consumers’ cultural needs and expectations are met.

Standard 3 Requirement (3)(g)

* Appoint a dedicated Infection prevention and control (IPC) lead and dedicated cleaning staff.
* Review the Outbreak management plan and ensure it provides sufficient guidance in relation to clinical handover processes and who to contact if the Facility manager is unavailable.
* Ensure staff competency, in relation to infection control and personal protective equipment (PPE). Monitor staff compliance with PPE requirements and ensure correct usage.
* Ensure signage is clear and directs consumers, visitors and staff in relation to donning and doffing of PPE, cough etiquette, social distancing and staying at home if unwell.

Standard 4 Requirements (3)(b), (3)(c) and (3)(f)

* Ensure staff have the skills and knowledge to identify when a consumer requires emotional support, and implement effective measures to ensure consumers’ emotional, spiritual and psychological needs are met.
* Implement effective measures to ensure consumers are engaged in meaningful activities.
* Support consumers who wish to participate in their community, engage with loved ones, and maintain connection to Country.
* Engage with consumers to ensure food is of suitable quality and variety, and implement measures to incorporate their input. Monitor food satisfaction regularly to ensure consumers’ changing needs and preferences are known and incorporated into the menu.
* Monitor compliance with food safety standards.

Standard 5 Requirement (3)(b)

* Review processes in relation to cleanliness of the environment, including monitoring to ensure the cleaning schedule is being followed.

Standard 6 Requirements (3)(b) and 3(d)

* Ensure all consumers are made aware of and have access to advocacy, external complaints and language services.
* Ensure feedback and complaints, including those received verbally are documented on the feedback register and appropriately actioned.
* Ensure feedback and complaints data is regularly reviewed to identify trends and improvement opportunities to the quality of care and services.

Standard 7 Requirements(3)(a)

* Ensure staffing numbers are sufficient to provide safe and quality care and services, including emotional support, activities, a clean environment and sufficient quality and variety of food.
* Implement monitoring process to ensure safe and quality care and services is being provided to 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 | Non-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

Requirement (3)(b)

The Assessment Team found the service collects information about consumers’ cultural identity and what is important to them, however, they were not satisfied the service demonstrated consumers’ cultural needs and preferences were met. The Assessment Team recommended the service does not meet Requirement (3)(b) and provided the following evidence relevant to my finding:

* Four consumers said they did not receive sufficient supports to maintain their cultural identity and provided examples to support their view, including not being able to leave to connect with family and/or Country, activities are not culturally appropriate to support their identity, and food is not what they are traditionally used to eating.
* Care planning documentation for seven sampled consumers showed the service collects information regarding their cultural identity and what is important to them, including hunting bush tucker, cultural ceremonies, celebration of culture through art, music and dance, and food preferences.
* The service does not have lifestyle staff to facilitate and assist consumers to participate in these cultural activities.
* Management acknowledged the lack of designated lifestyle staff has impacted the service’s capacity to provide culturally appropriate activities. Management said all staff have received cultural awareness training and while care staff provide lifestyle support, staff of Aboriginal background are engaged to provide culturally appropriate care and services. Management also stated their bus has been vandalised and their driver has lost their licence, which has impacted their ability to take consumers out into community.
* The service has not received a lot of feedback from consumers, including in relation to their dissatisfaction with cultural services and supports. One consumer said consumers would not speak up and offer feedback to non-indigenous staff.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that one named consumer is from a community of significant distance away and as a result, the service cannot provide staff to attend these long trips. The consumer’s family has been contacted and invited to attend the service on numerous occasions, however, none have attended to date. The consumer is cognitively impaired and can be negative when interviewed. A Care plan consultation report was provided to demonstrate the service was aware of the consumer’s desire to eat traditional foods prior to the Site Audit. The provider explained they have been trying to recruit a chef to meet these needs, however, in the interim an agency cook has been engaged and commenced on 5 December 2022.
* Progress notes demonstrating one of the named consumers has attended the community to visit their family. However, the provider explains there are underlying reasons why the consumer’s family chooses not to see them. A Dignity of risk assessment was provided demonstrating they have been assessed as requiring a modified texture diet, however, their preference to eat food they are traditionally used to eating is known, and mitigation strategies have been implemented to support this choice.
* Contracts for two new leisure and lifestyle staff to demonstrate the service has attempted to recruit new staff. Explanation that both roles remained unfilled and recruitment is difficult due to the service’s remote location.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, reviewed activities calendar to incorporate cultural activities, requested Dietitian menu review to incorporate culturally-specific food, commenced recruitment for leisure and lifestyle staff, and undertook plan of care consultation with consumers. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, care and services were not culturally safe.

I acknowledge the service’s processes were effective in recognising consumers’ cultural identity and needs, however, I have considered the service has not implemented effective measures to meet consumers’ cultural needs and expectations.

I have considered that four consumers said their cultural needs have not been met, and while seven consumers’ cultural needs and preferences have been identified, these needs and preferences have not been supported.

In relation to one named consumer, I acknowledge the provider’s assertion that their community is of a significant distance away, however, no evidence was provided to demonstrate how the service has worked with the consumer to address this need and ensure they feel respected, valued and safe. I also acknowledge the service was aware the consumer wants to eat traditional food, however, this preference was not met at the time of the Site Audit and interim measures were not implemented to ensure the consumer’s preference was supported whilst waiting for a chef to be recruited.

In relation to the other named consumer, I have placed weight on evidence in the provider’s response demonstrating they have attended the community to visit their family and acknowledge their family dynamic is complex, which makes it difficult to support this need. I have also considered the service was aware the consumer wants to eat traditional food and there is no evidence the consumer’s meal preferences have been met. The provider’s response included a Dignity of risk assessment to demonstrate risks associated with the consumer’s choice have been identified and planned for, however, there was not evidence demonstrating this risk identification and planning has been integrated into care and service delivery.

