Performance

Report

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| Name of service: | HammondCare Waratah |
| Service address: | 15 Tinonee Road WARATAH NSW 2298 |
| Commission ID: | 0369 |
| Approved provider: | HammondCare |
| Activity type: | Site Audit |
| Activity date: | 30 May 2023 to 2 June 2023 |
| Performance report date: | 2 August 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 HammondCare Waratah (**the service**) has been prepared by G Hope-Simpson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 Approved Provider’s response to the assessment team’s report received 19 July 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 1(3)(c) – The Approved Provider ensures consumers are supported to make and express decisions about their care and services, and each consumer is supported to freely move about and socialise in the service environment. The Approved Provider ensures legal requirements are met, for all consumers who are subject to environmental restrictions.
* Requirement 5(3)(b) – The Approved Provider ensures consumers can move freely inside and outside the service, consumers enjoy freedom of movement and access to all areas of the service environment in line with their assessed needs and preferences. The Approved Provider ensures legal requirements are met, for all consumers who are subject to environmental restrictions.
* Requirement 8(3)(c) –The Approved Provider ensures legal requirements are met, for all consumers who are subject to environmental restrictions at the service. The Approved Provider ensures appropriate oversight of restrictive practice use at the service and ensures there is effective oversight of continuous improvement actions launched in response to the site audit findings. The Approved Provider ensures improvement actions are monitored, evaluated and sustained.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | 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 |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Assessment Team recommended Requirement 1(3)(c) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and have agreed with the Assessment Team’s recommendation. Relevant (summarised) evidence from the Site Audit Report is as follows.

The Assessment Team found that some consumers were supported to exercise choice and make decisions about how their care and services were delivered but found that many others were not. The Assessment Team identified that many consumers could not move about the service or exit the service as they chose, but the service did not recognise these consumers were subject to restrictive practices. As a result, the service did not meet the legislative requirements for use of environmental restrictive practice for those consumers.

The Site Audit Report brought forward detailed evidence in relation to a sample of 4 such consumers. The Assessment Team found the restricted consumers were prevented from moving freely throughout the service as a number of the service’s cottages were locked secure units. The Assessment Team found that most consumers were not given the PIN code to enter and exit their cottages independently. Consumers relied on staff to grant them any access they required but some said staff were not always available to assist them. Service staff cited consumer safety as the reason for not allowing consumers to move about the service as they wished. One consumer said they wanted to socialise when they felt like it but could not as a result of the restrictions, others simply could not access activities or facilities in other parts of the service as they wished.

The Site Audit report identified consumers, or their representatives had signed ‘consent to live in a secure environment’ forms, however they did not reflect informed consent for use of an environmental restraint. One consumer reported signing the form because they were asked to. These consumers also did not have any assessments that identified a need for the environmental restraint, nor were the consumers being reviewed to determine the impact of the restraints.

Lastly, the site audit report also noted that most consumers said they were supported to maintain relationships however, the service did not provide rooms for married couples who all resided in different wings of the service. These consumers noted that the arrangements had not impacted them.

The Approved Provider’s written response, received on 19 July 2023, disputed the Assessment Team’s recommendation for non-compliance with Requirement 1(3)(c), but accepted the recommendations of non-compliance made in other Requirements 5(3)(b) and 8(3)(c), that were based on the same deficits. The written response clarified some inaccuracies in the site audit report, disputing a finding about the total number of consumers subject to environmental restraint. However, the Approved Provider accepted the overall finding that there were a number of consumers being environmentally restricted without legal requirements being met and identified this applied to 24 consumers. The Approved Provider considered, however, that the evidence in the site audit report demonstrated overall, the service was supporting consumers’ choice and independence in all other ways, and that the service’s failures in relation to environmental restrictive practices ought not be carried over to Requirements 1(3)(c) and 2(3)(a), as to do so would be contrary to the intent of those Requirements.

The response also outlined an improvement program planned to address the deficits in understanding and management of restrictive practices at the service. Planned and implemented actions included a full review of the accessibility arrangements at the service with the aim of removing keypads, as well as training on understanding environmental restrictive practice for registered nurses. The Approved Provider confirmed they already completed such training with the service’s management team.

