Performance

Report

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| Name of service: | Harbourside Haven Gardens |
| Service address: | 89a Shoal Bay Rd SHOAL BAY NSW 2315 |
| Commission ID: | 2738 |
| Approved provider: | Port Stephens Veterans and Citizens Aged Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 August 2023 to 16 August 2023 |
| Performance report date: | 13 October 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 Harbourside Haven Gardens (**the service**) has been prepared by J Durston, 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 Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received on 18 September 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(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 |

Findings

The service was found non-compliant in Requirements (1)(3)(a), 1(3)(c) and 1(3)(d) following a site audit from 25 October to 28 October 2022.

Requirement 1(3)(a)

Following the 2022 Site Audit it was found the service did not consistently treat all consumers with dignity and respect, in areas such as hygiene and toileting support.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service delivered staff training on treating consumers with dignity and respect and reviewed consumers’ hygiene and toileting needs to ensure they receive timely and appropriate support.

The Assessment Team found most sampled consumers and representatives said they are treated with dignity and respect and their identity, culture and diversity is valued. All consumer care plans reviewed had consumer background information about their life before entry to the service. Staff were observed to address consumers politely and respectfully and were aware of consumers’ backgrounds and cultural diversity.

In their response to the Assessment Team report, the approved provider submitted additional information to support its compliance with this requirement. The approved provider noted that a named consumer in the Assessment Team report was noted to have said they had waited for 30 minutes for a response to their call bell ‘on occasion’. However, the approved provider advised the consumer has since confirmed the delay occurred once, when the staff member acknowledged the call bell and went to seek another staff member to assist, and the consumer has provided positive feedback regarding improved call bell response times with the new call bell system.

Requirement 1(3)(c)

Following the 2022 Site Audit it was found the service did not always provide all consumers with choices or support for their independence. The visitor booking system reduced easy access for consumers to family, friends and the community.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The Resident of the day schedule and tasks were reviewed and updated. Care conferences were offered on admission, training delivered to staff on care planning policy and processes and the resident of the day system and all care plans are to be reviewed over 6 months.

The Assessment Team found All the consumers and representatives interviewed were satisfied they have opportunities to exercise choice on how their care is delivered and consumers have independence and maintain relationships in line with their wishes.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 1(3)(d)

Following the 2022 Site Audit it was found the service did not demonstrate that each consumer is supported to take risks to enable them to live the life they want.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Consumers’ lifestyle assessments were reviewed to incorporate dignity of risk where applicable, education was delivered for lifestyle staff on documentation requirements, the lifestyle program was reviewed with input from consumers, and the dignity of risk policy was reviewed.

The Assessment Team found through interviews with sampled consumers and/or their representatives, observations and review of care documentation, that consumers are supported to take risks to enable them to live the best life they can.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 1(3)(a), 1(3)(c) and 1(3)(d) compliant.

# Standard 2

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

Findings

The service was found non-compliant in Requirements (2)(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) following a site audit 25 October to 28 October 2022.

Requirement 2(3)(a)

Following the 2022 Site Audit it was found the service did not demonstrate an effective assessment and care planning system, and risks to consumers’ health, safety and wellbeing were not identified and documented to inform the delivery of effective care and services.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Consumer care plans have been reviewed and updated. Respite and permanent admission checklists have been reviewed. Staff training was delivered on assessment and care planning. Clinical coordinators commenced regular audits of consumer documentation and daily reviews of new admissions to ensure effective care and services. The service demonstrated their ability to regularly and effectively assess and plan to meet consumers’ needs, including consideration of risk.

The Assessment Team found consumers and representatives said they are involved in planning their care and risks are explained throughout the decision-making process. Care documentation showed risks are identified during consumers’ entry to the service, when changes are identified and when incidents occur.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 2(3)(b)

Following the 2022 Site Audit it was found the service did not demonstrate that care plans were reflective of consumers’ current needs, goals and preferences., including end of life care.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Consumers’ care plans were reviewed and updated to meet their needs and preferences. Other improvements include implementation of a regular care plan reviews and timely reviews when consumers’ condition/circumstances change, case conferences with consumers and their representatives are held on admission, annually and as needs change. Clinical and care staff were educated on the assessment and planning processes, documentation and end of life care. Clinical Care Coordinators regularly audit and review consumer documentation.

