Performance

Report

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| Name of service: | Performance report date: |
| Indochinese Aged Care Services | 20 July 2022 |
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| Indochinese Aged Care Limited | 7 June 2022 to 10 June 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 Indochinese Aged Care Services (**the service**) has been considered by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the Assessment Team’s report for the site audit undertaken 7 June to 10 June 2022; 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 following information given to the Commission, or to the Assessment Team for the site audit of the service - nine consumers and 18 consumer representatives provided feedback to the Assessment Team.
* The approved provider emailed the Commission acknowledging the Assessment Team’s report on 18 July 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 | **Non-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.

Requirement 1(3)(c) The approved provider must demonstrate that there are processes in place for identifying and documenting when or how decisions makers are identified, with education provided to guide staff practice in this element of consumer care.

Requirement 1(3)(d) The approved provider must demonstrate all staff are aware of the need to consult with consumers and their representatives to safely take risks to enable consumers to live the best life they can. The service must ensure that risks are documented, evaluated and risk mitigation strategies are in place and reviewed when not effective with new strategies put in place to reduce the reoccurrence of the risk occurring.

Requirement 2(3)(b) The approved provider must demonstrate that assessment and planning address current needs, goals and preferences and this information is updated regularly to meet the consumers’ needs. End of life planning and Advance Care Directive include the consumers’ wishes and is reviewed when the consumers condition changes.

Requirement 2(3)(e) The approved provider must demonstrate that assessments are reviewed and/or updated following incidents or changes in consumers’ condition. Pain is documented and monitored following incidents. Risk Assessments are regularly reviewed, and behaviour support plans are in place for changes to a consumer’s behavioural condition.

Requirement 3(3)(a) The approved provider must demonstrate that staff can identify clinical deterioration and document, assess and monitor changes to a consumer’s condition not limited to skin integrity, wound management, pain management, behaviours of concern and falls and that incidents are investigated with strategies evaluated to prevent reoccurrence.

Requirement 3(3)(b) The approved provider must demonstrate that staff have a practical knowledge of high impact high prevalence risks associated with each consumer and that all incidents are documented and monitored.

Requirement 3(3)(g) The approved provider must demonstrate evidence of an infection prevention and control program, and infection prevention and control procedures for the workforce. The service must demonstrate COVID-19 preparedness, with a tailored COVID-19 Outbreak Plan relevant to the needs of the service. Staff COVID-19 vaccination status must be recorded and current.

Requirement 4(3)(a) The approved provider must demonstrate that 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.

Requirement 4(3)(c) The approved provider must demonstrate consumers are supported to participate in their community and maintain social and personal relationships outside the organisation’s service environment.

Requirement 5(3)(a) The approved provider must demonstrate that the service reflects a welcoming environment that is personalised for the consumers and that there are familiar or recognisable environmental cues for the consumers to assist with their way finding.

Requirement 5(3)(b) The approved provider must demonstrate that the service effectively manages environmental risks by completing required preventative maintenance and fixes safety issues or hazards so that the service environment is fit for purpose in line with statutory requirements.

Requirement 5(3)(c) The approved provider must demonstrate all scheduled maintenance has been completed within required timeframes and that there is sufficient furniture and equipment for consumer’s needs.

Requirement 6(3)(a) The approved provider must demonstrate that consumers and representatives are encouraged to provide feedback and make a complaint, with proactive follow up by the service. All complaints and feedback are documented and managed with actions taking to address the complaint or feedback with follow up from the service.

Requirement 6(3)(c) The approved provider must demonstrate that appropriate action or investigation is undertaken in response to feedback and complaints, and that open disclosure is always used when things go wrong.

Requirement 6(3)(d) The approved provider must demonstrate feedback and complaints are documented and reviewed and used to improve the quality of care and services.

Requirement 7(3)(a) The approved provider must demonstrate that personnel changes do not affect the safety and quality of care and services. Staff can feel safe to provide feedback and concerns about workload pressures that may impact on consumer care.

Requirement 7(3)(c) The approved provider must demonstrate staff personnel records have current qualifications documented and that all staff complete mandatory training to meet the care needs of consumers.

Requirement 7(3)(d) The approved provider must demonstrate that staff have the practical training and knowledge to address the gaps identified in clinical care and review processes.

Requirement 7(3)(e) The approved provider must demonstrate that the service has a system in place for regular assessment, monitoring and review of the performance of each member of the workforce and that annual appraisals are completed.

Requirement 8(3)(a) The approved provider must demonstrate that consumers are engaged in the development, delivery and evaluation of care and services. The management and the Board introduce initiatives to engage with consumers and representatives.

Requirement 8(3)(b) The organisation’s governing body has systems to oversee the promotion of a culture of safe, inclusive and quality care and services and has oversight of accountability for the delivery.

Requirement 8(3)(c) The organisation demonstrates effective organisation wide governance systems to meet the gaps identified for this requirement. The Board uses the governance systems to oversee and drive continuous improvement.

