Performance

Report

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| Name of service: | Japara Lower Plenty Garden Views |
| Service address: | 390 Main Road LOWER PLENTY VIC 3093 |
| Commission ID: | 4093 |
| Approved provider: | Calvary Aged Care Services Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 5 September 2022 to 7 September 2022 |
| Performance report date: | 9 November 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 Japara Lower Plenty Garden Views (**the service**) has been prepared by M. Nassif, 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 12 October 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **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 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 4(3)(f) - where meals are provided, they are varied and of suitable quality and quantity.
* 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.
* Requirement 7(3)(e) - regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Requirement 8(3)(c) - effective organisation wide governance systems in relation to information management, continuous improvements, financial governance, workforce governance, regulatory compliance and feedback and complaints.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Assessment Team recommended Requirement 1(3)(d) was not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 1(3)(d), consumers and representatives said consumers are supported to take risks and staff described consumers who wanted to take risks and how they were supported to do so. However, the Site Audit report identified the following deficiencies:

* Risk assessments for one consumer who smokes was not regularly reviewed.
* The dignity of risk assessment for one consumer who used side bed poles to support their transfer in and out of bed was not reviewed in over a year. The named consumer also had their bed positioned against a wall for which no risk assessment was completed.

The provider’s response provided clarifying information that evidenced that the named consumers mentioned above have appropriate risk assessments in place and these have been regularly reviewed.

Overall, I am satisfied each consumer is supported to take risks to enable them to live the best life they can. Therefore, based on the evidence before me, I find Requirement 1(3)(d) is compliant.

I am satisfied the remaining 5 Requirements in Quality Standard 1 are compliant.

Consumers said they are treated with dignity and respect, with their identity and culture valued. Staff described what treating consumers with dignity and respect means. Care planning documents provided information on consumers’ background, identity and culture.

Staffs demonstrated awareness of consumers culture backgrounds, values and beliefs and described how this influenced the delivery of care. Care planning documents demonstrated the service has sought information about consumers’ cultural background. Consumers said they feel safe, and their cultural backgrounds are recognised.

Consumers and representatives said consumers are supported and encouraged to exercise choice and independence. Staff described how consumers keep and maintain relationships of their choice through outings with family and friends. Care planning documents demonstrated consumers’ choice for care and support to remain independent.

Consumers said they receive the information they need to make decisions relating to their care and lifestyle. Staff explained verbal and non-verbal communication methods they use to provide consumers with information and explained that menus and activities programs are distributed to consumers regularly.

Consumers reported that their privacy and confidentiality is respected and described staff practices such as knocking on doors prior to entry. This was consistent with staff feedback. The service had a privacy policy to advise how personal information is kept confidential.

# 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. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Assessment Team recommended Requirements 2(3)(a), 2(3)(d), and 2(3)(e) was not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 2(3)(a), the Site Audit report evidenced the following deficiencies:

* Three consumers receiving chemical restraint medication did not have behaviour support plan (BSP) in place.
* One consumer’s care planning document was not updated to reflect recent recommendations made by a skin specialist.
* Staff were unable to explain why a named consumer was on fluid restriction per their care planning documents, with no assessment or recommendation from a medical officer for the restriction.
* One new consumer’s pain assessment and management was not completed and included in their care planning document. However, the Site Audit report states that this was completed by the end of the audit.
* One consumer who has a history to self-harm did not have a risk assessment completed and was not reflected in care planning documents. The consumer also did not have a risk assessment in relation to their wish to smoke.
* Five consumers activities plan have not been updated to reflect consumers receive psychotropic medications and strategies to manage were not documented.

The provider’s response evidenced that for all named consumers, evaluation of care planning documents, including lifestyle activity evaluations, is completed regularly. I have considered this under Requirement 2(3)(e) where it is relevant. The provider’s response did not address the deficiencies identified in the Site Audit report specific to Requirement 2(3)(a) as listed above.

I find the evidence presented in the Site Audit report is sufficient to demonstrate assessment and planning, including consideration of risks, does not always inform the delivery of safe and effective care and services. Therefore, based on the evidence before me, I find Requirement 2(3)(a) non-compliant.

Regarding Requirement 2(3)(d), the Assessment Team identified 3 named consumers whose care plans reviews were not effectively communicated to consumers and their representatives and copy of the care plans were not provided to some of them. The Site Audit report stated that management confirmed care planning documents had not been offered during case conferences and this was identified through the service’s internal audit system and clinical staff were provided education in relation to this.

The provider’s response evidenced consumers and representatives were consulted when evaluation of care planning occurred. In relation to care planning documents being readily available, while the Site Audit report brought forward evidence that care planning documents are not actively offered, there is no evidence that care planning documents are not available.