Regarding consumers not being supported to maintain relationships, the Approved Provider’s response confirmed that married consumers were living in separate areas of the service due to differing care needs, as per their choice and that at other times, married consumers had lived together or in adjoining rooms. I was persuaded by this aspect of the response and find it is not strong evidence the service failed to support consumers to maintain relationships of choice.

Having considered the evidence in the site audit report and the response, I find the service is not compliant with Requirement 1(3)(c). I find the service fundamentally failed to ensure 24 consumers could exercise the most basic choices being to leave their cottage environment unassisted, when they wanted to. In this, the service failed to support consumer independence. The consumers’ choice to leave their rooms and cottages and walk to other areas in the service unassisted, or to exit the service, was removed without proper assessment or evidence to justify the restriction. One consumer reported it made socialising difficult, that they could not go for walks outside the cottage when they chose; another was prevented from taking themselves to the weekly on-site church service, as was their wish. Another consumer said they had been advised they were ‘not allowed’ to go outside unaccompanied as they wanted, to go for walks within the service. A fourth consumer could not access the gym or an outside balcony that they wanted to use. I am satisfied these four examples support the finding that consumers were not supported to make decisions about how their care and services were delivered, as they were not allowed to choose to move about unsupported by staff.

As the service failed to demonstrate compliance with Requirement 1(3)(c)(i), I find the service is not compliant with Requirement 1(3)(c) as a whole. While I acknowledge the Approved Provider’s response, I consider at the time of the Site Audit, the service did not demonstrate that consumers were consistently supported to choose how their care and services were delivered. While the Approved Provider outlined a review of access arrangements at the service, there was insufficient information in the response to demonstrate that the service had taken sufficient steps, since the site audit, to safely restore independent freedom of movement to consumers in the service. Further monitoring by the Commission is necessary to ensure appropriate steps are taken to ensure consumers’ choice and independence in decision making are recognised and honoured, appropriate dignity of risk measures taken and that any decision to curtail freedom of movement meets all legal requirements for environmental restraint.

For these reasons, I find the service is non-compliant with Requirement 1(3)(c).

I am satisfied the service complies with the remaining 5 requirements of Quality Standard 1.

Overall consumers said they were treated with dignity and respect, however some consumers were not provided with door PIN codes to allow them to come and go at will. Staff were respectful when discussing consumers and were familiar with their background and life history. Staff practice was guided by a diversity and inclusion policy.

Consumers said care provided was mostly consistent with their cultural traditions and preferences. Staff were familiar with consumers’ cultural needs, and tailored care and services accordingly. The lifestyle calendar reflected a range of cultural activities of relevance to consumers and care plans showed assessment and planning that was cognisant of consumers’ religion, language and cultural beliefs.

The service demonstrated some understanding of dignity of risk, and had a Choice and Decision-Making policy to support consumers to take chosen risks. Most consumers said they were supported to take risks and live the best life they could, and care planning documentation contained evidence of risk assessments with mitigation strategies documented and dignity of choice consultation records on file. However, as outlined in Requirement 1(3)(c), several consumers expressed frustration at not being allowed to move around the service or exit the service independently. This evidence has been used to support non-compliance in 3 other requirements, and on balance, the Assessment Team were satisfied the majority of consumers were supported to take risks to support their quality of life.

Consumers and representatives said they received current, accurate and timely information. Staff described various ways consumers were informed of daily activities including through phone calls and emails. Newsletters, menus and activity calendars were displayed on noticeboards.

Consumers confirmed their privacy was respected, and their personal information kept confidential. Staff confirmed a privacy policy guides their practice and practical examples given to support its implementation included closing doors prior to providing care and storing care information on password protected computers. Observations confirmed staff respected consumer privacy in provision of personal care.

# Standard 2

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

Findings

The Assessment Team recommended Requirement 2(3)(a) was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and have disagreed with the Assessment Team’s recommendation. Relevant (summarised) evidence from the Site Audit Report included:

The Assessment Team’s recommendation was based on the service’s failure to correctly recognize a number of consumers who were environmentally restricted, as outlined previously in Requirement 1(3)(c). In addition to that evidence, at Requirement 2(3)(a), the Site Audit Report identified a further cohort of consumers who were restrained without restrictive practice requirements being met. The report emphasised the lack of assessments undertaken by the service, to consider the risks of restraint or to justify the use of the restraints on those consumers. The report also noted that there was no ongoing assessment as to the impacts of the restraints on consumers’ health and being. Several the consumers did not have behaviour support plans in place and there was a lack of dignity of risk assessments on file for sampled consumers who wanted to mobilize independently inside the service, to support them to do so. Although the service had assessment and care planning policies in place to guide practice, the assessment and care planning process conducted did not align with the policies.