Requirement 8(3)(d) The organisation demonstrates that there is effective risk management systems, policies, practices and procedures and that risks to consumers are documented in an incident management system to track and analyse risks to consumers to mitigate these and drive continuous improvement.

Requirement 8(3)(e) The organisation demonstrates an effective clinical governance framework with supporting policy and procedures understood and demonstrated in a practical way.

# Standard 1

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| Consumer dignity and choice | | Non-compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Non- compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | 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 Quality Standard is assessed as Non-compliant as two of the six specific requirements have been assessed as Non-compliant.

**The following two requirements have been assessed as Non-compliant.**

* Requirement 1(3)(c) Each consumer is supported to exercise choice and independence, including to:

(i) make decisions about their own care and the way care and services are delivered; and

(ii) make decisions about when family, friends, carers or others should be involved in their care; and

(iii) communicate their decisions; and

1. make connections with others and maintain relationships of choice, including intimate relationships.

The Assessment Team identified that there were no clear processes in place for identifying when or how decisions makers are identified and documented, and the service was unable to provide evidence there of procedures to guide staff practice in this element of consumer care. Management seemed unclear on the difference between power of attorney and enduring guardianship.

The Assessment Team interviewed staff, who demonstrated how they engage consumers in making informed choices about their care and services through informal conversations in everyday care and had an awareness of consumers social networks and relationships within the service.

Consumers interviewed by the Assessment Team said they felt supported to exercise choice and independence, including making decisions about day to day care and services.

There is no clear guidance for staff as to who in the service is responsible for identifying when or how decisions makers are identified; or identifying where a consumer lacks the capacity to make decisions, where they may have a court or tribunal-appointed guardian to make decisions on their behalf, or how consumers make decisions in regard to when family, friends, carers or others should be involved in their care

Based on the lack of processes and understanding in relation to this requirement, I find that the approved provider is not compliant with this requirement.

* Requirement 1(3)(d) Each consumer is supported to take risks to enable them to live the best life they can.

The Assessment Team found that the service was unable to demonstrate each consumer is supported to safely take risks to enable them to live the best life they can. The service was unable to provide evidence of policies and procedures that support the workforce to identify where consumers choice may include an element of risk; assess the risk and inform the consumer of the risks; document risk mitigation strategies; and evaluate and review the risk assessment and interventions.

The Assessment Team found that management were unable to provide evidence to indicate they had informed 2 consumers and representatives of risks associated with their choice of diet and were unable to provide evidence of clear risk minimisation strategies to safely support consumers choice and live the way they choose. Management acknowledged supporting consumers to take risks and maintaining the associated documentation is an area requiring development.

I acknowledge that the provider has identified that this is an area for improvement, however find that the approved provider is not compliant with this requirement.

**The following requirements have been found to be Compliant.**

* Requirement 1(3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* Requirement 1(3)(b) Care and services are culturally safe
* 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.
* Requirement 1(3)(f) Each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team interviewed consumers and representatives who mostly confirmed that they that are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Consumers reported that the service provides care and services that are in line with their culture and values and that their privacy and confidentiality is respected. Most consumers said staff interacted with them in a kind and respectful manner, they felt safe at the service and described staff as attentive and caring.

Consumers provided feedback indicating they are given information which enables them to exercise choice in their day to day activities. However, consumers and representatives said there is a lack of communication from management particularly around frequent changes to the management team.

The Assessment Team interviewed staff who spoke about consumers in a manner that indicated respect and understanding however it was noted at times consumers were referred to by their room number not their preferred name. Staff were able to identify consumers’ preferences and interests and staff interactions with consumers were observed to be respectful and considerate. Staff demonstrated awareness of consumers social networks within the services community and how they support consumers in maintaining those relationships

The Assessment Team reviewed care planning documentation, which was found to include personalised information regarding consumer likes and dislikes, culture and religion, social interests and hobbies, life events, working life and important relationships.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | 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. | 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. | Non-compliant |

## Findings

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

**The following two requirements were assessed as 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.

The Assessment Team reviewed care planning documentation and found that although assessment and planning addresses needs, goals and preferences, gaps were identified in the currency of some consumer information. There was limited evidence of end of life planning. The service has an Advance Care Directive which most consumers have completed. Management said the Advance Care Directive document requires updating to reflect contemporary practice. Additional gaps were identified in care planning documentation which include where a consumer has a continence assessment without a toileting plan, where consumers have behaviours of concern without any follow up behaviour support plan or assessment for cognitive impairment.

The Assessment Team interviewed staff who advised that senior staff usually discuss end of life planning with family when the consumer’s condition deteriorates and then get doctor to review and identify if reversable; then discuss Advance Care Directives with family. They said they plan to use End of Life Directions for Aged Care (ELDAC) for education in July 2022 for staff. Management acknowledged that the Advanced Care Directive did not always provide information about consumer wishes which is an area that they want to improve on.

I acknowledge the providers initiative to provide education for staff for Advance Care Directives, however I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team identified that assessments are not always reviewed and/or updated following incidents or changes in consumers’ condition. Examples were identified where pain was not monitored following incidents with injury or when skin integrity breaches were documented and when dental treatment was required.