The evidence presented under this Requirement is insufficient alone to support outcomes of assessment and planning are not effectively communicated to consumers and documented and care planning documents are not readily available consumers. Therefore, based on the evidence before me, I find Requirement 2(3)(d) compliant.

Regarding Requirement 2(3)(e), the Site Audit report evidenced the following deficiencies:

* One named consumer had not been reviewed post fall by a physiotherapist and care planning document was not reviewed or updated. Incident reports and record of the infection found post fall was not completed.
* One consumer was not reviewed and updated post identification of a skin infection by a specialist.
* One consumer had multiple skin tears and bruises was not reviewed post injuries including identification of cause.
* One consumer’s behaviour assessment and plan were not reviewed for effectiveness post a serious incident.

The provider’s response evidenced that for all named consumers, evaluation of care planning documents, including lifestyle activity evaluations, is completed regularly. In relation to the consumers mentioned above, the response evidenced:

* For the consumer who was not reviewed post fall, they were reviewed post fall, and this is reflected in their care planning document. An incident report and infection record were also completed.
* For the consumer who was identified with a skin infection, the service is regularly reviewing and updating care needs, including consulting with specialists as required.
* For the consumer with multiple skin tears and bruises, skin assessments were reviewed an updated post incident.
* For the consumer whose behaviour assessment and plan was not reviewed post serious incident, all behaviours are recorded including the cause, intervention and effectiveness of intervention.

Overall, care planning documents demonstrated that 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. Therefore, based on the evidence before me, I find Requirement 2(3)(e) compliant.

I am satisfied that the remaining 2 Requirements of Quality Standard 2 are compliant.

Care planning documents were observed to be generally individualised to consumer needs, reflecting their preferences for care including advance care planning. Staff described the needs and preferences for consumers and their care requirements, in line with their care planning documents.

Care planning documents identified involvement of consumers, representatives, medical and allied health professionals. Staff described how consumers and representatives, and other health care providers are involved in the assessment and care planning process. Consumers and representative confirmed they are informed of changes or incidents and are involved in the assessment and planning process.

# Standard 3

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

Findings

The Assessment Team recommended Requirements 3(3)(a) and 3(3)(b) was not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 3(3)(a), the Site Audit Report identified the following deficiencies:

* Several named consumers were not receiving showers, as per their preference, due to staff shortage.
* The named consumer was observed lying in bed with pillows on either side of them, appearing to restrict their movement. The consumer was observed not to have a call bell within reach however when raised with management this was addressed immediately.
* For one named consumer, wound charting did not commence after a specialist found an infection of the skin.
* For one consumer, the service was unable to provide evidence that informed consent was obtained prior to use of the psychotropic medications as chemical restraint. The service also did not demonstrate evaluation of effectiveness of psychotropic medication on 2 occasions.

The provider’s response provided the following clarifying information in relation to the above deficiencies in support of compliance:

* For the consumer’s not receiving their personal hygiene in line with their preferences due to staff shortage, the response evidenced overall consumers are receiving personal care in line with their needs, for example by having nail, hair and denture care needs attended to. Consumers not receiving personal care in line with their preferences due to staff shortage is considered under Requirement 7(3)(a) where it is relevant.
* For the consumer observed lying in bed with pillows around them, the response stated that the pillows were there for the comfort of the consumer. The Site Audit report and response did not bring forward sufficient information regarding the pillows around the consumer being used as a restraint. Therefore, I am unable to form a view and hence have not considered this example.
* For the consumer with an infection of the skin that did not have wounds charted, the response stated that wound charting was not appropriate as the issue was dealt with as an infection with an infection recorded and medicating charted.

In relation to lack of consent obtained before psychotropic medication was administered, this is considered under Requirement 8(3)(c) where it is more relevant to regulatory compliance. In relation to not reviewing the effectiveness of psychotropic medication on 2 occasions for a named consumer, this appears to be an isolated event and no evidence of further occurrences was brought forward to suggest this is a systemic issue. Therefore, this alone is not sufficient evidence for non-compliance.

The Site Audit report provided feedback from consumers and representatives that was mixed with some feeling that consumers do get the personal and clinical care they need. Two representatives considered the consumer they represent did not receive good care however did not elaborate further, including impacts this was having on the consumers.

The evidence presented under this Requirement is insufficient alone to support that the consumers do not get safe and effective personal and clinical care that is best practiced, tailored to meet their needs and optimised their health and well-being. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(a) compliant.