The Assessment Team found sampled consumers and their representatives said they are asked about their care preferences and the care they receive is aligned with their preferences. Fifteen consumer files sampled reflected that the needs of the consumer are identified and include the use of advanced care directives and/or end of life care and preferences. Care documentation showed care plans were reviewed when consumer care needs changed.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 2(3)(c)

Following the 2022 Site Audit it was found the service did not demonstrate there was an ongoing partnership with consumers and representatives. There was no system at the service to ensure consultation occurred or was recorded. Care documentation was not up to date in relation to consumer care needs.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Care plans were updated and redesigned to make them easier to understand for consumers and their representatives. A system has been set up by clinical management to ensure regular auditing and review of consumers’ care plans.

The Assessment Team found that the service demonstrated consumers and their representatives are partners in the assessment, planning and review of a consumer’s care and services. All consumers and representatives sampled provided positive feedback regarding staff communication of consumer needs and their involvement in planning of their care and service. Care documentation showed other organisations and providers of care and services are also included in assessment and planning.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 2(3)(d)

Following the 2022 Site Audit it was found the service did not demonstrate that consumers and their representatives were provided with or had access to their care plan.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Training was delivered to staff on partnerships in care. Registered nurses were educated to contact representatives regarding changes to consumer care plans. Management conducted interviews with consumers about how to improve consultation and communication with staff to inform future improvements.

The Assessment Team found 10 sampled consumers and their representatives stated that they were provided with their care plans. Care planning documentation showed that outcomes of care planning and assessments were documented in a timely manner and communicated to consumers and representatives through case conferences and/or phone calls, and outcomes of discussions are documented within consumer files.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 2(3)(e)

Following the 2022 Site Audit it was found the service did not demonstrate comprehensive care plan review is conducted when circumstances change, or incidents occur that impact the needs goals or preferences of the consumer. Care documentation showed that changes in consumers’ condition were not being managed effectively, and reported incidents were not routinely evaluated to minimise risks to consumers.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Staff training was delivered on incident management, Serious Incident Reporting Scheme (SIRS) and incident prevention strategies. The service updated its policies and procedures to include regular care plan review and review when circumstances change which may impact the consumer’s needs, goals and preferences. Flow charts on the procedures for reportable incidents were developed, and monthly audits are attended by clinical nurse coordinators to ensure effective and complete incident reporting.

The Assessment Team found care plans are regularly reviewed and follow-up actions documented. Care documentation showed there is comprehensive investigation of incidents, and consumer care plans are subsequently reviewed for effectiveness to minimise risk future risk.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) compliant.

# Standard 3

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

Findings

The service was found non-compliant in Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d) and 3(3)(e) following a site audit from 25 October to 28 October 2022.

Requirement 3(3)(a)

Following the 2022 Site Audit it was found the service did not demonstrate safe and effective personal or clinical care was provided to consumers that was tailored to their needs, goals and preferences. Clinical care including wound care, diabetes management, pain management, enteral nutrition, falls management and clinical observations was not in line with best practice standards.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Training was developed for all staff on falls management, skin integrity and wound and pressure injury management and pain management. Registered nurses were provided with training targeting complex care needs, including enteral feeding, catheters, diabetes management, high risk medications and postural hypotension and documentation for these cares. Regular audits by clinical care coordinators were implemented for wound management and charting. New complex care assessment tools were implemented. Consumers’ diabetic management plans were reviewed by clinical management with general practitioners (GP’s) ensure individualisation.

The Assessment Team found each consumer receives safe and effective personal and clinical care. Consumers and representatives provided positive feedback regarding staff knowledge and provision of personalised care. For example, care documentation reflected consumers’ current condition, needs, goals and preferences. Consumers living with diabetes are monitored and blood glucose levels (BGLs) are managed as per their GP’s instructions. Consumers who experience weight loss have all been seen by a dietician and strategies and directives are in place to manage this. Wound charts sampled show consistent monitoring of wounds including the use of consistent photographs and measurements.

The Assessment Team noted that there were discrepancies between the dietician’s nutrition recommendations and what was reflected in the medication signing sheet for a named consumer with percutaneous endoscopic gastrostomy (PEG) feeds. However, when raised with the clinical care manager, the service requested the pharmacy to align nutrition prescriptions more closely with the dietician’s recommendations.