The Assessment Team noted for one consumer a risk assessment had not been updated since February 2021 despite frequent wandering. A physiotherapy review was not undertaken for a consumer following a fall. The Assessment Team found there are many new staff who were not familiar with all of the review processes.

I find that the approved provider is not complaint with this requirement.

**The following requirements were found to be Compliant.**

* 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.
* Requirement 2(3)(c) The organisation demonstrates that assessment and planning:

(i) 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

(ii) includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

* 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.

The Assessment Team interviewed consumers and representatives who mostly considered that they feel like partners in the ongoing assessment and planning of their care and services. Consumers and their representatives confirmed that they are involved in care planning to some extent.

The Assessment Team found that assessment and planning generally informs delivery of safe and effective care and services. There is an initial assessment process for consumers entering the service. There is evidence the outcomes of assessment and planning of care and services for consumers are available and communicated to consumers and representatives. Staff were able to describe how they communicate changes effectively to the consumer representatives and document any changes in care. There was positive feedback from representatives regarding communication about assessment and planning. The organisation seeks input from various health professionals to ensure the consumer receives comprehensive assessment of their needs.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission-based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

## Findings

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

**The following three requirements were assessed as Non-compliant.**

* Requirement 3(3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

(i) is best practice; and

(ii) is tailored to their needs; and

(iii) optimises their health and well-being.

The Assessment Team found that each consumer does not get safe and/or effective personal and/or clinical care that is best practice, tailored to their needs and/or optimises their health and well-being.

The Assessment Team reviewed care planning documentation and identified consumers who had experienced skin integrity deterioration without appropriate management or wound charting with consumers’ pressures injuries first identified and documented as stage 2 injuries. Pain management is not always supportive of consumer wellbeing. The physiotherapy hours have been decreased and there was feedback the pain management program has been reduced. Pain is not always monitored following incidents or change in consumer condition. Pain monitoring was not always evident in pain assessments or related to behaviours.

For consumers with behaviours of concern, and consumers who had experienced falls, review and investigation into incidents were not evident, with new strategies evaluated.

The Assessment Team interviewed staff who confirmed that consents for use of physical restraint were not current. They had last been reviewed in 2021. Physical restraint use is high and is not well understood by staff or management. There is a Restrictive practices pathway to direct staff practice although it does not appear to have been followed.

Based on the personal and clinical care, not being best practice. I find that the approved provider is not compliant with this requirement.

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team found that high impact high prevalence risks associated with each consumer are not well understood; although general risks have been identified. Staff interviewed were unfamiliar with high impact or high prevalence risk. Management are new to the service and were unfamiliar with clinical incident data and audits. Internal clinical audits were not provided. When it was found a clinical indicator, program was in use the information provided appeared to be incorrect.

The Assessment Team identified that there has been high incidence of unexplained bruising and falls. It was unclear if all incidents are reported and/or monitored. There has been feedback from family members about consumer unexplained bruising. There have been some high-risk medication incidents. Pressure injuries have been first identified as stage 2 injuries; as documented in standard 3 Requirement 3(a). Falls incidence is an identified risk. Although a clinical governance meeting has commenced at the service clinical data does not appear to have been maintained to reflect high impact high prevalence risk.

Based on the limited understanding of high impact and high prevalence risks, I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team found that the service was unable to provide evidence of a documented infection prevention and control program, or infection prevention and control procedures for the workforce. The service does not have a dedicated and trained Infection Prevention Control Lead and does not have a process for monitoring and ensuring staff use of PPE is best practice.

The service was not able to demonstrate COVID-19 preparedness. The COVID-19 Outbreak Plan was not tailored to the individual needs of the service and omitted key information to guide staff practice. Staff demonstrated confusion regarding the location of infection control outbreak kits and the COVID-19 outbreak kit had not been replenished since use in May 2022.

The service was unable to demonstrate a process is in place to determine and record staff COVID-19 vaccination status. Staff vaccination records provided to the Assessment Team were not up to date and staff considered unvaccinated per the services records were rostered and working.

The Assessment Team did identify that staff demonstrated they have a clear understanding of infection control and antimicrobial stewardship principles, and the service has an antimicrobial stewardship policy in place. Staff were observed practicing good hand sanitising and hand washing technique and were wearing surgical masks appropriately throughout the visit.

Based on the absence of infection prevention and control program and procedures. I find that the approved provider is not compliant with this requirement.

**The following requirements were found to be 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.
* 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.
* 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.
* Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team interviewed consumers and representatives who consider that that they receive personal care and clinical care that is safe and right for them. Consumers and representatives believe they get the care they need. Representatives report consumer deterioration and end of life care has been well managed. Consumers are referred to a range of services and organisations, in a timely manner, to support their clinical and personal care provision. A range of services were noted to have been accessed for consumers. Physiotherapy, medical officers and podiatry services regularly attend the service. Where weight loss is identified the consumer has been referred to a dietician. Dementia support Australia has recently reviewed several consumers. A speech pathologist has recently reviewed consumers. No issues were raised relating to referral of consumers.