I have also considered management’s comments that their ability to take consumers into community has been impacted by vandalization of the bus and the driver’s loss of licence. The provider’s response did not include any commentary to demonstrate these issues have been addressed.

I have considered the lack of lifestyle staff and limited feedback and complaints from consumers under Requirement (3)(a) in Standard 7 Human resources and Requirement (3)(a) in Standard 6 Feedback and complaints respectively, as core deficits identified are better aligned with the intent of these Requirements.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 1 Consumer dignity and choice.

Requirements (3)(a), (3)(c), (3)(d), (3)(e) and (3)(f)

Consumers said they are treated with dignity and their culture is respected by staff. The service employs several local community members who understand consumers’ cultural beliefs, practices and norms. These staff provide care and services to consumers and advice and assistance to other staff when required. Most staff knew the consumers well, and all staff were observed to be treating consumers with dignity and respect.

Processes are in place to obtain consumers’ preferences about the way their care and services are delivered and facilitate decision making, including relationships of choice. Three consumers described how they are supported to exercise choice and independence, including doing their own shopping, visiting family and mobilising independently.

Most consumers said they are supported to make choices, even when their choices include an element of risks. These consumers provided examples of strategies in place to minimise risk associated with leaving independently and/or consuming alcohol, which include packing water, notifying staff, and returning at an agreed time. Risk assessments were completed for sampled consumers and mitigation strategies were documented to ensure consumers’ well-being and safety. However, one consumer said they are at risk of choking and want to have a regular diet but this has not been supported. This consumer is new to the service and has not yet been seen by a Speech pathologist. Management said they will implement strategies to support the consumer’s choice.

Consumers said staff talk with them to understand their preferences, including when they would like care provided and where they would like to eat and be seated for the day. Staff said verbal communication is the most effective way to communicate with consumers and explained they use plain English and words they have learned in Jaru. Staff said family care conferences are held with consumers and their family members to ensure they have the information they need to exercise choice. While the consumers can access information about most aspects of care and services, the menu is not posted or described to them and they had no information about activities as they are being undertaken on an ad hoc basis.

Consumers said staff respect their privacy. Staff provided examples of how they maintain consumers’ privacy, such as use of privacy screens and modesty towels. Management said new privacy screens have been purchased and are ready to install, which will enhance consumers’ privacy. The service uses an electronic records management system, which is password protected and staff have different levels of accessed depending on their role. Staff were observed respecting consumers privacy by shutting doors when providing care.

Based on the information summarised above, I find the service compliant with Requirements (3)(a), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

# Standard 2

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

Findings

Files for eight sampled consumers showed they were assessed on entry to identify and plan for risks associated with their health and well-being. These risks included allergies, pressure injuries, mobility, and choking. Where risks were identified, interventions to minimise risk of harm to the consumer were documented to inform the delivery of safe and effective care. Staff were knowledgeable about assessment and planning processes, including the use of validated assessment tools.

There are processes to ensure assessment and planning identifies and addresses consumers’ current needs, goals and preferences. Care plans for five sampled consumers included their preferences for activities of daily living, gender of staff providing care, and advance care and end of life directives. Staff were knowledgeable about how assessment and planning processes identify the needs and preferences of consumers. Consumers confirmed the service asks them what they like.

Care plans were reflective of the consumer, and inclusive of others who provide care and services, such as the Medical officer, Dementia Support Australia, Dietitian, and Speech therapist. Staff confirmed they regularly check with consumers to understand their needs and preferences, and ensure recommendations and assessments from other providers of care are documented in the care plan.

Consumers said their care plan is discussed with them and guides outlining their care needs were observed to be available in their room. Care files sampled showed care plans had been discussed with consumers and representatives.

All care plans have been reviewed and updated, as the service has recently moved to an electronic record system. Processes are in place to ensure regular review of care and service needs, including automated flagging in the electronic record system. Care files for sampled consumers demonstrated their care and services were reviewed following change in condition and/or incidents. Staff were knowledgeable about care plan review processes and explained the need to undertake reassessments of care and service needs following change in consumers’ condition or incidents.

Based on the information summarised above, I find the service compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Requirement (3)(d)

The Assessment Team was not satisfied the service demonstrated 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. The Assessment Team recommended the service does not meet Requirement (3)(d) and provided the following evidence relevant to my finding:

* While Consumer A’s bowels were recorded daily, interventions were not taken until six days after their bowels had not opened. Staff said the consumer was not symptomatic, had bowel sounds and were unsure whether documentation was accurate, so did not intervene earlier. The consumer was transferred to hospital nine days after their bowels had not opened. Management said the expected and best practice intervention is to administer aperients after three days of bowels not opening. The consumer has a history of constipation and was prescribed medication to assist bowel motions.
* Progress notes demonstrated Consumer B’s condition was deteriorating due to end-stage liver failure. Staff documented the consumer was out of breath on multiple occasions, and in response, they were reviewed by a Medical officer who changed their diuretic medications. While the consumer’s condition was noted to have improved on 23 August 2022, it worsened following an outing on 29 August 2022. The consumer’s family was informed they were end stage of life and agreed to transfer them to hospital on 2 September 2022 for end of life care. The consumer passed away on 11 September 2022. The consumer’s deterioration was actioned and reviews were undertaken by a Medical officer, however, there was no evidence indicating the consumer’s condition was monitored from 21 August 2022 to 2 September 2022. Management said the consumer’s vital signs were not monitored in line with the organisation’s deterioration procedure.
* Documentation showed a Medical officer was contacted and hospital transfer was arranged in a timely manner when Consumer C was showing signs of stroke.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that Consumer A has a history of constipation and in the past has required hospitalisation for bowel management. The Medical officer is aware and supportive of this.
* Menkawum Ngurra doctor and Allied health visit report to demonstrate Consumer A was regularly reviewed by a Medical officer in the six months prior to the Site Audit.
* Medication charts to demonstrate Consumer A was receiving daily aperients.
* Explanation that Consumer B’s deterioration was managed to the best of their expertise. All Medical officer recommendations were actioned, several discussions occurred with family to ensure their decisions were followed. The consumer’s care was collaborative and all parties were agreeable to actions taken. While vital signs were taken at a lesser frequency towards the consumer’s end of life was a decision of clinical staff, their rationale is fully supported. The consumer received the best clinical and personal end of life care and their needs were responded to in a timely manner.
* Doctor’s visit chart to demonstrate all clinical concerns were escalated to a Medical officer.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, developed clinical pathways on clinical escalation and palliative care, and staff education and training. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, and have come to a different view from the Assessment Team. I find that at the time of the Site Audit, deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition was recognised and responded to in a timely manner.

