Performance

Report

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| Name of service: | Harbourside Haven Nursing Home and Hostel |
| 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: | Site Audit |
| Activity date: | 25 October 2022 to 28 October 2022 |
| Performance report date: | 8 December 2022 |

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 Nursing Home and Hostel (**the service**) has been prepared by M.Wyborn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 25 November 2022

# Assessment summary

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

**Standard 1**

**Requirement 1(3)(a)**

* Provide education and training to staff to ensure each consumer is treated with dignity and respect.
* Ensure that the service’s Decision Making and Consent Policy is reviewed and made up to date.

**Requirement 1(3)(c)**

* Implement consistent consumer assessment and planning procedures to ensure care and services are tailored and support consumer choice and independence.

**Requirement 1(3)(d)**

* Ensure the service’s Risk Management Policy is reviewed and made up to date.
* Ensure that consumer lifestyle risk assessments are consistently completed and that they effectively identify, assess and record risk for consumers.

**Standard 2**

**Requirement 2(3)(a)**

* Ensure that the service is up to date on consumer care planning tasks, care plan review tasks and resident of the day tasks.

**Requirement 2(3)(b)**

* Ensure consumer care planning documentation records consumers' current needs, goals and preferences and addresses consumers' individual needs or preferences.
* Provide staff education on consumer advanced care directives to ensure that consumers’ preferences are considered in relation to the care and services they provide.

**Requirement 2(3)(c)**

* Ensure care plans are consistently updated to include changes in consumer care needs, wishes, and goals and are based on ongoing partnership with the consumer and others that the consumer wishes to involve in their assessment and planning,

**Requirement 2(3)(d)**

* Establish a system to ensure suitable consultation occurs and that appropriate records are maintained and appropriately shared in response to consumer assessment and planning outcomes.

**Requirement 2(3)(e)**

* Provide education to staff to ensure that reportable risk incidents are consistently recorded, managed and evaluated with a focus on minimisation and strategy to prevent reoccurrence.

**Standard 3**

**Requirement 3(3)(a)**

* Provide education and training to staff to ensure that clinical care around wound care, diabetes management, pain management, enteral nutrition, neurological observations and clinical observations is safe and effective.

**Requirement 3(3)(b)**

* Provide education and training to staff around identifying, assessing and managing consumer high impact and high prevalence risks.
* Ensure the service has a system to identify, assess and manage high impact and high prevalence consumer risk.
* Ensure the service has an effective system for recording, monitoring and reviewing the use of psychotropic medications.
* Provide education and training to staff on mechanical restraint.

**Requirement 3(3)(c)**

* Ensure the service’s information systems are better integrated.

**Requirement 3(3)(d)**

* Ensure appropriate education and training to identify consumer deterioration.
* Ensure that appropriate records are maintained and that appropriate action is taken in areas such as wound management, medication side effects and allergy, and challenging behavioural issues.

**Requirement 3(3)(e)**

* Provide education and training to staff to understand when to appropriately refer a consumer to another individual, other organisation and provider of other care and services.

**Requirement 3(3)(f)**

* Ensure the service has a system to check that active consumer referrals are followed up and that specialist recommendations are implemented.

**Requirement 3(3)(g)**

* Ensure the service maintains an effective system to manage standard and transmission-based precautions to prevent and control infections.

**Standard 4**

**Requirement 4(3)(d)**

* Ensure the service applies a multidisciplinary team communication approach, ensuring that management and staff are aware of recommendations received by other care providers.

**Standard 6**

**Requirement 6(3)(c)**

* Provide education and training to staff to ensure that complaints are recorded, evaluated and actioned in a timely manner.
* Provide education and training to staff about open disclosure.

**Requirement 6(3)(d)**

* Ensure that the service is effectively reviewing complaints and providing follow up records, including action planning, resolution status, feedback and evaluation of the complainant’s satisfaction.

**Standard 7**

**Requirement 7(3)(a)**

* Ensure the service is adopting effective workforce planning strategies, including strategies to minimise the impact of agency staff on consumers’ care and services.

**Requirement 7(3)(c)**

* Provide education and training to staff on the risks relating to pressure injuries, falls, restraint and behaviour management.

**Requirement 7(3)(d)**

* Provide education and training to staff on the aged care quality standards, serious incident response scheme, consumer restricted practices and open disclosure.

**Requirement 7(3)(e)**

* Ensure the service is providing regular performance appraisals for all staff.