The Assessment Team noted that although there have been ongoing changes to management and registered staff at the service no example of unidentified consumer deterioration was identified. Consumers have been transferred to hospital following incidents with injury and where consumer condition deteriorated. There was positive representative feedback regarding this requirement.

The Assessment Team found that generally, consumers and representatives were satisfied with communication of their needs and preferences within and outside the service. Concerns were raised with some organisational communication although most of it did not relate to clinical care.

# Standard 4

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

## Findings

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

**The following two requirements have been assessed as Non-compliant.**

* 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.

The Assessment Team found that the service did not demonstrate 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. Specifically, the service was not able to demonstrate it is providing effective services and supports for daily living with regard to the provision of consumer laundry services and the laundry service is not being delivered in line with consumer needs and preferences.

The Assessment Team interviewed consumers and representatives and reviewed survey results and consumer meeting minutes which indicate dissatisfaction with the laundry service. The consumer satisfaction survey undertaken in April 2022 identified 7 consumers were dissatisfied with laundry service and consumer meeting minutes for December 2021, January, February, March, April and May 2022 indicated issues with laundry service had been raised, with no actions by the service documented.

The Assessment Team reviewed consumer care plans which reflected lifestyle and activity preferences, important relationships in their life, needs and preferences in relation to emotional, social, spiritual, and cultural support. Staff demonstrated everyday ways they endeavour optimise consumer independence and quality of life. Most consumers sampled stated they felt staff supported them to do the things they want to do and optimised their independence and quality of life.

Whilst I acknowledge that the service has lifestyle activities that optimise the consumers’ independence and quality of life, based on the feedback from consumers and representatives and the review of meeting minutes and surveys in relation to their dissatisfaction with laundry. I find that the approved provider is not compliant with this requirement.

* Requirement 4(3)(c) Services and supports for daily living assist each consumer to:

(i) participate in their community within and outside the organisation’s service environment; and

(ii) have social and personal relationships; and

(iii) do the things of interest to them.

The Assessment Team found that although the service could demonstrate services and supports for daily living to assist consumers to do the things of interest to them, and support consumers to maintain relationships and participate within services community, they did not demonstrate consumers are supported to participate in their community and maintain social and personal relationships outside the organisation’s service environment.

The Assessment Team interviewed management who confirmed at the time of the site audit they were currently operating under green access code, however the service has a self-imposed rule that consumers who leave the service for more than 4 hours are required to isolate for 7 days and strict visiting restrictions are in place. Whilst some consumers have chosen to undertake the isolation or manage outings within the rule requirements, all sampled consumers and representatives expressed dissatisfaction. The rule has had an impact on one consumer whose family have chosen to cease his outings to the family home, so he does not have to isolate on return to the service.

Management advised the Assessment Team these conditions were discussed and agreed upon at a staff meeting and acknowledged no consultation with consumers or representatives was undertaken. Management also confirmed the 4-hours is a blanket rule and there is no further risk assessment undertaken such as where the consumer visits, if a mask is worn, if they and others are vaccinated against COVID-19.

I have found that the approved provider is not compliant with this requirement, as the service does not support consumers to participate outside the organisations service environment for longer than 4 hours without having to isolate and the consumers and representatives have expressed dissatisfaction with this rule. There has also been no consultation with consumers or representatives prior to the implementation of this condition.

**The following five requirements were found to be Compliant.**

* Requirement 4(3)(b) Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.
* 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.
* Requirement 4(3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 4(3)(f) Where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 4(3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team found that some sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

The Assessment Team interviewed consumers and representatives who mostly confirmed they were supported to participate in the activities that are of interest to them where they can participate to enhance their daily living.

The Assessment Team reviewed care planning documentation which showed consumers’ needs, preferences and what is important to them is documented and communicated as required and informs how services are provided.

Staff interviewed described what is important to individual consumers, their needs, and preferences. They provided examples of how they assist and support consumers to do the things they like as well as provide emotional and psychological support when required.

The service has a monthly lifestyle activities calendar which is distributed to all consumers and extra copies are located around the service. The lifestyle program is based on the preferences and interests of consumers. Activities are provided either in a group setting or one-to-one with individual consumers. The Assessment Team observed consumers participating in a range of activities in 3 different communal rooms.

Lunchtime meal service showed the environment to be calm and consumers appeared to be enjoying their meals. Most consumers expressed satisfaction with meals although the service did not demonstrate feedback regarding food is actioned.

# Standard 5

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| Organisation’s service environment | | Non-compliant |
| 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. | Non-compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

## Findings

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

**The following three requirements has been assessed as Non-compliant.**

* 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.

The Assessment Team interviewed consumers and representatives and found that overall feedback was positive about the environment. The garden areas are welcoming and relaxing. However, observations of the service environment did not show consumer rooms have a personal character and feel; and the living areas did not reflect a welcoming environment that created a sense of belonging. Bathroom renovations are incomplete with no action plan to complete the renovations.