In relation to Consumer A, I have considered they have a history of constipation and their lack of bowel movement does not indicate a change in condition or deterioration. I have placed weight on evidence in the provider’s response demonstrating the consumer was administered daily aperients during the period they were suffering from constipation. I have also considered that staff were monitoring the consumer’s bowel sounds and escalated their concerns when they were faint or not present.

In relation to Consumer B, I have placed weight on evidence in the Assessment Team’s report and provider’s response indicating the service recognised and responded to their deterioration in a timely manner. I find the lack of vital sign monitoring has not impacted the delivery of care and acknowledge this monitoring can reduce when end of life is near.

I have also considered the service recognised and responded to Consumer C’s deterioration in a timely manner when they were showing signs of stroke.

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

Requirement (3)(g)

This Requirement was found non-compliant, as Outbreak management team meetings undertaken from 1 April 2022 to 4 April 2022 demonstrated severe and immediate risk to consumers. Specifically, the service did not have an IPC lead on site, there was no cleaner engaged and cleaning processes were inadequate, COVID-19 positive consumers were unable to isolate in their rooms and some were not wearing masks, one manager who resided at the service was not isolating, the service was unable to locate their anti-viral medication, staff could not access PPE storage, there were insufficient staffing numbers to effectively manage the outbreak, and no contingency plans were in place to replace or support staff if required.

At the Site Audit, the Assessment Team was satisfied the service demonstrated minimisation of infection related risks through implementation of standard and transmission based precautions to prevent and control infections. The Site Audit report and the Infection control monitoring checklist includes the following evidence relevant to my finding:

* The service does not have an IPC lead, however, plans are in place to appoint one when a permanent clinical staff member has been engaged.
* The service’s Outbreak management plan did not identify donning and doffing locations, flow or entry and exit points for staff, or include other external points of contact and processes for lockdown and clinical handover. Additionally, the Outbreak management plan did not clearly identify what actions should be taken when an outbreak occurs, other than contacting the Facility manager. There was no guidance to staff in the event the Facility manager was unable to be contacted.
* Shared equipment was not observed to be wiped down after use.
* Processes were not in place to ensure staff competency following PPE and infection control training.
* Posters/instructions for donning and doffing of PPE, cough etiquette, social distancing and advice to stay at home were not available.
* As demonstrated in Requirement (3)(b) in Standard 5 Organisation’s service environment, the service does not have a cleaner and care staff are performing cleaning duties.

It is unclear whether the provider accepts of refutes the Assessment Team’s findings. However, the provider’s response includes the following evidence to demonstrate action has been taken and/or planned to address deficits highlighted in the Assessment Team’s report and Infection control monitoring checklist:

* The Outbreak management plan was provided to demonstrate it has been updated and includes donning and doffing locations and zoning, floor plans, responsibilities for engagement with key contacts.
* Copies of signage that has been printed in relation to staying at home if unwell, stopping the spread and cough etiquette.
* Spreadsheet detailing core mandatory training undertaken by staff.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, and have come to a different view from the Assessment Team. I find that at the time of the Site Audit, infection related risks were not minimised through implementation of standard and transmission based precautions to prevent and control infections.

I have considered that some deficits which contributed to the escalation of severe and immediate risk have not been sufficiently addressed. The service continues to not have an IPC lead, despite being required to have one that is employed by and reports to the provider, works on site and is dedicated to the service. Furthermore, the service does not have any cleaning staff, with cleaning duties undertaken by care staff.

I have considered there were significant gaps in the service’s Outbreak management plan to guide staff in effectively managing an outbreak. While the provider’s response includes evidence demonstrating actions have been taken to address these deficits, the Outbreak management plan continues to not include processes for clinical handover or who staff should contact if the Facility manager is unavailable.

In relation to staff competency in relation to PPE practices, the provider’s response includes a spreadsheet detailing core mandatory training undertaken by staff. This spreadsheet makes no reference to PPE training or how competency is monitored. I have placed weight on information in the Infection control monitoring checklist, which demonstrates there were no processes in place to ensure staff competency following PPE and infection control training.

Finally, I have considered that staff were not observed wiping down shared equipment between use and signage was unclear and did not direct consumers, staff or visitors in relation to donning and doffing of PPE, cough etiquette, social distancing and staying at home if unwell.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f)

The service has process and guidelines to guide staff to ensure 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. Three consumers said they were satisfied with the care they receive and provided examples of tailored care, including having carers of a preferred gender. Staff were able to describe the care needs and preferences of consumers and identified consumer preferences. Overall, care files sampled demonstrated best practice and tailored care in relation to diabetes and wounds. While blood glucose levels were not documented prior to the administration of insulin on four occasions for one consumer, there was no adverse impact to the consumer.

Processes and policies are in place to manage high impact or high prevalence risks associated with the care of consumers. Staff were knowledgeable of consumers’ risks and interventions used to manage or minimise risk of harm. Care files and interviews with staff demonstrate effective management of high impact or high prevalence risks, including wounds, falls and restraint.