In their response to the Assessment Team report, the approved provider submitted additional evidence to support its compliance with this requirement, that showed required enteral feeds and flush volumes/times for the named consumer were recorded on multiple areas including medical chart, dietician report, nutrition and hydration assessment care plan. Also, an enteral feeding chart was supplied by the approved provider that captured fluid volumes separated into formula and water amounts. In addition, training has been delivered to registered nurses on enteral feeds and the clinical care coordinator is monitoring enteral feeding charts and progress notes daily to ensure correct volumes are entered.

Requirement 3(3)(b)

Following the 2022 Site Audit it was found the service did not demonstrate that high impact or high prevalence risks were managed effectively, particularly in relation to restrictive practices. Clinical staff could not identify the high impact/high prevalence risks for consumers in their care.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Training was provided to all staff on the use of restrictive practices, and to registered nurses on recognition and management of high prevalence risk. A new psychotropic register was created, and service staff and management worked with the nurse practitioner and GPs to ensure correct charting of psychotropic medications.

The Assessment Team found the service demonstrated that there are systems in place to manage high impact/high prevalence risks associated with the care of each consumer. Documentation showed risks, including those related to restrictive practices and behaviour support, are managed appropriately. Management and staff could identify high risk consumers and outline the care strategies to manage their risks. Care plans included strategies to mitigate risks to consumers to live their best life. The electronic medication management system was audited to check missed medications by clinical management and staff on each shift. Care documentation showed staff appropriately assess, manage and escalate falls incidents in line with the service’s post falls policy and procedures. All consumers sampled who have experienced a fall are reviewed by their GP and by the physiotherapist.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 3(3)(c)

Following the 2022 Site Audit it was found the service did not demonstrate that consumer comfort is maximised or dignity is preserved towards the end-of-life. Documentation regarding monitoring end-of-life of symptoms and management of care was not attended and not all consumers sampled had an advanced care directive or end of life care plan in place.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Education was provided to clinical and care staff on end-of-life assessment and planning processes, care and documentation.

The Assessment Team found the service demonstrated recognition of the needs, goals and preferences of consumers nearing the end of their life and ensured their comfort and dignity was maximised as per consumer and representative wishes. This was reflected in care documentation and consumer and representative feedback.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 3(3)(d)

Following the 2022 Site Audit it was found the service did not demonstrate that consumers with deteriorating conditions were identified or managed appropriately. Care documentation showed a there was a lack of records regarding appropriate actions taken to manage wounds, medication side effects and allergies and challenging behavioural issues.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service delivered staff training on early identification of changes/deterioration in a consumer’s condition. Clinical management is monitoring and reviewing the effectiveness of the new system for early identification of deterioration in a consumer’s condition.

The Assessment Team found the service demonstrated appropriate recognition of consumers who have experienced a change in their condition, cognitive or physical function, capacity or mental health, and their needs are recognised and responded to in a timely manner. Consumers and their representatives told the Assessment Team that they are happy with the communication and responsiveness of the staff when further clinical care is needed.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 3(3)(e)

Following the 2022 Site Audit it was found that information on consumer care and services was inconsistent and unable to be easily located by management and staff when requested by the Assessment Team. Staff said important information regarding consumer conditions was not always communicated within the service or where responsibility for care was shared.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service implemented an updated communication policy and process including a new notification system for general practitioners that can be tracked by registered nurses. Training was delivered to staff on referral systems and the list of service providers, and specialists was updated for registered nurses to access.

The Assessment Team found the service effectively communicates the care needs of consumers. Consumers’ information is updated by a registered nurse on care plans and nursing notes on the electronic care management system, and verbally passed onto care staff in regular handovers and huddles.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 3(3)(f)

Following the 2022 Site Audit it was found the service did demonstrate that referrals occurred in a timely manner. The service had no system in place to track and ensure referrals were made.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The list of service providers, specialists and after-hours providers was updated for registered nurses to access. Clinical care coordinators continually monitor progress notes and other clinical documentation to ensure referrals are sent and followed up in a timely manner, and care plans are current. Training was provided to registered nurses regarding the referral process.