The Assessment Team observed there are limited navigational aids in the service, such as the use of familiar furniture, light fittings or colours in the environment. The service has pictures of consumers on the bedroom doors as well as room numbers but there are no other familiar or recognisable environmental cues for the consumers to assist with their way finding. Some of the consumer bedrooms were spacious but none of the consumer bedrooms observed by the Assessment Team had personal furniture, artwork or family photographs displayed in their rooms.

One representative said previous management had commenced renovations, but they were unsure of the status of the project. They said their consumer’s room needed work as it was dated and damaged. The representative pointed out to the Assessment Team scuff marks and cracks to the walls and the bottom of the ensuite door to be cracked and broken.

I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team observed some consumers to be moving freely both indoors and outdoors and the service environment was noted to be clean and comfortable. Whilst there are systems in place for the cleaning and maintenance of the service environment; It has not been demonstrated that the service effectively manages environmental risks by completing required preventative maintenance and fixing any safety issues or hazards so that the service environment is fit for purpose in line with statutory requirements.

The Assessment Team witnessed two power surges at the service during day one on the site audit. The electrical technician said the residual current device (RCD) would normally have switched the power off but did not. The RCDs are electrical safety devices designed to immediately switch off the supply of electricity when electricity leaking to earth is detected at harmful levels. They offer high levels of personal protection from electric shock. The Assessment Team asked if the RCD had been tested regularly as per the SafeWork NSW legislation and were advised there were no records of the service completing tests of the RCDs. The team were advised that staff were not able to organise an electrical contractor to come to the service to test the RCD’s until the board approves the cost of the electrical contractor.

I find that the approved provider is not compliant with this requirement, as there was no evidence that routine preventative checks had been undertaken on plumbing, pest control and electrical equipment.

* Requirement 5(3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The Assessment Team found the service has processes in place to ensure furniture, fittings and equipment are safe, clean and well maintained however not all scheduled maintenance has been completed within required timeframes. The fire safety equipment is fit for purpose. Some consumers said they felt their equipment was suitable for their needs. However, observation of furniture and equipment demonstrated that there was not sufficient furniture and equipment for consumer’s needs.

The Assessment Team observed lifter slings slung over the lifters in the corridor where consumers and staff walk past. The services fire stairs, opposite the kitchen, were observed to filled with excess furniture and equipment such as shower chairs and wheelchairs. Storerooms had equipment roughly stacked on top of each other and broken equipment was observed outside the storeroom doors limiting access to the storerooms. Beds observed in some of the Banksia rooms had rust starting to appear on their frames, however appeared to be in good working order.

The Assessment Team interviewed consumers and representatives and received feedback from representatives who said there are not enough over the bed tables for each consumer and the consumers need to share them. One representative said she is not sure what the service did when all of the consumers needed to isolate in their rooms due to COVID outbreak restrictions, but each time she comes to the service she needs to ask for a table so that her parent can have a table to enjoy dinner the family has brought in from home. One representative said they are willing to purchase the over the bed table for the consumer and were advised by the service they would be charged a $50.00 administration fee on top of the cost of the table. The Assessment Team discussed this with management and advised that the regulatory requirement is that over bed tables are an item listed to be provided by the service.

I find that the approved provider is not compliant with this requirement.

# Standard 6

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| Feedback and complaints | | Non-compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Non-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 Quality Standard is assessed as Non-compliant as three of the four specific requirements have been assessed as Non-compliant.

**The following three specific requirements has been assessed as Non-compliant.**

* Requirement 6(3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

The Assessment Team interviewed some consumers and representatives who advised they are encouraged to provide feedback and make a complaint, however others said they are not encouraged and there is limited follow up from the service. Some representatives expressed concern there may be negative consequences to the consumer if they raise a concern. Evidence suggest complaints are inconsistently recorded and managed.

The Assessment Team found that all consumers and representatives interviewed said they understood how to provide feedback and make a complaint. Some representatives were aware of the feedback forms and other representatives said they prefer to provide feedback to management via email. All consumers interviewed said they were very happy with the service and if they raised a concern, they said the staff would ‘fix it’ straight away.

The Assessment Team however found that most representatives were not happy with the services response or lack of a response when they raised a concern about the care provided at the service.

The Assessment Team observed internal feedback and complaint forms in the service environment as well as Aged Care Quality and Safety Commission forms on how to make a complaint. Resident meeting minutes show the consumer voice in the minutes, with consumers raising concerns in the meeting, however, there is limited evidence in the resident minutes, or the complaints register, that show these concerns are followed up by the service or that feedback or a resolution is provided to the consumers.

I find that the approved provider is not compliant with this requirement.

* Requirement 6(3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team found that the service was unable to demonstrate appropriate action or investigation is undertaken in response to feedback and complaints, or that open disclosure is always used when things go wrong.