Recent improvements have been implemented to ensure the goals and preference of consumers nearing end of life are recognised addressed, their comfort maximised, and their dignity preserved. Staff said they are guided by the consumer and respect their wishes, and the goal of care in the end stage is to be comfortable and free from pain. The local palliative care service is used to ensure best practice end of life care for consumers.

Processes are in place to ensure information about the consumer’s condition, needs and preferences is communicated within the organisation and others where responsibility is shared. These include verbal handover, a handover book and access to the electronic record system. Consumers confirmed staff know what they need. A handover between care staff was observed to include changes to sampled consumers’ condition, such as falls and dressing changes. The Medical officer attends rounds and has access to the electronic record system and documents changes to care delivery.

There are processes in place to ensure appropriate and timely referrals to individuals or other care and service providers. While the service’s location has resulted in limited access to other service providers, referrals are made where available. Staff said they use a referral guide, which is easily accessible. Consumers confirmed, and records showed, they can see other service providers as required, such as a Medical officer, Podiatrist, and Dentist. The Assessment Team noted one consumer had not been seen by a Physiotherapist to review their mobility, however, management and staff said it would not be of benefit as the way they mobilise is a custom.

Staff were also knowledgeable about antimicrobial stewardship and confirmed they have the supplies to collect urine specimens and swab wounds. For two sampled consumers, infections were reviewed and antibiotic use was monitored. When the infection was identified, strategies were implemented to guide staff in the delivery of care.

Based on the information summarised above, I find the service compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 3 Personal care and clinical care.

# 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. | Non-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. | Non-compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement (3)(b)

This Requirement was found non-compliant following a Site Audit undertaken from 17 August 2021 to 19 August 2021, where it was found services and supports for daily living did not promote each consumers’ emotional, spiritual and psychological well-being.

The Assessment Team provided evidence of actions taken by the service to address the non-compliance, which includes, but is not limited to, engagement of a Lifestyle officer, and strengthening of the leisure and lifestyle program to include consideration of emotional, spiritual and psychological well-being of consumers.

The Assessment Team found these improvements were not effective, as the Lifestyle officer has not performed their role since October 2022 and will not be returning. At the time of the Site Audit, this position had not yet been filled and impact this has had on consumers’ emotional, spiritual and psychological well-being had not been adequately addressed. The Assessment Team recommended the service does not meet Requirement (3)(b) and provided the following evidence relevant to my finding:

* Care plans were reflective of consumers’ emotional and spiritual needs, however, the service does have an activity program, one-to-one program, or other formalised process to meet these needs.
* Supports were observed to be provided to consumers on an ad-hoc basis, however, this relied upon staff availability and capacity. Staff said they are performing various duties, such as caring, laundry, and cleaning, and do not always have the time to provide activities and the level of emotional support consumers require to maintain their well-being.
* Two staff provided an example of where they were unable to provide emotional support to one consumer. They said the consumer is often teary and would like to spend more time with them, however, they need to move on to assist other consumers and complete cleaning and laundry tasks.
* Progress notes and diversional therapy activity charts for sampled consumers included minimal activities documented and evidence showed this impacted their emotional well-being and changed behaviours.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that the service has made every effort to attract leisure and lifestyle personnel to be able to promote consumers’ emotional, spiritual and psychological well-being. Contracts of employment for two unfilled Leisure and lifestyle co-ordinator roles were provided to support this assertion.
* Staff meeting minutes for August to December 2022 demonstrating discussions in relation to the activities program.
* Explanation that they have consulted with consumers about their emotional and psychological well-being, including gathering feedback and listening to concerns. Care plan consultation records were provided to support this assertion.
* Explanation that religious organisations have been engaged to meet consumers’ spiritual needs. No evidence was provided to support this assertion.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, advertised vacancy for leisure and lifestyle staff, re-developed the activities program, and ensured a dedicated staff member is scheduled. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, services and supports for daily living did not promote each consumers’ emotional, spiritual and psychological well-being.

I acknowledge the service has had difficulties in retaining leisure and lifestyle staff, however, at the time of the Site Audit, other measures were not in place to ensure consumers’ emotional, spiritual and psychological well-being needs were being. Evidence in the Assessment Team’s report and provider’s response shows the service is effective in collecting information to understand consumers’ needs, however, there was no evidence demonstrating this information is used to plan or guide staff in how to best support these consumers within current staffing limitations.

While evidence in the provider’s response demonstrates activities are regularly discussed at staff meetings, these discussions are of a generalised nature and do not highlight specific consumers who need the most support to ensure their emotional, spiritual and psychological well-being is maintained.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 4 Services and supports for daily living.

Requirement (3)(c)

This Requirement was found non-compliant following a Site Audit undertaken from 17 August 2021 to 19 August 2021, where it was found services and supports for daily living did not assist each consumer to do things of interest to them.

The Assessment Team provided evidence of actions taken by the service to address the non-compliance, which includes, but is not limited to, engagement of a Lifestyle officer, and strengthening of the leisure and lifestyle program.

The Assessment Team found these improvements were not effective, as the Lifestyle officer has not performed their role since October 2022 and will not be returning. At the time of the Site Audit, this position had not yet been filled and there was no formalised activity program in place to support consumers to do things they are interested in. Additionally, consumers who expressed a desire to participate in the external community independently, to maintain connection with friends, family, and Country, were not supported to do so. The Assessment Team recommended the service does not meet Requirement (3)(c) and provided the following evidence relevant to my finding:

* The service did not have dedicated lifestyle staff and relied on care staff to provide supports for daily living.
* An activity and/or one-to-one program, or other formalised process, was not in place at the time of the Site Audit to guide staff and ensure consumers are supported to do things of interest to them. Activities conducted are irregular and provided on an ad-hoc basis.
* Only two activities were observed over the three-day Site Audit. For one of these activities, only four consumers attended and minimal engagement was observed. For the duration of the Site Audit, consumers were mostly observed either seated and watching television, or seated outside their rooms with minimal engagement.
* Diversional therapy and activity charts for six sampled consumers over a two-month period showed participation in minimal activities, other than watching various television programs, which was not reflected as their preferred interest in their care plans.
* Staff said they perform various duties, such as caring, laundry, and cleaning, and do not always have the time to provide activities and social support to consumers. Staff said where they can, they offer pampering and craft activities. Staff acknowledged they cannot facilitate activities every day.
* Management confirmed care staff are required to provide activities as part of their role, as the Leisure and lifestyle officer appears to have abandoned the position. Management explained that recruitment can be difficult due to the service’s remote location.
* Management explained the service’s bus has been vandalised and the driver has lost their licence, making it difficult to transport consumers into the community.
* Management does not monitor to ensure activities are provided or that they are tailored to meet consumer interests.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that the service has made every effort to attract leisure and lifestyle personnel to be able to promote consumers’ emotional, spiritual and psychological well-being. Contracts of employment for two vacant Leisure and lifestyle co-ordinator positions were provided to support this assertion.
* Staff meeting minutes for August to December 2022 demonstrating discussions in relation to the activities program.
* Explanation that consumers are involved in important town activities, such as rodeo, funeral services, carols, shopping and community outings. No evidence was provided to support this statement.
* Service improvement request form and invoice demonstrating equipment and furniture has been purchased for activities.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, advertised vacancy for leisure and lifestyle staff, re-developed the activities program, and ensured a dedicated staff member is scheduled. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, services and supports for daily living did not assist each consumer to participate in their community within and outside the organisation’s service environment, and do the things of interest to them.

I acknowledge the service has had difficulties in retaining leisure and lifestyle staff, however, at the time of the Site Audit, supports were not in place to engage consumers in meaningful activities, and enable them to maintain community connections. While some aspects of recruiting and retaining staff can be uncontrolled, there are still things the service can do to ensure supports are in place to enable consumers to do things of interest and participate in their community. These include, but are not limited to, ensuring activities align with consumer interests where provided, and monitoring to ensure activities promote a high level of engagement. I find this did not occur, which resulted in minimal consumer engagement to support consumers’ daily living and well-being.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(c) in Standard 4 Services and supports for daily living.

Requirement (3)(f)

The Assessment Team was not satisfied the service demonstrated meals are varied and of suitable quality. The Assessment Team recommended the service does not meet Requirement (3)(f) and provided the following evidence relevant to my finding:

* All consumers expressed dissatisfaction with the quality and variety of food, and said they are not aware of what is on the menu until it is served. Consumers said if they do not like what is served, they either eat or leave it, and were not aware if other choices were available. Consumers said they do not have access to or input into the menu.
* The service’s four-week menu only reflected breakfast and the protein that will be served at lunch or dinner. As the lunch and dinner dishes were not described, the Assessment Team were unable to determine whether the menu was varied. The menu did not reflect an alternate choice for consumers, other than sandwiches, should they not like the meal available.
* Staff said some consumers like the food and others do not. They were unaware whether alternate options were available for consumers who did not like what was being served. Staff said they do not seek consumer feedback regarding food satisfaction.
* The cook said they prepare meals based on available produce and ensures protein is varied. The recommendations of the Dietitian and dietary requirements of consumers are followed.
* Management said they are aware the food is not always to an expected standard and this is an area of focus. Some improvements include, development of a Food safety plan, engagement of an experienced cook, and arranging a Dietitian review of the menu. Management also said they have received minimal feedback about meal satisfaction.
* The Food safety plan was not followed, as hygiene checks were not consistently undertaken.
* Observations demonstrate the menu was not posted anywhere visible to consumers, fortified drinks and supplements were provided to consumers in addition to meals and/or when meals could not be tolerated, the kitchen was unclean and an abundance of flies were present in food preparation areas and on food. Meals were observed left on a trolley outside for at least 10 minutes on a 35-37 degree day.

The provider acknowledged more work needs to be done to improve the quality of meals, however, does not agree with some aspects of the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Another cook had been recruited but not yet commenced at the time of the Site Audit.
* Every effort has been made to ensure the cook complies with the Food safety plan.
* Pest management certificate of treatment dated 22 November 2022, demonstrating treatment occurred for cockroaches, black ants, and spiders, both internally and externally.
* Standard 4 audit report for an internal audit undertaken during August 2022 to demonstrate overall, five sampled consumers were satisfied with the quality and quantity of meals.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, menu review with Dietitian and consumer input, undertaking a food satisfaction survey, published menu which is available to consumers, and engaged agency cook whilst awaiting the new cook to commence. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, meals were not varied and of suitable quality.

I have considered that all consumers expressed dissatisfaction with the quality and variety of food, they do not have access to or input into the menu, and are unsure of any alternative meals available if they do not like what is served. This has resulted in consumers either eating food they do not like or leaving it. This does not align with the intent of the Requirement which expects services to take into account consumers’ preferences when providing food and drink and emphasises the importance of the dining experience in day-to-day life and supporting a sense of belonging.

I have also considered the food safety practices observed by the Assessment Team, including an unclean kitchen, flies in the meal preparation areas and on food, and meals being left out on a hot day. The service has implemented a Food safety plan, however, this is not being consistently followed. I find these deficiencies demonstrate the service has not met food safety legislative requirements and have placed consumers at risk of harm.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(f) in Standard 4 Services and supports for daily living.

Requirements (3)(a), (3)(d), (3)(e) and (3)(g)

Consumers provided examples of the services and supports they receive to meet their needs, goals and preferences, and optimise their independence, health and well-being. These include, use of specialist equipment, support to self-mobilise, and eating independently. Staff confirmed they aim to maximise consumer independence and escalate to management when they identify consumers need further support. Staff confirmed they initiate referrals to Allied health specialists to support consumer independence.