The Assessment Team found the service demonstrated consumer referrals to behavioural support/dementia specialists, physiotherapists for post fall reviews, a dietician regarding weight loss/management and a speech pathologist for swallowing difficulties, are timely and appropriate. Care documentation, including care plans of sampled consumers, included input from allied health professionals and showed their care recommendations were implemented. The service also has a nurse practitioner to review changes in consumers’ condition and to complete routine health checks.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 3(3)(g)

Following the 2022 Site Audit it was found the service did not demonstrate an effective infection control system including standard and transmission-based precautions. Staff were not able to locate an outbreak management plan. The service did not have the legally required infection prevention and control lead and the service had not collected data on infections for several months.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service trained 2 infection prevention and control (IPC) leads, Staff were trained in infection control practices such as waste disposal correct face mask fitting, donning and doffing PPE and hand washing. The service outbreak management plan was updated, and extra wall sanitisers were ordered.

The Assessment Team found the service demonstrated effective infection control and antimicrobial stewardship practices. The service had an outbreak management plan and 2 IPC leads. The service had a consumer and staff vaccination register and an infection control register to track current and previous consumer infections. Staff and management were able to explain the key principles of effective antibiotic use, and care documentation reflected effective antimicrobial stewardship practices.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

The service was found non-compliant in Requirements 4(3)(d) following a site audit from 25 October to 28 October 2022. The service did not demonstrate effective multidisciplinary team communication regarding the care needs and preferences of consumers. Staff were unaware of care recommendations received by other care providers, and the service did not have an effective care management system to support communication.

Requirement 4(3)(d)

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Weekly leadership team meetings including lifestyle staff have been implemented and the care services monthly meeting was re-instated. Group email was implemented to improve lines of communication and follow-up on care actions.

The Assessment Team found Consumers and representatives interviewed did not raise any concerns in relation to information sharing to support their daily living needs. Staff described how information about consumers’ condition, needs and preferences is communicated within the organisation and care documentation reflected this.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in this requirement.

Accordingly, I find Requirement 4(3)(d) compliant.

# Standard 6

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

Findings

The service was found non-compliant in Requirements 6(3)(c), 6(3)(d) following a site audit from 25 October to 28 October 2022.

Requirement 6(3)(c)

Following the 2022 Site Audit it was found the service did not demonstrate appropriate action is taken in response to all complaints and that open disclosure is always used when things go wrong. There was a lack of timely follow-up in relation to consumer complaints, and the service did not seek and evaluate consumer satisfaction as part of complaints management. Staff were unable to explain how open disclosure applied to their work.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service reviewed the format of its continuous improvement system and open disclosure approach to be implemented with all feedback received. The service reviewed its feedback system to ensure all avenues for capturing feedback are included.

The Assessment Team found that overall, the service demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. This was reflected in feedback from sampled consumers. Incident forms for 5 sampled consumers showed open disclosure had occurred following each incident. Most staff demonstrated an understanding of the principles of open disclosure and management and staff demonstrated an understanding of the process that is followed when feedback or complaints are received. However, most complaints logged did not record open disclosure had occurred. Management confirmed registered nurses received training in open disclosure documentation which is now being completed.

In their response to the Assessment Team report, the approved provider submitted additional information to support its compliance with this requirement. The approved provider disputed the finding that most complaints did not document open disclosure. The provider supplied evidence that review of the feedback system over the last 3 months showed 96% of feedback forms lodged during that period demonstrated elements of open disclosure and appropriate action occurring. This included timely discussion with consumers or representatives, addressing immediate needs, providing support and explaining the steps taken to address the complaint.

Requirement 6(3)(d)

Following the 2022 Site Audit it was found there were minimal follow-up actions recorded for complaints at the service, including action planning, resolution status, feedback and evaluation of complainant satisfaction with the organisation’s response. Therefore, the service was unable to accurately track complaints or analyse trends to be incorporated in the plan for continuous improvement.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. All outstanding items in the feedback system were actioned and the key concerns and complaints were managed through the complaints systems.

The Assessment Team found on balance the service demonstrated feedback and complaints are reviewed and used to improve the quality of care and services. The plan for continuous improvement provided by the service did not contain items sourced directly from the feedback and complaints log. However, there was evidence that the plan for continuous improvement included feedback and complaints raised through other avenues.