The Assessment Team spoke with consumers and representatives were not confident that the service acts appropriately and promptly when responding to feedback and complaints. Several consumer representatives raised concerns about having to pay the service for face masks and rapid antigen tests (RAT) to visit the consumers. The representatives said they understood the commonwealth government supplies all aged care services RAT and PPE supplies free of charge. Several consumer representatives raised concerns about not having enough equipment or equipment being broken and the service taking a long time to fix or replace the item

The Assessment Team reviewed documentation including staff training records which indicate that open disclosure is not part of their mandatory training.

The Assessment Team reviewed management and family meeting minutes from 28 May 2022 state there are many complaints that have been submitted anonymously, however these have not been registered in the service’s complaints folder. The minutes state the management has asked family and representatives to please go to the management first with their complaints rather than straight to the Commission.

The complaints register provided to the Assessment Team demonstrated that there are no complaints on file between January to May 2022. However, the resident meeting minutes indicate that there have been consistent complaints throughout this time. The electronic complaints and feedback register printed for the Assessment Team to view and the complaints folder have very limited evidence of follow up occurring in response to the complaints.

I find that the approved provider is not compliant with this requirement.

* Requirement 6(3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team interviewed consumer and representatives and found that they were not able to describe any improvements as a result of complaints and the documentation provided showed very few improvements made as a result of complaints. Overall, it has not been demonstrated feedback and complaints are used on an ongoing basis to improve the quality of care and services.

Most consumer representatives interviewed expressed their concern about the frequent management change at the service. They said issues they have raised previously do not get addressed and then new management start, and they need to raise the issue again and wait for the new management team to respond. They are very concerned about the impact on the consumer’s care and communication at the service.

The Assessment Team interviewed management who were not able to describe the complaint trends for the service. Review of the service’s feedback management policy (dated 1 April 2022), confirms management do not follow complaint and feedback policy or procedures including complaints being part of the continuous improvement program.

I find that the approved provider is not compliant with this requirement.

**The following requirement was found to be 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.

The Assessment Team interviewed consumers and representatives were aware of external complaint mechanisms but not advocacy services. However, promotion of advocacy services and external complaint mechanisms were observed throughout the service. Consumers and representatives said they would talk to staff and management if they needed to make a complaint. Some representatives were confident in other external complaints avenues they could use if required.

The Assessment Team interviewed management and staff who were aware of the external aged care complaints mechanism. However, staff were not able to identify OPAN as an advocacy service the consumers could access if they required and could not recall an occasion when they needed to assist a consumer or representative to access advocacy services.

The service’s resident handbook includes information on how to make a complaint and there were aged care advocacy service posters and brochures displayed in the service environment, both in English and in Cantonese, which were readily visible to consumers and their visitors.

# Standard 7

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| Human resources | | Non-compliant |
| 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 Quality Standard is assessed as Non-compliant as four of the five specific requirements have been assessed as Non-compliant.

**The following four specific requirements have been assessed as Non-compliant.**

* 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.

The Assessment Team found that overall the services workforce is planned to enable the delivery and management of safe quality care and services. It was noted that the number and mix of staff working was consistent with the master roster. There have been numerous changes at the service in terms of key management personnel over the past two years. It was noted that the key personnel changes affected the safety and quality of care and services. Many staff have been recently recruited into key positions and do not have experience in the role. When reviewing the past four weeks of rosters it was found that there is an effective process in place for filling day to day vacant shifts.

Most consumers and consumer representatives felt that staff were generally visible and available when they were required however there was also feedback received stating there is not enough staff.

The Assessment Team interviewed staff who gave mixed feedback including concern about workload and the lack of guidance for the new graduate staff. Staff discussed feeling stressed. There was feedback received from staff stating that especially during the lockdown period there was a high level of stress and fatigue amongst employees from working extended shifts including double shifts.

Staff said most get through the required tasks with some stating they can complete all their tasks and some stating that they are rushed. Call bell records demonstrated that call bells were answered in a timely manner on most occasions however there were a few that were over an extended period. Staff interviewed were not able to explain the reasoning for this however stated that they always make a conscious effort to attend to the call bells in a timely manner.

I find that the approved provider is not compliant with this requirement.

* Requirement 7(3)(c) The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team interviewed management who advised that staff have been recruited with the right qualifications for the role. The Assessment Team reviewed a sample of staff personnel records which showed those staff have qualifications relevant to their role. It was found however that the services Australian Health Practitioner Regulatory Agency (AHPRA) registrations for their Registered Nurses were out of date although the service was able to procure up to date AHPRA registration certificates by the end of the site audit.

The Assessment Team reviewed training records which showed not all staff had completed their mandatory training. The education officer stated that she plans to have all education completed in the coming months however acknowledged the service is behind now.

The Assessment Team interviewed staff who spoke of a consumer who had to wait for an extended period as the assisting staff member did not speak English and was unable to understand that they were required to get the lifter to transfer the consumer. Through staff interviews it was identified that staff had a limited understanding of restrictive practice.