Consumers’ needs and preferences are documented in their care plan, which is accessible to staff and other providers of care and services. Processes in place to ensure consumer needs and preferences include handover meetings and buddy shifts, and use of a diary.

Care files show consumers are referred to other providers of care for services and supports, such as disability and social support services, including pastoral care.

Staff said, and observations showed, equipment is cleaned throughout the day. While the service has a cleaning schedule, staff interviewed were not knowledgeable of its existence. However, furniture and equipment used to support daily living was observed to be clean and well maintained.

Based on the information summarised above, I find the service compliant with Requirements (3)(a), (3)(d), (3)(e) and (3)(g) in Standard 4 Services and supports for daily living.

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Requirement (3)(b)

The Assessment Team was not satisfied the service demonstrated the service environment is safe, clean and well maintained. The Assessment Team recommended the service does not meet Requirement (3)(b) and provided the following evidence relevant to my finding:

* There are no processes to ensure cleaning occurs and is to the appropriate standard. The service does not have a cleaner.
* Care staff were observed cleaning throughout the Site Audit.
* A smell of urine was noted in female and male rooms throughout the Site Audit. Management said this could be as a result of one consumer who urinates around the service environment or due to the old bathrooms that need renovating. Management said these renovations have been planned.
* One consumer said there were times when their room had not been cleaned for weeks.
* The kitchen was observed to have a build-up of grease on surfaces and flies were in the kitchen during meal preparation.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Photographs of the service environment prior and following March 2022, demonstrating efforts have been made to clean and improve the service environment to ensure it is up to the required standard.
* Contracts of employment for two unfilled roles for cleaners to demonstrate the service has been actively recruiting cleaning staff. Explanation that retention has been an issue and previous cleaners are no longer employed by the service.
* Staff meeting minutes from August to December 2022 demonstrating cleaning is discussed regularly.
* Explanation that while care staff performing cleaner duties is not ideal, the current system is working well to ensure the environment is clean and management monitors compliance in this area.
* While they cannot comment on one consumer’s statement their room has not been cleaned for up to two weeks at times, explanation that they are committed to cleaning all rooms daily. Staff are aware of this responsibility and will be reminded at the next meeting. An undated cleaning schedule was provided and the service explained this will be attended to and monitored daily.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, implementing processes to ensure compliance with the cleaning schedule is monitored, clean up of kitchen, recruitment of additional kitchen staff to ensure hygiene standards are maintained. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, the service environment was not safe, clean and well maintained.

I acknowledge the service has undertaken significant clean up activities to improve the service environment and has had difficulties in retaining cleaning staff. However, at the time of the Site Audit, the service was not observed to be clean and one consumer said their room at times had not been cleaned for weeks. I acknowledge the difficulties staff have had in undertaking cleaning in addition to their carer role, however, the service did not have systems in place to monitor the cleaning schedule and ensure tasks were being undertaken and to an appropriate standard.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

Requirements (3)(a) and (3)(c)

The service environment is welcoming and easy to understand. Consumers said they were happy with their rooms and the communal areas. The service environment was observed to be easy to navigate and consumers were moving independently from their room to the communal area. The communal area has a fenced off fire pit that consumers can enjoy in the cooler months. The women’s rooms have murals of Australian animals on the walls. The service encourages consumers to bring in their personal belongings, however, many consumers did not have many.

Furniture, fitting and equipment were observed to be overall safe, clean and well maintained, and suitable for consumers. Consumers were satisfied with the equipment and furniture, and staff described how they ensure it is clean and maintained. A maintenance plan is used for regular preventative maintenance. The service is in the process of purchasing new furniture and fixing doors observed to be damaged.

Based on the information summarised above, I find the service compliant with Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment.

# 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. | Non-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. | Non-compliant |

Findings

Requirement (3)(b)

The Assessment Team was not satisfied all consumers have access to advocates, language services and other methods for raising and resolving complaints. The Assessment Team recommended the service does not meet Requirement (3)(b) and provided the following evidence relevant to my finding:

* Interpreter and advocacy information is provided to consumers in the admission pack, however, it is only available in English and in written form. Brochures or information relating to interpreter and advocacy services were not observed in common areas of the service environment.
* One consumer who entered the service a few years ago said they did not know about advocacy services or what to do if they were not satisfied with the outcome of a complaint. Management said they have not considered providing this information to consumers who entered the service prior to it being included in the admission pack.
* One consumer said ‘they’ (referencing the Aboriginal consumer cohort) ‘won’t talk up to the white man’.
* Local staff said they would act as advocates for consumers, however, would feel some discomfort in reporting issues to management.
* Management was unsure of any local community groups who would be able to provide advocacy or assistance to provide feedback for consumers with language barrier. Management said they had not considered consumers and staff may not feel comfortable providing feedback.
* The feedback register and forms only contained one record for the six months prior to the Site Audit.

The provider did not agree with the Assessment Team’s findings and maintains that language and cultural barriers have not prevented consumers from giving feedback. The provider’s response states consultations have occurred with consumers and local staff have interpreted for those who cannot speak English. Additionally, the provider asserts that sparse feedback is not indicative of lack of system or willingness of management to listed. This is merely a reflection of consumers’ culture.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, ensuring information relating to feedback, complaints and Aged Care Rights are prominent in communal areas, reviewed Consumer handbook to ensure it is easy to understand and includes information relating to advocacy and complaints mechanisms, provided the Consumer handbook to all consumers, applied for substitute decision makers for consumers who do not have cognitive capacity to make informed decisions and/or are vulnerable to financial abuse, and held discussions with the local language centre and engaged local staff to assist with consumers who do not speak English. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, consumers were not made aware of and did not have access to advocates, language services and other methods for raising and resolving complaints.