The Approved Provider responded on 19 July 2023 and disputed the Assessment Team’s recommendation in relation to Requirement 2(3)(a), noting that the site audit report did not provide any evidence of lacking assessment and planning, aside from that relating to flawed application and identification of environmentally restricted consumers. The Approved Provider considered the recommendation was not in keeping with the intent of the Requirement and they noted the numerous findings in the report of effective assessment and planning for the clinical and personal care of most consumers residing at the service. Other relevant aspects of the response have been outlined earlier in Requirement 1(3)(c), which I have considered.

Having regard to the evidence throughout the entirety of the site audit report, and in the Approved Provider’s response, I have reached a different conclusion to the Assessment Team. While there was a lack of assessment and planning relation to environmental restraints, these failures have been adequately assessed through findings of non-compliance in other more relevant Requirements. Throughout Quality Standards 2 and 3, there were sufficient examples of assessment and planning that identified risks relating to falls, skin integrity, diabetes management and pain. As no other evidence was led to show the service did not use effective assessment and planning to inform the delivery of safe and effective care and services, on balance, I am satisfied the service complies with Requirement 2(3)(a).

I find the service also complies with the remaining 4 requirements of Quality Standard 2:

Consumers and representatives confirmed consumers’ goals and preferences, including for advance and end of life care, were discussed with them either in-person, by telephone, or during case conferences. Staff confirmed, and care documentation evidenced, consumers’ care plans contained their individual needs, goals and preferences.

Consumers and representatives said they felt like partners in the planning of care. Staff confirmed care consultations and case conferences were regularly held with consumers, representatives, and external professionals. Care documentation reflected input from consumers, representatives, medical officers and allied health professionals.

Consumers and representatives confirmed they had copies of the consumer’s care plan and were kept updated when care changed. Management confirmed meetings were conducted regularly to evaluate the care provided. Staff confirmed care plans were readily available to them at the point of service delivery, via the electronic care management system. Care plans showed the service documented the outcomes of assessment and planning and communicated their outcomes to consumers and representatives via regular care plan reviews and care conferences.

Management and staff described how and when consumers’ care was reviewed, or reassessment occurred. Care documentation evidenced care was reviewed every 3 months, or when a change or incidents occurred. Additionally, monthly ‘Resident of the Day’ reviews were held. Consumer representatives confirmed care reviews were routinely scheduled and considered that needs were assessed in a timely manner after changes or incidents.

# Standard 3

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

Findings

Most consumers and representatives said consumers were receiving safe and effective personal and clinical care tailored to their needs and that optimised their health and well-being. Staff could describe consumers’ individual needs and preferences and how these were delivered in line with care plans. Clinical documentation for sampled consumers mostly reflected individualised care that was safe, effective, and tailored to the specific needs and preferences of the consumer. Charting showed care directives for pressure injuries were followed by staff, pressure area care strategies were identified and implemented, pain was assessed and managed with non-pharmacological and pharmacological methods. The use of restrictive practices, except for environmental restraints, was in line with requirements. As outlined previously, the service had deficits in its understanding of environmental restrictive practices, however, this has been assessed in more relevant Requirements. On balance, the weight of evidence reflected the service complied with Requirement 3(3)(a).

Consumers and representatives reported they were involved in developing risk management strategies and they felt the service managed these risks well. Management and staff gave practical examples of how high impact and high prevalence risks were managed. Care documentation contained strategies to minimise risks to consumers, including in relation to falls, diabetes, pain and catheter management. Care plans, along with performance indicator reporting, demonstrated the service was effectively monitoring and managing high-impact and high-prevalence risks. Staff were supported by clinical policies and procedures in management of high impact, high prevalence risks.