The Assessment Team interviewed consumers and representatives and received mixed feedback regarding confidence in whether staff are skilled enough to meet their care needs. One consumer representative stated that the old staff are the service are well trained however believes the new staff require further training and one representative was concerned about the unexplained bruises that the consumer had and was concerned they may be related to manual handling.

I find that the approved provider is not compliant with this requirement.

* Requirement 7(3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team found that the service has tried to recruit, train, equip and support its workforce, however has had numerous management changes over the last couple years in all roles including senior management. The Assessment Team noted gaps in the clinical care and in clinical review processes. There were gaps in the clinical governance framework as provided by the service. The Assessment Team noted that issues including increased bruising, post falls management, medication incidents and inappropriate restrictive practices could be the result of inadequate training. Staff training records were not up to date and not all staff had completed mandatory training or received training appropriate to their roles.

The Assessment Team identified that the organisation has systems in place to identify staff training needs as evidenced by the matrix document however it was found that this document was not always regularly updated and that the service still has outstanding staff who have not completed their mandatory training. The service has had 2 COVID-19 outbreaks however only 80% of staff have completed their donning and doffing PPE competency. In terms of Serious Incident Response Scheme /Incident Management requirements the service has 64% staff members who have completed the training.

I find that the approved provider is not compliant with this requirement.

* Requirement 7(3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team found that the service has a system in place for regular assessment, monitoring and review of the performance of each member of the workforce. Some staff members confirmed they receive feedback from management and complete annual appraisals. The service demonstrated a checklist for staff appraisals however it was found that not all staff have completed their appraisals.

The Assessment Team interviewed staff who confirmed that some staff participate in performance appraisals where they discuss their performance and goals with the management team. The performance appraisal contains a self-appraisal and an interview with management or direct report such as care service employees meeting with Registered Nurses.

The Assessment Team reviewed the service’s list of appraisals where 38/106 staff completed appraisals in 2022 and 18/106 staff in 2021 indicating that regular assessment is not occurring in line with the services plan. Staff at the service stated this was related to the high number of changes in management personnel.

I find that the approved provider is not compliant with this requirement.

**The following requirement has been assessed as Compliant.**

* Requirement 7(3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

The Assessment Team interviewed consumers and representatives who confirmed that the staff are kind, caring and treat consumers well. Consumers felt that staff are qualified and generally well trained and equipped with the knowledge and skills to deliver safe and quality care and services.

The service demonstrated policies, processes and systems in place to ensure the recruitment and training of a competent workforce who are equipped, trained and supported to deliver the responsibilities of their role.

The Assessment Team identified that most consumers and representatives sampled expressed their dissatisfaction with care staff numbers at the service providing examples of where staff shortages have impacted consumers’ care and service delivery. Staff interviewed expressed concerns regarding care staff shortages; being unable to deliver care in accordance with consumers’ needs and preferences in a timely manner and how this impact both consumers as well as staff personally.

# Standard 8

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| Organisational governance | | Non-compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-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 Quality Standard is assessed as Non-compliant as five of the five specific requirements have been assessed as Non-compliant.

**The following five requirements have been assessed as Non-compliant.**

* Requirement 8(3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The Assessment Team found that consumers were not engaged in the development, delivery and evaluation of care and services. The Assessment Team found that management and the Board lacked understanding of this requirement.

The Assessment Team spoke to senior staff who advised that there have not been any actions undertaken to engage consumers in the development or delivery of the service and education has been provided to the Board and management about their responsibilities. It was found that the Board has not engaged regularly with consumers or their representatives. The service has not explained or reassured consumers about the ongoing changes to leadership of the organisation or introduced the new General Manager. The new General Manager does not have aged care experience and although the Board was invited to participate in the site audit, did not chose to provide input.

The Assessment Team interviewed management who stated that they receive feedback from consumers and their representatives at consumer meetings and completing regular consumer surveys monthly. On review it was found that the consumer meeting minutes contained minimal feedback. Management stated that they are working with an external consultant to assist the service with actively engaging consumers in the development, delivery and evaluation of care and services. The plan is for consumer meetings to occur regularly and minutes to be discussed at management and Board meetings and information from Board and management meetings to be discussed at consumer meetings. The service acknowledged this is the plan in place however currently it is not occurring at the service.

I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team interviewed consumers and representatives who provided mixed feedback on how the service is run, however overall everyone stated that they felt it met their cultural needs. There was mixed feedback regarding the overall quality of the care and services provided. Speaking to management it was found that the organisation had a lack of systems to oversee the promotion of a culture of safe, inclusive and quality care and services and there was no oversight of accountability for the delivery.

The Assessment Team identified the service has newly implemented policies and procedures in place, however, management were not able to provide information on how the governing body of the service monitors data and uses it to improve the care and services. It was found that the service’s Board did not actively play a role in promoting a culture of safe and inclusive care. Management stated that with the previous site audit findings, the Board hired external consultants to assist with improving the quality of care and assist with meeting the quality standards however it was found that there were large turnover of staff including management and consultants and as a result still numerous gaps identified with the care and service provision.