**Standard 8**

**Requirement 8(3)(b)**

* Ensure the organisation’s suite of policies and procedures are reviewed.
* Provide ongoing education and training to staff on the suite of organisational policies.

**Requirement 8(3)(c)**

* Ensure the organisational governance systems related to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints are effective.

**Requirement 8(3)(d)**

* Ensure the service maintains an integrated continuous improvement planning system.
* Ensure the service maintains effective risk and incident management systems to detect, address and prevent consumer risks and abuse and neglect of consumers.

**Requirement 8(3)(e)**

* Ensure the service maintains an effective clinical governance framework around antimicrobial stewardship, consumer restraint and open disclosure.

# 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. | Non-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. | Non-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 received feedback that the service was not consistently treating all consumers with dignity and respect. One consumer advised that they have needed to contact their family in order to receive care for toileting, especially in the mornings. Another consumer raised concern about lack of personal hygiene support and not regularly being supported to transfer out of bed. In their response to the Assessment Team Report, the service demonstrated their immediate and appropriate action in response to these concerns and highlighted their plan for continuous improvement in respect to these concerns.

The Assessment Team observed staff interactions with consumers to be positive and highlighted that consumers provided positive feedback in regard to staff and management interactions. The service demonstrated an appropriate diversity policy.

The service demonstrated provision of culturally safe care and services. Information regarding consumers’ cultural background and preferences are captured on admission. All consumers at the service can speak English and staff demonstrated their awareness of individual consumer backgrounds. The service’s lifestyle program appropriately includes celebrations and traditions important to consumers, including inviting local cultural and linguistically diverse community groups to the service on a regular basis.

The Assessment Team observed that the service does not always provide all consumers with choice or support for their independence. The service was implementing a visitor booking system, which was impacting on easy access to family, friends and the community. However in their response to the Assessment Team Report, the service explained that community and visitor restrictions were ceased from 4 November 2022. The Assessment Team observed that assessment and planning was not consistent, thus impacting on tailored care and services delivered to consumers. The service’s Decision Making and Consent Policy has not been reviewed since June 2017. Management advised the Assessment Team that they are working to improve their communication processes to ensure that consumers are directly involved and offered choice and independence, thus respected, in relation to the care and services they receive.

The service was unable to demonstrate that each consumer is supported to take risk to enable them to live the life they want. The Assessment Team’s review of lifestyle risk assessments demonstrated that assessments are only completed on occasion, and that systems designed to identify, assess and record risk were not effective in capturing consumer needs. The service’s Risk Taking Policy was last reviewed in April 2017 and their Risk Management Policy was last reviewed in March 2017. The organisational policies appropriately dictate that these policies should be reviewed within three years or if a change is required.

The service demonstrated that consumers are provided with information in a range of ways to support their understanding. The service has a weekly menu where the staff will speak to consumers and provide them options to make choices on what food they would like for the week. The service holds a monthly meeting with consumers and a copy of the minutes are available in common areas on noticeboards. The service also holds quarterly ‘focus meetings’ to discuss a range of issues and topics including food and menus, cleaning and laundry, care services, and leisure and lifestyle activities. The service displays a monthly activities calendar and a daily activities schedule on whiteboards across all common areas. The Assessment Team observed staff verbally providing consumers with information to help enable them to make choices.

The service demonstrated awareness and focus on consumer privacy and the Assessment Team observed that consumer personal information is kept confidential. Staff advised that they do not speak in common areas when discussing consumers and were clear that this act can lead to disciplinary action. Consumer personal information is protected by a password to access the computer and requires a subsequent password to access the electronic care management system. Observations supported that staff lock computers when not in use.

The Quality Standard is assessed as non-compliant as three of the six specific requirements have been assessed as non-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. | Non-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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

The service was unable to demonstrate an effective assessment and care planning system for consumers. Consumer risk is not effectively identified and documented to ensure consumer health and well-being is managed. Registered nurses advised that there is no distinction between the assessment process for new consumers and consumers undertaking respite at the service. The Assessment Team observed however that the service has a computerised assessment checklist to guide assessment over the first two weeks after admission and there is a separate admission checklist to guide consumer assessment for the first 24 hrs. The registered nurses advised the Assessment Team that assessments for new consumers and those in respite are not up to date and also explained that the service is not up to date on care planning, care plan reviews and resident of the day processes.