I have considered that consumers only received information regarding advocacy and language via one mechanism, the admission pack, which was in English and in writing only. As a result, consumers who cannot speak or read English were not able to understand this information. I have also considered that consumers who entered the service prior to implementation of improvements to the admission pack, had not received any information regarding advocacy and language services.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 6 Feedback and complaints.

Requirement (3)(d)

This Requirement was found non-compliant following a Site Audit undertaken from 17 August 2021 to 19 August 2021, where it was found feedback and complaints were not reviewed and used to improve the quality of care and services.

The Assessment Team noted the service, in response to the non-compliance and feedback from consumers, engaged leisure and lifestyle staff to improve the quality of services, however, the staff have since left and consumers remained dissatisfied with the current activities available.

The Assessment Team recommended the service does not meet Requirement (3)(d) and provided the following evidence relevant to my finding:

* The service has a plan to seek more feedback from consumers through audits and meetings, however, at the time of the Site Audit, these audits had not yet occurred and only one meeting had taken place.
* The service’s Plan for continuous improvement does not include improvements as a result of feedback and complaints.
* The service has implemented security patrol and has arranged installation of a more secure front door in response to feedback from staff. However, one staff said the security patrols are not always outside.
* The service provided manual handling education to staff in response to a complaint lodged to the Aged Care Quality and Safety Commissions.
* The service’s feedback and complaints processes were not effective in identifying consumer dissatisfaction and implement improvements in relation to cultural safety and food.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that care plan consultation has been undertaken with consumers to ensure their feedback is heard.
* Service request forms and invoices to demonstrate requests for activities equipment and furniture were actioned prior to the Site Audit.
* Explanation that patrols are not meant to be outside at all times and are required to patrol both residential and staff accommodations. Additionally, staff can phone them at any time if they have concerns.
* Reports for audits undertaken during September and November 2022 demonstrating feedback has been sought from consumers and staff in relation to food and staffing respectively.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, development of a Service improvement request form that is accessible to staff, consumers and representatives, review of the menu and activities to address feedback and complaints, and developed a new audit system. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, feedback and complaints were not reviewed and used to improve the quality of care and services.

I have considered that while the provider was able to demonstrate some improvements that stemmed from feedback and complaints, it is unclear how these improvements benefited consumers and the quality of care and services. For example, the provider’s response shows that activities equipment and furniture were purchased as a result of staff feedback, however, deficits were identified under Requirement (3)(c) in Standard 4 Services and supports for daily living, as services and supports were not effective in ensuring consumers are supported to do things of interest to them and processes were not in place to engage consumers in meaningful activities.

Improvements implemented, such as added security, manual handling education and purchasing activities equipment has not been sourced from consumer feedback and complaints, rather from staff or an external complaints process. This is supported by the internal audit for Standard 7, which did not incorporate consumer satisfaction and was based on staff feedback.

I have considered the service’s Plan for continuous improvement does not include any improvements as a result of feedback and complaints, and the provider’s response does not indicate complaints data is analysed to identify trends.

Furthermore, the Assessment Team at the previous Site Audit undertaken from 17 August 2021 to 19 August 2021 identified consumer dissatisfaction with services and supports for daily living. Information and evidence in the Assessment Team’s report for the Site Audit undertaken from 29 November 2022 to 1 December 2022 demonstrates this issue has not been adequately addressed.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

Requirements (3)(a) and (3)(c)

Processes are in place to encourage and welcome feedback, including consumer meetings, policies and feedback forms. Staff said they would assist consumers if they wanted to make a complaint. The Admission pack provided to consumers on entry includes information about how to make a complaint and feedback forms were observed at the front reception.

Feedback from two consumers regarding their meals was addressed and implemented actions were observed to be occurring. While examples of open disclosure in the Assessment Team’s report were in response to incidents, rather than feedback and complaints, these examples show the concept of open disclosure is known and applied by staff.

Based on the information summarised above, I find the service compliant with Requirements (3)(a) and (3)(c) in Standard 6 Feedback and complaints.

# 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement (3)(a)

This Requirement was found non-compliant following a Site Audit undertaken from 17 August 2021 to 19 August 2021, where it was found the workforce was not planned to enable the delivery and management of safe and quality care and services.

The Assessment Team noted the service, in response to the non-compliance, implemented an improvement plan to address the deficiencies, which included appointment of a Facility manager, registered staff, leisure and lifestyle staff, kitchen hands, cleaning and laundry staff and an administration officer. However, some of these staff have since left and remain vacant which impacts the service’s capacity to provide culturally safe care and services, activities and opportunities for consumers to do things of interest to them, promote consumers’ well-being and access community to maintain connections with loved ones and Country.

The Assessment Team recommended the service does not meet Requirement (3)(a) and provided the following evidence relevant to my finding:

* The service does not have dedicated lifestyle staff and relies on care staff to provide supports for daily living, including activities and emotional support.
* For the duration of the Site Audit, only two lifestyle activities were observed. Interactions between staff and consumers were brief.
* As demonstrated in Requirement (3)(b) in Standard 1 Consumer dignity and choice, four consumers said they did not receive sufficient supports to maintain their cultural identity and provided examples to support their view, including not being able to leave to connect with family and/or Country, activities are not culturally appropriate to support their identity, and food is not what they are traditionally used to eating. Management acknowledged the lack of designated lifestyle staff has impacted the service’s capacity to provide culturally appropriate activities.
* The cook advised they work 12 hours per day and 7 days per week and have done so since the kitchen hand left, which has impacted their ability to fulfil all their duties. As demonstrated in Requirement (4)(f) in Standard 4 Services and supports for daily living, all consumers interviewed expressed dissatisfaction with the quality and variety of food, and the kitchen was observed to be unclean.
* As demonstrated in Requirement (3)(b) in Standard 5 Organisation’s service environment, the service does not have a cleaner and care staff are performing cleaning duties. Some areas of the service environment were observed to be unclean and one consumer said there were times when their room had not been cleaned for weeks.
* Care staff confirmed they are performing multiple duties, which include caring, laundry, and cleaning, and said they do not have the time to provide regular activities or provide sufficient emotional support to maintain consumers’ well-being.
* Management said they are proactive in recruiting staff as required, however, there are ongoing challenges with attracting and retaining staff due to the service’s remote location and ongoing security challenges reported in the media. To address these challenges, a retention bonus is given to staff.
* As demonstrated in Requirement (3)(g) in Standard 3 Personal care and clinical care, the service does not have a designated IPC lead, however, plans are in place to appoint one when a permanent clinical staff member has been engaged.