It was found that the Board looked predominantly at financial situations and recruitment of personnel but was not involved in reviewing the quality of care and services including clinical information. Management were not able to recall what skills the Board has to enable them to run the service in a way that is safe and inclusive with quality care and services. There was a lack of understanding of the Boards role in being accountable for the delivery of the overall service.

Management were not able to describe any changes made in the last six months driven by the Board because of consumer feedback, experience and incidents. It was evident that the Board was not involved in incidents related to the safety of consumers. It was evident that the Boards understanding of the quality standards was minimal and the consultant was working towards educating them on their roles and responsibilities.

The General Manager said there are 30 Board members although only 7 active members. He said Board members are all small business owners and the organisational constitution allows Board members to individually contract services to the service, which may lead to the perception or actual conflict of interest. No information was provided about the prudential arrangements regarding these arrangements.

I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team found that the service was unable to provide information on a range of areas and management stated that there were gaps this requirement.

The Assessment Team identified in relation to information management that the service did not have a record of Serious Incident Response Scheme incidents that it could provide. Numerous staff raised concerns that there were issues with communication. Management stated the email communication is used to communicate to staff however it was also found that there was a large amount of staff at the service who could not communicate in English resulting in them not being able to reply to emails. Based on the interviews conducted staff can access certain documents however could not access all the required information that they may require.

The Assessment Team found in relation to continuous improvement, that there were no clear systems in place to track and monitor opportunities for continuous improvement. Management were not able to provide information on how the service, including the Board use critical incidents to drive continuous improvement. Management stated that the governing body procured the services of consultants and hired personnel to assist with meeting the Quality Standards however were not able to provide any further examples of Boards involvement in continuous improvement.

The Assessment Team found that in relation to financial governance, management were not able to state how the service seeks to change the budget or expenditure to support the changing needs of the consumers due to only commencing with the service less than one week before the Site Audit. The service’s Board declined to speak to Assessment Team during the Site Audit. Staff interviewed stated that the management at the service has been requesting to arrange single slings for consumers as opposed to shared slings for best practice infection control however that the Board were did not approve this due to costing. An upgrade to the call bell system has been stalled by Board approval and as a result it was evident that consumers who were assessed as requiring bed and chair sensors were not provided these.

The Assessment Team identified gaps in relation to regulatory compliance with management stating that there were no systems in place at the organisation to track changes to the aged care law and communicate these to staff. The service has started to subscribe to the Commissions updates and gets email reminders as per advice of the consultant. The obligation to maintain a Serious Incident Response Scheme register was acknowledged although none was provided. Management were not able to state how the Board supports the service to ensure regulatory compliance is being met and indicated that the Board had a minimal role in this area.

The Assessment Team found that it was not evident how the service monitors feedback and complaints and uses it to help improve quality of care and services. There was no collated information with comments, feedback and complaints. There was consistent feedback received stating that the communication from the service was poor and issues took prolonged periods of time to fix identified issues. One consumer stated that the service does not respond to complaints.

I find that the approved provide is not complaint with this requirement.

* 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.

The Assessment Team found that the service has policies and procedures which were recently acquired to guide staff and provide a framework on how to operate. However, systems are fragmented and management lack knowledge to ensure effective risk management systems. The service did have an incident management system to keep track of their incidents which was accessible through their electronic system. It was not evident that the risks to consumers care was analysed on a higher level and use to mitigate these and drive continuous improvement. Although a clinical governance meeting has commenced the system is not sufficiently established to support effective risk management.

The Assessment Team found that there is no Serious Incident Response Scheme register, and no management or staff member were able to provide information regarding this.

The service was unable to demonstrate each consumer is supported to safely take risks to enable them to live the best life they can and was unable to provide evidence of policies and procedures that support the workforce to identify where consumers choice may include an element of risk and how to manage that risk.

I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team found that there was not a clinical governance framework in place that clearly demonstrated an oversight of the clinical indicators or data at a higher level. After being reviewed by the deputy director of nursing, management were not able to indicate how the data or information was used.

The Assessment Team identified that the organisation had the policies in place to reflect this requirement, however the policies and practice were not well understood or demonstrated in a practical way.

The restrictive practices policy states that restrictive practices are regularly reviewed by appropriate health care professionals with a view to easing or reducing the practice. However physical restraint has not been reviewed, minimised or managed.

The open disclosure policy states that the purpose was open communication about incidents and near-misses and improve safety and quality of care however it has been evident that in practice this has not been occurring.

A policy relating to antimicrobial stewardship, with the purpose of the policy is to raise awareness and adherence to improved antimicrobial stewardship with the aim of reducing inappropriate antimicrobial use, improve consumer care outcomes and mitigate adverse consequences of antimicrobial use including antimicrobial resistance and opportunity for spread of microorganisms.

The Assessment Team asked management what changes had been made to the way that care and service were planned, delivered or evaluated as a result of the implementation of these policies. Management were not able to provide examples.

I find that the approved provider is not compliant with this requirement.

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-2)