Management acknowledged the issues aligned with the clinical assessment and care planning systems and advised they are working to find a suitable solution, with a focus on ensuring minimal impact on consumers. The Assessment Team observed that consumer assessments and care planning documentation does not record or address consumers' current needs, goals and preferences and does not adequately address consumers' individual needs or preferences. Although the service has a system for advanced care directives this does not always result in care as per the consumers’ preferences. The Assessment Team observed that for consumers receiving palliative care, care plans are not always updated to include changes in their care needs, their palliative care wishes and goals.

The service was unable to demonstrate an effective ongoing partnership with consumers and their representatives. Consumers and representatives advised the Assessment Team that some registered nurses were not engaging and did not follow up on issues raised by representatives in regard to changes in consumer health status. Management explained that there is no system for ensuring suitable consultation occurs or is appropriately recorded.

Consumers and representatives provided positive feedback in relation to the service’s overall communication about changes in consumer needs, however the Assessment Team observed that consumer assessment outcomes and consumer planning are not effectively communicated. Consumers and representatives were not aware of their consumer care plan or how to access it if necessary. This limits the consumer or representative’s opportunity to thoroughly read the document to ensure that they agree with the outcomes. The registered nurses explained to the Assessment Team they discuss care with the consumers and representatives, however a copy of the care plan is not offered. Management explained that the service does not have a process to educate consumers and representatives on how they can access the care plan. In their response to the Assessment Team Report the service has actioned a plan for continuous improvement whereby consumers will be offered a copy of their care plan at the first care meeting, post-entry, at care review times and other times as requested.

The Assessment Team’s review of care and service documentation demonstrated that care plans are not comprehensively reviewed for effectiveness or updated when a consumer’s circumstances change. This extends to when an incident occurs that impacts on the needs, goals or preferences of consumers. The service demonstrated that it has not had clinical oversight of consumer incidents for several months and registered nurses advised, due to changes to the clinical systems at the service, it is not clear which staff are responsible for review of clinical care. The Assessment Team observed via access to the care plan review system that the service has eight consumers who need their care reviewed and the Assessment Team’s review of the resident of the day system shows there are seven consumers who have not had their resident of the day review.

The Assessment Team observed that reported incidents are not routinely evaluated to ensure minimisation of risk or that the service adopts effective strategies to prevent reoccurrence. The Assessment Team observed unactioned incident reports due to delegated staff unavailability. In their response to the Assessment Team Report, the service has demonstrated their plan for continuous improvement aligning their Clinical Governance Committee to tasks such as risk evaluation, adoption of minimisation strategies, staff education and are working towards establishing a system alert for when a consumer is due for a resident of the day review.

The Quality Standard is assessed as non-compliant as five of the five specific requirements have been assessed as non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | Non-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. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

The service was unable to demonstrate consumers receive safe and effective personal or clinical care that is tailored to their needs, best practice and optimises their health and well-being. Some consumers and representatives provided positive feedback about their clinical care and advised staff knowledge regarding consumer care needs was good, however, the Assessment Team identified that safe and effective clinical care is not consistently provided by the service in relation to wound care, diabetes management, pain management, enteral nutrition, neurological observations and clinical observations.

A review of the wound chart for one consumer demonstrated that photos were taken without measurement and a description was missing from the chart. In addition, the wound was not recorded as an incident in the care plan system in order for the service to review and avoid reoccurrence. Further, the service did not investigate appropriate support such as a wound specialist.

The service was unable to demonstrate that high impact or high prevalence risks have been managed effectively. Clinical staff could not identify consumer’s current high impact, high prevalence risks in their care. Management explained they do not have a system to identify high impact or high prevalence risks, and they acknowledged there has been a lack of clinical governance in this area for several months because of a lack in clinical managers. The management team advised they had already identified weight management as a problem and they had discovered previous reports indicating that weights were monitored when in fact they were not. Management has developed a plan for continuous improvement around this issue and some consumers have been referred to the dietician.

The service does not have an effective system for recording, monitoring and reviewing the use of psychotropic medications in order to minimise chemical restraint. The Assessment Team identified that some consumers had occasionally received opioid pain relief for agitation management and this practice was not identified or addressed by management. Not all staff understood mechanical restraint such as using lo-lo bed and bed against the wall. The Assessment Team identified lo-lo beds were commonly used, without proper assessment, as part of falls prevention strategy for consumers who can mobilise.