In their response to the Assessment Team report, the approved provider submitted additional information to support its compliance with this requirement. The approved provider advised the service continues to explore all avenues to capture complaints and feed through into its feedback system.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 6(3)(c) and 6(3)(d) compliant.

# Standard 7

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

Findings

The service was found non-compliant in Requirements 7(3)(a), 7(3)(c), 7(3)(d) and 7(3)(e) following a site audit from 25 October to 28 October 2022.

Requirement 7(3)(a)

Following the 2022 Site Audit it was found the service did not demonstrate it has a sufficient number and mix of staff deployed to ensure the effective management of and delivery of safe, quality care and services.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service has significantly increased the number and mix of staffing to meet consumer needs.

The Assessment Team found concerns were raised by consumers, representatives and staff regarding staff shortages and call bell response times, and that the service has insufficient numbers of staff to deliver safe and quality care and services during the nightshift, impacting consumer care and services. However, the Assessment Team did not identify significant impact for consumers safety, health and wellbeing related to staffing levels. Documentation shows both the morning and afternoon shifts are mostly filled and the call bell report shows 96% of calls answered under the 12-minute benchmark. Management confirmed there is still ongoing work to ensure adequate staffing over the night shift, through work with recruitment agencies and advertising. The management team has increased staffing numbers in the Richardson House wing for morning shifts to meet consumer preferences, and documentation shows a decrease in SIRS incidents.

In their response to the Assessment Team report, the approved provider submitted additional information to support its compliance with this requirement. The approved provider noted that the service has had decreased bed occupancy rates for the past 4 months and has been rostering to current numbers, not to full occupancy on the night shift. The approved provider disputed care and services were being impacted by staff shortages on the night shift, providing evidence of no complaints received regarding the night shift being short staffed. In addition, the approved provider stated that one named consumer interviewed by the Assessment Team about call bell wait times in relation to falls was not an aged care recipient of the service and was not receiving funding under the Aged Care Act at the time of the fall the consumer raised.

The approved provider acknowledged the service is impacted by sick leave and confirmed most unfilled shifts are filled by reallocating or staff agreeing to do early and late finishes and by agency staff. The approved provider confirmed they had undertaken a review of care provided by staff including asking staff to feedback when they are unable to provide care due to staffing issues, but no issues have yet been raised by staff. Evidence was provided that ninety nine percent of morning shifts and 100% of afternoon shifts are filled. The current roster was supplied and showed the service is 10% over on the majority of shifts. The approved provider advised the service has many recruitment strategies in place and has been active within the local community to help engage employees.

Requirement 7(3)(c)

Following the 2022 Site Audit it was found the service did not demonstrate staff had the competence and clinical knowledge to effectively perform their roles.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Competency assessments were carried out for 90% of staff for all mandatory and clinical competencies and frequent toolbox talks were delivered on restrictive practices, open disclosure, SIRS, medication safety and responsibility, skin tears, wound charts and assessments. Job role descriptions were developed including qualifications and skills for specific roles. Observations and ongoing regular checks by management and registered nurses were implemented to determine staff performance including monitoring care documentation, staff interactions with consumers and general practitioners, and clinical care delivery.

The Assessment Team found most staff were able to demonstrate a working knowledge of competencies and clinical knowledge and could articulate practical examples relating to effective management of pressure injuries, falls, restraints and challenging behaviours. Staff and registered nurses were able to describe different types of restrictive practices and how they are assessed, recorded and strategies used to minimize their use.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 7(3)(d)

Following the 2022 Site Audit it was found the service did not demonstrate that staff received sufficient training to deliver the outcomes required by the standards.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Staff training is now informed by risk, incident and clinical data and training outcomes are monitored through results in reducing risk and incidents key areas. The service has a registered nurse graduate program with ongoing training, education and assessments.

The Assessment Team found Consumers and representatives said staff are professional and competent in providing care and services. Training attendance records showed staff have completed mandatory training on SIRS, the Quality Standards and restrictive practices. Staff demonstrated their understanding of policies and processes and how they are applied in practice.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 7(3)(e)

Following the 2022 Site Audit it was found the service did not demonstrate regular assessment, monitoring and review of staff performance.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Performance reviews are monitored and tracked through a spreadsheet with completion status and due dates. The management team have created a coordinator position to support volunteers. Volunteers are assessed, monitored and reviewed with the same process as staff members.