Care documentation for a consumer who recently passed away reflected the consumer was kept comfortable and their representative confirmed the consumer’s end of life wishes had been respected. Staff described how end of life care emphasised comfort and dignity, through regular repositioning, pain management, oral care and emotional and spiritual support. The service collaborated with palliative care specialists and medical officers. Policies and procedures supported staff to deliver appropriate end of life care.

Consumers and representatives gave positive feedback, stating staff promptly recognised and responded to deterioration in consumers’ condition. Staff confirmed seeking medical officer review to assess identified deterioration or referring consumers to hospital for urgent needs. Care documentation evidenced prompt identification of and response to changes. A recognition of clinical deterioration policy and procedure was in place to guide staff practice.

Consumers and representatives said they were satisfied information about consumers’ needs, and preferences was effectively communicated between staff. Staff were able to explain how changes in consumers’ care and services were communicated, including via handover at the commencement of each shift and through care plans and progress notes.

Consumers and representatives said referrals to individuals, other organisations and providers were timely and appropriate. Staff understood referral pathways, and care documentation reflected referrals made to a range of allied health professionals, medical officers, dementia support and other services. Procedures were in place setting out referral processes.

Consumers and representatives gave positive feedback regarding the service’s infection management practices. Staff were knowledgeable about antimicrobial stewardship, strategies to minimise infections and were guided by an Infection Prevention and Control Lead who monitored practices. Observations confirmed sufficient supply of personal protective equipment and that a high proportion of staff and consumers had been vaccinated.

# Standard 4

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

Findings

Consumers said they were supported to engage in activities of interest which optimised their health, well-being, and quality of life. Staff described supporting consumers to engage in group activities or undertake independent activities, if appropriate. A calendar reflected a range of activities tailored to consumers’ interests, including bedside activities for consumers who were non-ambulant.

Consumers generally felt supported to maintain social, emotional, and spiritual connections which were important to them. The service’s Pastoral Care team provided spiritual and emotional support for consumers, their families and for staff. Care documentation reflected consumers’ spiritual preferences.

Consumers said they were supported to maintain important relationships and participate in the community. Staff described the supports in place to enable consumers to participate in the wider community, including a companionship program with the local primary school and the service ran a volunteer program to support linkages with the community. Pet therapy, music, arts and crafts, as well as walking and games programs were run by volunteers at the service.

Consumers and representatives said the service shared consumer information effectively with those involved in care. Staff gave practical examples of how consumers’ daily living needs were communicated between different service areas, including handovers and meetings. Care documentation contained consistent information on consumers’ individual support and dietary needs.

Staff described collaborating with other care providers to supplement consumers’ care and interests, including those aligned with consumers’ specific preferences. Care documentation evidenced timely and appropriate referrals were made to support consumers’ lifestyle and emotional needs, including, for example, to a local not for profit group providing a volunteer visitor and companionship program.

Most consumers (32 of 37) gave positive feedback about the quality and quantity of food. However other consumers expressed concerns in relation to the quality of fish and chips and a lack of culturally appropriate food. Hospitality staff and management confirmed they were aware of the feedback raised and had conducted a survey and met with individual consumers regarding their preferred choices. Management said the survey responses were positive and they had placed an order for an alternative fish product and were awaiting delivery. A more tailored cultural meal plan had been developed with one named consumer, to ensure more appropriate meals were offered to them.

Consumers said they had access to safe, clean, and well-maintained equipment. Staff described their role in ensuring shared equipment was kept clean. Equipment to support mobility and manual handling was observed to be clean and maintenance documentation evidenced that it was regularly serviced.

# 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

The Assessment Team recommended Requirement 5(3)(b) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and I have agreed with the Assessment Team’s recommendation. Relevant (summarised) evidence outlined in the Site Audit Report is as follows.

Although consumers and representatives said the service environment was clean, well maintained and comfortable, the service did not enable a significant number of consumers to move freely both indoors and outdoors as they were not given PIN codes for internal doors. The Site Audit Report reported observations of consumers who were not able to exit their wing of the service on their own and had to request staff to enter the PIN code into the keypads to provide them with access. Most times staff were not readily available to provide the access when required so consumers had to wait to be let out or back into their wing. Consumers said they had to be escorted to where they wanted to go. A number of interviewed consumers were unhappy about being unable to move about as they wished. Staff reported the measures were in place for consumer safety and that consumers had signed consent forms for a secure environment on admission. Refer to Quality Standard, Requirement 1(3)(c) for further detail.