Although the service has a process to recognise consumers’ needs, goals and preferences as they near their end of life, staff were unable to demonstrate how consumer’s comfort is maximised or their dignity preserved. Review of care documentation for one consumer who recently passed away demonstrated there was no record that comfort care was regularly monitored to effectively manage discomfort and there was no end of life care plan, or advanced care directive.

The service was unable to demonstrate how consumer deterioration or change in care needs is responded to in a timely manner. The Assessment Team’s review of clinical files demonstrated that consumer deterioration is not identified, recorded, or that appropriate action is taken in areas such as wound management, medication side effects and allergy, and challenging behavioural issues.

Consumer care and services records demonstrate inconsistent information that is not easily retrievable when needed. The Assessment Team observed that staff, including management, had difficulty locating documents and staff advised that the service’s current information management systems are not integrated. Observations and interviews with staff indicated important information about a consumers’ condition is not always communicated within the organisation or with others where responsibility for care is shared. The Assessment Team identified that the service does not have a clinical directive folder to share information.

The service was unable to demonstrate that appropriate referral to individuals, other organisations and providers of other care and services occur in a timely manner for consumers. Management advised that there is no current list of specialists or allied health providers for reference within the service. In addition, management advised there is no referral tracking system to best support consumers and no system to ensure that active referrals are followed up and that specialist recommendations are implemented. Consumer clinical documentation demonstrates that timely and appropriate referrals are not occurring when a consumer need arises.

The service was unable to demonstrate an effective system to manage standard and transmission-based precautions to prevent and control infections. Staff were able to demonstrate a sound knowledge of infection prevention and control, and antimicrobial stewardship, however the Assessment Team observed that these practices are not always administered. Staff and visitors were observed breaching infection control protocols by wearing masks under their noses or chins or not wearing masks within the service. Staff were not clear on the location of the service’s outbreak management plan and the service has not had a mandatory infection prevention and control lead since March 2022. Infection data has not been collected since January 2022 and the service’s current electronic care plan system does not support collection of infection data. The Assessment Team observed clean linens and bed protectors located on the floor of a consumer’s room and observed the service’s utility rooms were unlocked and that soiled linen in alginate bags were not covered by a suitable linen skip, rather were placed on a linen trolley and on the floor.

In their response to the Assessment Team Report, the Approved Provider explained that the service has appointed a nurse practitioner to review consumers with specialist needs in order to better manage the clinical oversight required to identify, assess, and manage high risk and high prevalence consumer risk. The service has implemented a morning huddle with key personnel from various sections of the service to communicate referral requests and other relevant information to best support consumers. Further, the service will update their iCare programme to ensure relevant information is accessed and utilised to best support consumers. The service has now appointed infection prevention and control leads at the service.

The Quality Standard is assessed as non-compliant as seven of the seven specific requirements have been assessed as non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Non-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 advised the Assessment Team that they felt at home at the service and were appropriately supported in relation to their well-being and quality of life. Lifestyle staff demonstrated how they actively work with consumers to develop the service’s activity program and lifestyle staff were able to demonstrate thorough knowledge of the consumers’ needs, goals and preferences that they look after. The lifestyle coordinator explained that the activities program incorporates information from consumer assessments, preferences, abilities, and choice. Activities are modified to meet the needs of consumers including using a trial and error approach to understand consumers’ abilities and limitations.

Lifestyle staff explained that the service captures a consumer’s spiritual, religious and other well-being support needs upon admission. The service demonstrated a range of regular visiting community services which consumers can attend if they wish. This includes Anglican, Baptist and Catholic religious services and individual pastoral visits organised by the service. The service offers mindfulness activities as part of their activities calendar.

The Assessment Team reported matters relating to consumer services and supports for daily living including reduced lifestyle activities on weekends, a reduction in the service organising bus trips, and entry and exit accesses to the service. In their response to the Assessment Team Report however, the Approved Provider supplied information that demonstrated their plan for continuous improvement explaining that recent resident meeting minutes show that consumers are satisfied with the weekend activities offered at the service and that all consumers have access to an alternative entry and exit point and that the service is undertaking relevant risk assessments to capture any impacts of environmental restrictive practices at the service. These response actions demonstrate appropriate measures are in place at the service and I find the Approved Provider’s findings to be more compelling in regard to compliance for this standard. The Approved Provider’s response demonstrated that the service effectively manages services and supports to assist consumers to participate in their community, have social and personal relationships and do things of interest to them. With these considerations, I find the service compliant in Requirement 4(3)(c).