The provider did not agree with the Assessment Team’s findings. The provider’s response includes the following information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that the service has always had sufficient clinical and care staff to meet consumers’ needs. Background information regarding improvements made to staff performance and numbers since March 2022 was provided.
* Explanation that the service’s ability to attract staff is impacted by deteriorating security in the community.
* Explanation that a number of staff have been hired and most of the positions required have been filled. The list of staff engaged notes activities personnel and cleaners have resigned.
* Explanation that contingency plans are in place to ensure activities and cleaning are undertaken. There are ongoing difficulties in maintaining these areas but not for lack of trying, rather, it’s reflective of being able to attract staff.

The provider’s response also includes a Plan for continuous improvement and supporting evidence to demonstrate actions to address deficiencies in the Assessment Team’s report have been taken and/or planned. These include, but are not limited to, rostering dedicated staff to undertake activities, advertising vacancy for leisure and lifestyle personnel, and recruited kitchen staff. I acknowledge actions taken by the service to address deficiencies identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, the workforce was not planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services.

I acknowledge the service has had difficulties in attracting and retaining leisure and lifestyle staff, cleaners and kitchen staff, however, at the time of the Site Audit, systems were not in place to ensure there was minimal impact to consumers.

I have considered that the lack of appropriate staff has resulted in consumers not receiving sufficient supports to maintain their emotional well-being, cultural identity or to do things that interest them. Additionally, all consumers were dissatisfied with the quality and variety of food, and some areas of the environment were unclean.

I have considered that the service is required to have an IPC lead that is employed by and reports to the provider, works on site and is dedicated to the service. At the time of the Site Audit, the service did not have an IPC lead and therefore did not meet this requirement.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 7 Human resources.

Requirements (3)(b), (3)(c), (3)(d) and (3)(e)

Consumers said staff are always kind, caring and respectful. Staff are required to adhere to the service’s code of conduct and values, including to provide culturally appropriate person centred care, which is kind and respectful. Staff provided examples of how they provide respectful care, which included knocking before entering rooms, speaking kindly, respecting consumers’ choices and wishes about how the like care provided. Observations of care in practice showed staff interactions towards consumers were kind, caring, and compassionate. Staff have received training in relation to person centred care.

Overall, consumers and representatives expressed confidence in staff competency and said consumers’ needs are being met. There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles, including obtaining evidence of required qualifications and registrations, completion of mandatory competency assessments, induction and orientation processes, and implementation of buddy shifts. However, while the organisation demonstrated it has policies and procedures in place regarding the reporting of consumer abuse and neglect, and staff had received training, management did not appear to have knowledge of their reporting obligations under the Serious Incident Response Scheme (SIRS).

On commencement, staff complete a corporate orientation program, which includes mandatory training. The service identifies any knowledge or experience gaps through consumer and staff feedback, observation, training/skills competency assessments and staff performance appraisals, audits and incidents. Documentation showed all staff were up-to-date with mandatory training. Staff considered they receive adequate training and education to provide safe and effective care.

Performance appraisals are conducted within three months after commencement of employment and annually thereafter. Performance management processes are initiated following feedback from consumers and staff, and where incidents have occurred. Further support is provided to staff where the need for improvement, training, monitoring is identified.

Based on the information summarised above, I find the service compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources.

# 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

Consumers and representatives are encouraged to make contributions to the way that consumers’ care and services are delivered through various mechanisms, including feedback and complaints processes, care plan review processes and Resident meetings. The service is in the process of implementing Resident satisfaction surveys.

The organisation’s corporate governance framework promotes a culture of safe, inclusive and quality care and services through overseeing security, renovations and building improvements, continuous improvement, compliance and operational matters, staffing and financial governance. An external consultant has been engaged and meets with management to discuss all aspects of care and services, including clinical indicators, incidents and opportunities for improvement.

A number of improvements have been implemented in response to the finding of non-compliance for Requirements (3)(c) and (3)(d) following a Site Audit undertaken from 17 August 2021 to 19 August 2021. These include; implementation of systems to ensure criminal history, flu vaccinations, and nursing registrations are checked, improvements to feedback and complaints processes, development of pathways to manage and document incidents, and implementation of processes to analyse, trend and evaluate incidents.

At the Site Audit, the Assessment Team found there are effective organisation wide governance systems in place to support information management, continuous improvement, workforce governance, financial governance and feedback and complaints. The Assessment Team also found there are systems and practices are in place to ensure effective management of high impact or high prevalence risks, identifying and responding to abuse and neglect, and supporting consumers to live the best life they can.

While some deficiencies were identified in relation to how feedback and complaints feed into the Plan for continuous improvement and numbers of staffing, these have been considered under Requirement (3)(d) in Standard 6 Feedback and complaints, and Requirement (3)(a) in Standard 7 Human resources respectively.

The organisation’s clinical governance framework guides staff in relation to minimising the use of restraint, open disclosure, and antimicrobial stewardship. Monitoring of clinical data and incidents, and feedback and complaints is undertaken to ensure consumer care is delivered in line with organisational policies and procedures and opportunities for improvement are identified. Sampled care files showed regular review of consumers’ subject to restrictive practices and antibiotic usage.

Based on the above evidence, I find the service compliant with all Requirements in Standard 8 Organisational governance.

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)