The Approved Provider responded on 19 July 2023 and acknowledged the deficits identified during the Site Audit, though they provided some clarification of the total numbers of consumers who were environmentally restrained without relevant legal requirements being met, at the time of site audit. The response also outlined a range of improvement measures planned to address the deficits. I have outlined the relevant parts of the Approved Provider’s written response in Requirement 1(3)(c).

Having had regard to the evidence in the Site Audit Report and the response, I am satisfied that the use of keypad locks throughout the service prevented a significant number of consumers from exercising their right to move freely, within and outside the service, and that this occurred without relevant legal requirements being met. I have outlined in detail the reasoning for my finding, in Requirement 1(3)(c), which also supports my finding of non-compliance in this Requirement 5(3)(b).

I acknowledge the corrective actions undertaken by the Approved Provider during and after the Site Audit however I note that while the service may have identified the deficits prior to the site audit, they had not taken timely action to remedy these, and staff and management understanding of restrictive practices was lacking. Time is required to implement corrective actions outlined in the response and monitoring will be required to ensure improvement actions are monitored, evaluated and sustained. For these reasons, I find this the service does not comply with Requirement 5(3)(b).

I find the service complies with the remaining 2 Requirements of Quality Standard 5.

Consumers and representatives said the service environment was open and welcoming and they felt at home. Staff explained how they make consumers feel at home by encouraging them to decorate their room with personal belongings. Most consumers were observed utilising the shared indoors and outdoors spaces however, some consumers’ interaction with the service environment was restricted as they were not free to come and go independently, as previously discussed. The service environment otherwise promoted independence and belonging with well-lit sitting areas with comfortable chairs for socialising, as well as clearly signed hallways to aid in wayfinding. Consumers were observed socialising with each other and with visitors during the site audit.

Consumers and representatives said, and observations confirmed, furniture, fittings, and equipment were safe, clean, and well maintained. Staff confirmed faulty items were immediately removed and assessed for repair. Records evidenced regular servicing of equipment and timely attendance to maintenance issues. The service had in house cleaners employed 5 days per week, with daily, weekly, monthly and quarterly cleaning schedules in place.

# Standard 6

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

Findings

Consumers and representatives said they were supported to provide feedback or make complaints and knew how to do so. Staff described how they supported consumers to provide feedback, and how they would assist them to complete feedback forms. Management described an open-door policy for consumers and representatives to voice their complaints and how these were actioned. Documentation and observations showed robust feedback processes were in place.

Consumers and representatives said they were aware of other avenues for raising complaints and were comfortable raising concerns with management. Staff were knowledgeable about advocacy services to support consumers with diverse needs. Brochures, newsletters, feedback forms and consumer handbooks promoted internal and external advocacy and complaints mechanisms, including the Commission. Information about interpreter services was displayed and multilingual volunteers were also used.

Consumers and representatives said management promptly responded and sought to resolve their concerns in response to complaints. Staff explained the underlying principles of open disclosure, and training records showed staff had received education on open disclosure. Review of the feedback register showed the service used open disclosure and resolved complaints in a timely manner, in line with service policy.

Consumers were satisfied with feedback processes and said they had seen improvements at the service following complaints and feedback. Trending and analysis of complaints, feedback, and concerns raised by consumers or representatives were used to inform continuous improvement activities across the service. This was documented in the Plan for Continuous Improvement. Management gave examples of changes implemented from feedback and complaints, such as implementation of the ‘Partnering in Care’ program during lockdowns, to support consumers to remain connected to family.

# Standard 7

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

Findings

Consumers and representatives said staff were delivering safe and quality care and services, but said they were aware there were staff shortages at times. Staff said there had been an improvement in staff numbers and the team worked together to do extra hours when the need arose. Management confirmed shift vacancies were filled from a staff pool or by agency staff as a last resort. Rosters evidenced adequate staffing levels and skill mix for each shift.

Consumers and representatives said staff engaged with consumers in was that were respectful, compassionate, and kind. Staff were observed interacting mindfully and attentively, and they knew sampled consumers’ needs, preferences, and cultural backgrounds.