The service was unable to demonstrate that information about a consumer’s condition, needs and preferences was being communicated effectively internally or with others where responsibility is shared. The service did not demonstrate a multidisciplinary team communication approach, therefore staff were unaware of recommendations received by other care providers, such as geriatricians, Dementia Support Australia (DSA) and other external care providers. In addition, the Assessment Team reported that the service does not have an effective information management system to support this requirement.

Lifestyle staff confirmed that the service does work effectively with other individuals, organisations and providers of care and services, including regular visits from relevant ethnic clubs. The service has retired servicepersons and regularly supports the local Returned and Services League Club to visit on special occasions including ANZAC day, key birthdays and other special days. The lifestyle coordinator also provided an example of a consumer who wanted to do weekly shopping, however the service was unable to provide the support, so they organised for a specialist community service to take the consumer.

Consumers and representatives advised the Assessment Team that meals are varied and of suitable quality and quantity. The Assessment Team observed well-presented meals and consumers were satisfied they are offered choice and can provide input into the menu. Kitchen staff advised that service works closely with all consumers to ensure that their meal experience is positive and that alternative options are provided. The Assessment Team observed that each menu is reviewed against a range of dietary guidelines by a dietitian.

The Assessment Team reported matters relating to safe, suitable, clean and well maintained equipment at the service. This included consumers needing to share lifter slings, having these slings hanging loosely over handrails and wheelchairs, and not being regularly cleaned between use. Also the Assessment Team reported on a wrong shower chair ordered for one consumer. In their response to the Assessment Team Report however, the Approved Provider supplied information that demonstrated their plan for continuous improvement explaining that the service is undertaking an immediate review audit of slings and that education has been provided to staff regarding cleaning responsibilities after each use and this task is added to the service’s preventative maintenance schedule. In addition, the Approved Provider took immediate action to support one consumer to effectively use the appropriate shower chair ordered for them. These response actions demonstrate appropriate measures are in place at the service and I find the Approved Provider’s findings to be more compelling in regard to compliance for this standard. The Approved Provider’s response demonstrates that the service maintains safe, suitable and clean equipment. With these considerations, I find the service compliant in Requirement 4(3)(g).

The Quality Standard is assessed as non-compliant as one of the seven specific requirements have been assessed as non-compliant.

# Standard 5

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

Findings

Consumers and representatives advised that they felt welcome at the service and consumers are warmly greeted by staff at the door when they return from outings with family and friends. The Assessment Team observed relevant dementia enabling design principles, including personal pictures and other keepsakes attached to the doors of consumers’ rooms to assist with recognition for consumers living with a cognitive impairment and to provide a sense of belonging. There are photos on notice boards in the lounge areas of consumers enjoying recreational activities, also creating a sense of belonging.

The Assessment Team reported matters relating to the service environment including limited signage, the positioning of nurses’ stations not allowing for clear line of sight, the need to install handrails and a rubbish bin blocking a fire exit. In their response to the Assessment Team Report however, the Approved Provider supplied information demonstrating their plan for continuous improvement showcasing that the service has added signage within the service environment to help improve consumer wayfinding, purchased laptops on wheels as part of their technology upgrade to allow staff to access a mobile nurses’ station anywhere on the floor and the service has already installed a handrail as per the Assessment Team’s recommendation. The service has also provided all staff education on maintaining clear fire exits and added a regular storage room organisation activity to the service’s plan for continuous improvement. These response actions demonstrate appropriate measures are in place at the service and I find the Approved Provider’s findings to be more compelling in regard to compliance for this standard. The Approved Provider’s response demonstrates that the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. With these considerations, I find the service compliant in Requirement 5(3)(a).

The service demonstrated a service environment that is safe, clean and well maintained. The Assessment Team observed a clean service environment in common areas, kitchen area and consumers’ rooms. The service maintains a cleaning roster seven days per week and consumers’ rooms are ‘spring cleaned’ on a 34 week cycle.

The Assessment Team reported matters relating to the service environment preventing consumers to move freely, including into external courtyards and gardens. In their response to the Assessment Team Report however, the Approved Provider supplied information that demonstrates the service has a standard practice to unlock doors to the courtyards and garden areas to support consumers to access these amenities. The service has appointed a Clinical Manager and Clinical Care Coordinator who will monitor this issue as part of their regular rounds on the floor. These response actions demonstrate appropriate measures are in place at the service and I find the Approved Provider’s findings to be more compelling in regard to compliance for this standard. The Approved Provider’s response demonstrates a service environment that is safe, clean, well maintained and comfortable; and enables consumers to move freely, both indoors and outdoors. With these considerations, I find the service compliant in Requirement 5(3)(b).