The Assessment Team found records showed 97% of performance reviews have been completed and the remaining 3% are related to staff on various types of long-term leave and are scheduled for completion on their return to the service. Staff confirmed they have received performance reviews and able to provide feedback to the management team in relation to their performance. Registered nurses said the service provides opportunities for further clinical and specialised medical training and education.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 7(3)(a), 7(3)(c), 7(3)(d), 7(3)(e) compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found non-compliant in Requirements 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e) following a site audit from 25 October to 28 October 2022.

Requirement 8(3)(b)

Following the 2022 Site Audit it was found the governing body did not ensure the organisation had effective policies and procedures to promote a culture of safe, inclusive and quality care and services, and did not ensure their delivery.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The board has engaged with external coaching providers to better understand its governance responsibilities and ensure accountability for the delivery of safe and quality care and services. The board has a clinical governance committee and a finance, risk, audit and infrastructure committee to identify areas of risks and support the board with communication to staff in promoting a culture of safe and quality care and services.

The Assessment Team found the governing body demonstrated regular communication with staff and consumers in the development and delivery of safe and quality care and services and has policies, processes and systems in place for the governance of key related areas. Some consumers and representatives said they felt the service is run well and they have seen improvements in staffing levels and new equipment. The board works with the management team to identify legislative changes and updates and to ensure staff are informed of the changes. The management team ensures staff are informed of board communications relating to changes and culture during handover and staff meetings, and staff are informed of the board’s vision and values through orientation, education and training.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 8(3)(c)

Following the 2022 Site Audit it was found the service did not demonstrate effective organisational governance systems.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service has implemented an electronic care management system to improve access to information on consumer’s care and service needs. Staff confirmed they can easily access all information needed to perform their roles. The service has an effective system for identifying, managing and evaluating continuous improvement initiatives with detailed descriptions of incidents and clear improvement actions and progress status. The board receives and reviews monthly reports related to risks, incidents and clinical data.

The assessment Team found there was evidence the board supports recommendations for expenditure to improve care and services such as new beds and call bell system and has systems in place to support financial developments. The service has significantly increased the number and mix of staffing to meet consumer needs and continues to work on strategies to improve night shift staff coverage. The board has ensured policies and procedures have been updated to reflect current legislative and regulatory requirements such as SIRS, restrictive practices, incident and risk management and quality standards. The service has systems for identifying, monitoring, and reviewing feedback and complaints. Consumers confirmed they did not have many complaints to report and most of their complaints where actioned by staff in the first instance. They also confirmed they are supported to make complaints and have access to advocacy services.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 8(3)(d)

Following the 2022 Site Audit it was found the service did not demonstrate effective risk management systems and practices.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service has employed a clinical consultant who analyses risk, incident and clinical data and makes recommendations to the board and the management team in relation to high impact high prevalence risk. The board and management team are informed by the clinical governance committee who investigate and recommend changes and improvements to mitigate identified risks. The service has updated its elder abuse policy to align with the Serious Incident Reporting Scheme (SIRS) legislation and current regulatory requirements. SIRS reports demonstrated incidents are being accurately identified, recorded and reported. Training has been implemented to identify and prevent the abuse and neglect of consumers, and there has been a decrease in SIRS incidents following a staff increase in in the Richardson House wing. The board reviews feedback during board meetings to understand what is important to consumers and how consumers can be supported to live their best life while mitigating risks. Staff and registered nurses were able to demonstrate a practical understanding of SIRS policies and processes.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

Requirement 8(3)(e)

Following the 2022 Site Audit it was found the service did not demonstrate it had an effective clinical governance framework.

During the Assessment Contact conducted on 15 August to 16 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The board and management team have implemented policies and processes and approved 3 clinical coordinator positions to support staff an provide clinical oversight relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. There is now a registered nurse on the board, the clinical governance committee support the board with clinical oversight, and an external service provides clinical advice and expertise to the board for the review of clinical care and services.

The Assessment Team found staff demonstrated a practical understanding of antimicrobial stewardship, minimising the use of restraint and open disclosure.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement.

I commend the improvements the approved provider has made in these requirements.

Accordingly, I find Requirements 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e) compliant.

1. The preparation of the performance report is in accordance with section s 68A – Assessment Contact, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)