Consumers felt confident staff were skilled to meet their care needs. Management detailed processes for ensuring the workforce was competent and had the qualifications or knowledge to effectively perform their roles. Staff records evidenced members of the workforce had relevant qualifications to perform their duties, police checks had been performed and RNs had current registrations.

Staff said they were trained, equipped, and supported to deliver safe and effective care. They were comfortable to request additional training if needed, to improve their performance. Education records identified staff participated in mandatory training and other training identified as required, with mandatory modules aligned to these Quality Standards. Consumers and representatives expressed confidence in the abilities of staff and the service employed an Education Officer and Workplace Coaches to provide training to staff.

Management described the schedule of routine performance monitoring and advised they had identified prior to the Site Audit that some annual performance assessments were overdue. Management had a plan to complete all outstanding appraisals by end of the financial year and were on track to achieve this. Management stated staff performance was otherwise monitored through staff surveys and performance issues were escalated by team leaders and addressed.

# 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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The Assessment Team recommended Requirement 8(3)(c) was not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit report and the provider’s response and have agreed with the Assessment Team’s recommendation. Relevant (summarised) evidence is as follows.

The Assessment Team found the service had effective organisational governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. However, as previously outlined in Quality Standards 1 and 5, the Team found deficits in the service’s management of restrictive practices. Notably, a significant number of consumers were subject to environmental restrictive practices and could not access communal areas, or exit the service, at their own leisure or without assistance. A number of these consumers subject to restraint were not identified as such, and as a result, regulatory compliance requirements were not met. The service utilised a blanket consent form that was signed by consumers or representatives on admission, however did not correctly identify all consumers who were environmentally restrained by the use of key coded locks on cottage doors, and thus did ensure relevant assessments had been completed to justify the use of the restraints, did not gain informed consent, and did not comply with other regulatory requirements. The organisation had relevant policies and procedures in place which were current and in line with legislative requirements. Refer to Standards 1 and 5 for further details.

The Approved Provider responded on 19 July 2023 and acknowledged the overall deficits identified during the Site Audit. The response described actions planned and completed following the Site Audit to address the deficits. Relevant aspects of the response have been detailed in Quality Standard 1, Requirement 1 3(c).

I have had regard to the evidence in the Site Audit Report and the response and I acknowledge the service has identified appropriate reforms and education needed to address the deficits in understanding and use of environmental restrictive practices. While the organisation’s internal governance mechanisms had apparently identified these deficits prior to site audit, evidence of this was not provided with the response and satisfactory steps had not been taken to rectify the problems before the site audit. A review and further education and training has commenced since the site audit, however the effectiveness of this review, and whether there is lasting change in staff practice as a result, is unclear at the time of writing this Performance Report. Monitoring by the Commission will be required to ensure the safety of consumers and compliance with the Quality Standards, moving forward.

For these reasons, I find the service does not comply with Requirement 8(3)(c).

I am satisfied the service complies with the remaining 4 requirements of Quality Standard 8.

Consumers and representatives said they were involved in discussions and development of the service through feedback forms, surveys, committees and resident and representative meetings. Feedback and suggestions made by consumers and representatives were used when planning engagement activities and programs.

Management described how the organisation’s governing body promoted a culture of safe, inclusive, and quality care and services. The governing body was supported by the Quality, Safety and Care subcommittee. Monthly reports submitted to the board via the committee captured information, including clinical indicators, incidents and complaint trends and results of routine audits, giving the board oversight of the service’s operations.

A risk management system was used to monitor and assess high impact or high prevalence risks associated with the care of consumers however, deficiencies were identified with how the service managed consumer’s subject to environmental restraints, as outlined previously. Incidents were used to identify knowledge gaps in staff training or procedures and to drive changes to policies and procedures. An online incident management system was in place. Members of the workforce had been trained in their obligations to identify and respond to abuse and neglect, under the Serious Incident Reporting Scheme. Dignity of risk processes were in place and adhered to, except in relation to consumers who wanted to move about the service and exit the service independently. On balance, the Assessment Team were satisfied there were overall, effective risk management systems and practices in place in all relevant areas.

A clinical governance framework that included policies promoting antimicrobial stewardship, minimising use of restrictive practices and open disclosure was in place however, the service did not effectively minimise the use of environmental restrictive practice. On balance, the Assessment Team were satisfied Requirement 8(3)(e) was met.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)