Consumers and representatives advised the Assessment Team that the furniture, equipment and consumers’ rooms are clean and well maintained and advised that they do not have concerns about their safety. The Assessment Team observed that reactive and preventive maintenance logs are up to date and staff and consumers advised that they do not have to wait long for items to be fixed when a request is logged either in the maintenance book or on the electronic maintenance system. The service’s annual fire safety certificate is current.

The Quality Standard is assessed as compliant as three of the three specific requirements have been assessed as compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(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. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The service demonstrated that consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. The service holds monthly resident meetings and representatives are invited to attend. These meetings cover relevant topics including feedback and questions to management and as well as management responses where available. There is also a monthly discussion point where consumers can provide feedback on their experience within the service. Review of recent minutes highlighted a discussion question, ’*Can you make decisions about your personal life, financial affairs and possessions?*’. Most consumers answered ‘Y*es*’. Other items include birthdays, remembering those that have passed away, upcoming recreational activities, feedback on the recreational program, consumer issues of concern and the service’s action plan.

The service demonstrated that consumers are aware of and have access to advocacy services, language services and other external methods for raising and resolving complaints. Consumers advised that if they had a complaint they would inform a trusted staff member or someone in their family. The handbook provided to consumers on admission to the service contains relevant information about how consumers can provide feedback and complaints, including raising concerns with staff, management or at resident meetings. The handbook details the service’s escalation process, and explains that feedback forms can be lodged in feedback boxes and that consumers can seek assistance from staff to complete these forms if required. The service provides information about consumer advocacy services such as the Older Persons Advocacy Network (OPAN), the Seniors Rights Service (SRS), and the Australian Government translating and interpreting service (TIS). The service displays posters and brochures throughout and translated brochures are available at reception.

The service was unable to demonstrate that appropriate action is taken in response to all complaints or that open disclosure is applied when things go awry. The Assessment Team identified a lack of timely follow up in relation to consumer complaints, and that the service does not seek and evaluate consumer satisfaction with regards to complaint management. The Assessment Team observed that some complaints recorded in the complaints register lacked relevant information and staff were unable to explain how open disclosure applies to their work.

The service was unable to demonstrate that all feedback and complaints are effectively reviewed in order to improve the quality of care and services. The Assessment Team’s review of the service’s complaints register identified a very low number of complaints had been registered on the system. There was minimal follow up action recorded, including action planning, resolution status, feedback and evaluation of the complainant’s satisfaction. Therefore, the service is unable to accurately track its complaints or analyse trends to be incorporated in their plan for continuous improvement.

The service employs an external auditing system that includes consumer and representative surveys. However, the service did not demonstrate that this feedback from consumers and representatives is used to effectively drive significant care and service improvements.

In their response to the Assessment Team Report, the Approved Provider supplied a copy of their Feedback and Complaints Policy that contains a link to the ‘Better Practice Guide to Complaint Handling in Aged Care Services’ produced by the Department of Health and Aged Care. The Approved Provider also advised that they are providing open disclosure training to staff and that the Clinical Manager and Clinical Care Coordinator will reinforce the requirement for open disclosure with staff. Further, the service advised that management would ensure the service’s plan for continuous improvement is maintained and that the Board of Directors will monitor the service’s progress of the actions with the plan as reinforced by the Chairpersons letter dated 22 November 2022.

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

Findings

The service was unable to demonstrate their workforce is sufficiently planned and that the number and mix of staff deployed enables the delivery and management of safe and effective care and services. The Assessment Team considered information obtained from staffing attendance sheets, feedback from consumers and representatives, feedback from staff, and call bell/sensor response times. The Assessment Team observed that staff do not have the time to complete their duties on their shift. One example of the impact is staff needing to sponge bathe consumers rather than assisting them to action the consumer’s preferred option of taking a shower. Another impact is staff not having the time to complete clinical documentation to the standard necessary to best support consumer needs and preferences. The Assessment Team identified there has been poor retention and a high replacement of key personnel at the service thus impacting on culture and experience available at the service. Care staff advised that ‘*there is lots of clinical stuff (sic) being missed and assessments and care plans are not being done’*. Call bell data is not effectively monitored at the service therefore evaluation is not taking place in order to best support consumers. Management advised that the service employs agency staff to cover gaps in rostering, however highlighted the impact that regular use of agency staff can have on the service including lack of staff knowledge of consumer needs and documentation requirements.

Consumers and representatives advised that staff are kind, caring and respectful towards them and their relatives. The Assessment Team, however, reported that some consumers are not experiencing interactions that are kind and caring and that this is negatively impacting consumer health and wellbeing. In their response to the Assessment Team Report, the Approved Provider highlighted their workforce challenges, including their regional location and the impact of COVID. The Approved Provider supplied details of their immediate response and appropriate support that was offered to the individual consumers referenced in this Requirement. These response actions demonstrate that workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity and with these considerations, I find the service compliant in Requirement 7(3)(b).

Consumers advised that they felt staff knew what they were doing, however the service was unable to demonstrate staff have the required competency and clinical knowledge to provide safe, effective, quality care and services for all consumers. In their responses to interviews with the Assessment Team, management and care staff were unsure of the risks relating to pressure injuries, falls, restraint and behaviour management and consistently referred to the acting care manager in relation to this critical information. Care staff and registered nursing staff were unable to demonstrate their knowledge of the different types of consumer restraints and how they would assess, record and minimise the use of restraint at the service. These personnel were unable to describe the serious incident response scheme (SIRS) and advised they had not received training in relation to SIRS. At the time of the Site Audit, the service did not have a registered infection prevention and control lead (IPCL). The Assessment Team were advised by newer staff and management that it was difficult to locate resources they needed such as up to date systems, processes, policies, training as well as comprehensive care plans, risk and incident data required to effectively perform their roles, thus impacting on the provision of care and services to best meet consumer needs and preferences.

The service was unable to demonstrate that the workforce is trained, equipped and supported to deliver the outcomes required by the aged care quality standards. While the service is supported by a human resources team and training department, the service’s mandatory training did not include modules in key areas required for the provision of safe, quality care and services. The Assessment Team identified an education gap in the aged care quality standards, serious incident response scheme, consumer restricted practices and open disclosure. Further, there were low staff completion rates for mandatory training, particularly for registered nurses, and the service is not effectively identifying and addressing mandatory training gaps.

The service was unable to demonstrate that regular assessment, monitoring and review of staff performance is undertaken in order to identify and minimise the significant gaps found in staff competency and clinical knowledge. Staff, including registered nurses and some management, were unable to advise if or when they completed their last performance appraisal and most were unable to explain the appraisal process to the Assessment Team. In their response to the Assessment Team Report, the Approved Provider supplied their performance appraisal policy and procedural documents for leaders and for employees. The Approved Provider provided a targeted timeframe to complete performance appraisals and advised that the service has already completed some appraisals. I acknowledge the actions taken since the Site Audit to achieve compliance in Requirement 7(3)(e) however in weighing the evidence, I find the Assessment Team’s recommendation of non-compliance to be more compelling in regard to Requirement 7(3)(e).

The Quality Standard is assessed as non-compliant as four of the five specific requirements have been assessed as non-compliant.

# 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. | Non-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. | Non-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. | Non-compliant |

Findings

The service was able to demonstrate that consumers are engaged and supported in the development, delivery and evaluation of care and services. Management highlighted consumer feedback groups in relation to food and menus, cleaning and laundry, care services and leisure and lifestyle activities in which consumers and representatives are able to have their say. The Board of Management explained consumers were invited to participate in the recent name change to the sections within the service, and explained that consumers will again be invited to attend Board meetings in order to be engaged and supported in the development of care and services.

The Assessment Team recognised that the governing body aims to provide safe, inclusive and quality care, and in their response to the Assessment Team Report, the Approved Provider supplied a statement from the Chair of the Board dated 22 November 2022 which demonstrated the Board’s commitment. However, the organisation was unable to demonstrate that effective measures are in place to ensure the service has sustainable systems to achieve this Requirement. The governing body has not effectively ensured policies and procedures are available to guide the workforce around quality care and compliance with the Aged Care Quality Standards. The Chief Executive Officer (CEO) advised the Assessment Team that the organisation had engaged external consultants to provide the organisation with support on various aspects of the business including updates to policies and procedures. However, the Assessment Team reported that the external consultants left the service suddenly following an outbreak incident and service management were unable to find all documents they completed. Further, in their review of the organisation’s High Impact and High Prevalence Risk Policy, it appeared to be a Dignity of Risk Policy and did not relate to high impact and high prevalence risks. The Assessment Team also identified that while Board meeting minutes had a standing agenda, recent meeting minutes demonstrated the executive team had recorded ‘nil to report’ in relation to clinical governance and organisational policies. Also noted was that while the Board were able to describe how they communicate with staff and consumers about the pandemic by using emails and memos, the organisation was unable to demonstrate how the Board effectively communicates with staff and consumers regarding other issues that may affect them such as the serious incident response scheme and the Royal Commission into Aged Care.

The service was unable to demonstrate effective organisational governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance or feedback and complaints. The Assessment Team reported that education and training is not reflective of regulatory requirements and the service does not have a system that accurately captures mandatory training attendance. In their response to the Assessment Team Report, the Approved Provider noted that the organisation is reviewing their education program and this is reflected in the service’s plan for continuous improvement. The Assessment Team observed that some policies and procedures are out of date and do not reflect best practice or regulatory requirements. Again the Approved Provided responded to inform that the organisation is reviewing their suite of policies and procedures. The service was unable to demonstrate that, at the time of the Site Audit, the service’s continuous improvement planning system was integrated to ensure the alignment of improvement strategies, priorities, and care and service outcomes. The Assessment Team reported that the organisation’s human resources department provided their own plan for continuous improvement separate from the service’s plan for continuous improvement. In their response to the Assessment Team report, the Approved Provider has supplied an updated plan for continuous improvement which integrates strategies to best support consumers.

In respect to organisational governance, the organisation was unable to demonstrate effective workforce planning, performance management, human resources and retention systems to ensure the workforce is sufficient, skilled and qualified to provide safe and quality care and services. The service’s current assessment, monitoring and review of staff is incomplete and does not adequately identify key deficiencies in staff competencies, which is evidenced by gaps in the quality of care and services provided to consumers, causing risk to consumer health, safety and wellbeing. Further, the Assessment Team observed that there are no policies relating to the serious incident response scheme and that the organisation’s risk management policy and procedures required review. In relation to minimising the use of consumer restraint, the service was unable to demonstrate a psychotropic medication self-assessment record, rather the service relies on a psychotropic medication report produced by the pharmacy for monitoring. The pharmacy reports reviewed by the Assessment Team did not adequately include reasons for prescribing the medications and did not identify whether the psychotropic medications are being used as a chemical restraint according to the legislation. Further in respect to organisational governance, the organisation was unable to demonstrate effective systems for capturing, monitoring, reporting, evaluating and trending feedback and complaints, thus negating the service’s opportunity to improve their delivery of care and services for consumers.

The organisation was unable to demonstrate effective risk and incident management systems to detect, address and prevent high impact and high prevalence risks, abuse and neglect of consumers, or to support consumers to live their best life by effectively managing and preventing incidents. The service’s High Impact and High Prevalence Risk Policy provides focus on dignity of risk for individual consumers rather than management of high impact and high prevalence organisational risks. The organisation’s Elder Abuse Policy requires review and had not been updated to include serious incident response scheme or reflected current regulatory requirements. The Assessment Team observed that the service’s incident management and investigation procedure focused on workplace health and safety incidents affecting staff and lacked procedure for clinical incidents. The Assessment Team observed that the service was not effectively analysing contributing factors, reviewing the effectiveness of current measures, or developing preventative measures to manage risk.

The service was unable to demonstrate an effective clinical governance framework around antimicrobial stewardship, consumer restraint and open disclosure. The organisation’s restraint policy had not been updated to reflect current regulatory requirements for minimising the use of restraint and the elder abuse policy did not include the serious incident response scheme. While management and the Board demonstrated knowledge of accountabilities in relation to clinical care, the Assessment Team observed that, in practice, this has not been consistently followed. The Assessment Team reviewed a schedule of committees including a monthly clinical governance committee. The Assessment Team identified however that there were no meetings between March and September 2022. The service has not had a Clinical Care Manager, or a Service Manager since March 2022. Management and staff advised the Assessment Team that this has directly impacted the service’s ability to monitor clinical compliance and clinical indicators, and negated the opportunity to analyse trends to determine high impact and high prevalence risks in order to deploy appropriate mitigation strategies.

The Quality Standard is assessed as non-compliant as four of the five specific requirements have been assessed as non-compliant.

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