Regarding Requirement 3(3)(b), the Site Audit report identified the following deficiencies:

* One consumer assessed to be at high risk of falls has documented preventative strategies in place including to have a call bell within reach. The consumer was observed not have a call bell in their room.
* One consumer’s high risk to skin injury was not effectively managed as not all recommendations of a specialist was implemented.
* A consumer with a chronic unstageable wound without effective pain management in place due to lack of assessments.
* One consumer’s behaviour assessment was not updated or reviewed to include their wandering behaviour. The consumer has been involved in several serious incidents due to their wandering behaviour.
* The service’s psychotropic register did not record all psychotropic medication administered to consumers and did not capture all chemical restraints.

The provider’s response and Site Audit report provided the following clarifying information in relation to the above deficiencies:

* For the consumer at high risk of falls who did not have a call bell within reach, the Site Audit report stated that once raised with management appropriate action was taken immediately to ensure the call bell was within reach for the consumer.
* For the consumer at high risk of skin injury, the Site Audit report stated that not all recommendations of the specialist could be implemented due to medication shortage at the pharmacy which were on order. The response provided evidence that the consumers skin is regularly reviewed by a specialist and medical officer and regular care is provided by the service to prevent further skin injury.
* For the consumer with wandering behaviour, the response evidenced that the consumers behaviour assessment does include their wandering behaviour. The response also evidenced that instances of wandering behaviour are recorded, included intervention implemented and the effectiveness of those interventions. The response also evidenced the involvement of another organisation to review and provide recommendations to manage the consumer’s wandering behaviour. The Site Audit report showed that staff demonstrated awareness of the consumer’s wandering behaviour and strategies to manage the behaviour.

In relation to the consumer with a chronic unstageable wound without effective pain management due to lack of assessments, this is a deficiency relevant to assessment and planning and has been considered under Requirement 2(3)(a) where it is relevant.

In relation to the psychotropic register not recording all psychotropic medication, no evidence was brought forward on the impacts this had on consumers. I consider an incomplete psychotropic register is more relevant to the effectiveness of the service’s clinical governance. Therefore, this is considered under Requirement 8(3)(e) where it is relevant.

The evidence presented under this Requirement is insufficient alone to support that high impact and high prevalent risks are not effectively managed. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(b) compliant.

I am satisfied that the remaining 5 Requirements of Quality Standard 3 are compliant.

Care planning documents for consumers who were nearing end of life showed their needs, goals and preferences are recognised. Staff described the way care delivery changes for consumers nearing end of life.

Care planning documents demonstrated timely identification of, and response to, deterioration and changes in function of consumers. Staff described the escalation process should they notice a change in a consumer. The service had policies and procedures to guide staff on the process of escalation. However, staff did not identify a skin infection of one named consumer which was discovered when the consumer was reviewed by a specialist. This appears to be an isolated incident and the consumer is regularly reviewed by the specialist. Therefore, this alone is not sufficient evidence for non-compliance.

Care planning documents provided adequate information to support care. Staff described how information is shared when changes occur through handover process. Consumers and representatives said staff are aware of the consumer’s preferences and care needs.

Consumers and representatives were satisfied that referrals are timely, appropriate, and occur when needed. Care planning documents confirmed input of other allied health professionals who can be consulted as necessary. Staff described the process for referring consumers to the internal clinical team and other health care professionals and how this informs care and services.

The service had policies and procedures to support the minimisation of infection related risks through the implementation of infection prevention and control principles and the promotion of antimicrobial stewardship. Infection control supplies were observed to be accessible throughout the service and staff adhering to infection control practices such as mask wearing and hand washing. Staff demonstrated an understanding of precautions to prevent and control infections and the steps they could take to minimise the need for antibiotics.

# Standard 4

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

Findings

The Assessment Team recommended the Requirements 4(3)(a), 4(3)(d) and 4(3)(f) were not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 4(3)(a), the Site Audit report identified the following deficiencies:

* Care and services being delivered were not aligned with consumers stated preferences. For example, a named consumer stated that the activities cater more to the female consumers at the service, and they miss out on activities of choice due to their physical limitations. This limitation was unknown to staff and not documented in the consumers’ care plan. The consumers also said they no longer participate in a social group at the service as staff loss meant the service was unable to hold the social group. Another named consumer’s representative said the service does not cater for the consumer’s interests and the family provides lifestyle activities instead.
* Staff interviewed could somewhat describe what was important to consumers and the activities they liked to participate in, however was limited due to care planning documentation inconsistencies.
* Recent consumer lifestyle survey indicated that 10% of consumers were satisfied with the lifestyle program, 70% were neutral and 20% were either dissatisfied or very dissatisfied with the lifestyle program.

The provider’s response provided clarifying information in support of compliance. The response provided activity records for the named consumers which showed they were informed of a range of activities of interest to them and the consumers either participated or declined to partake in activities. The response outlined engagement of appropriate staff to run social groups for consumers.

The Site Audit report stated low consumer satisfaction rate in overall lifestyle program has resulted in a review of lifestyle activities and implementation of new and varied activities scheduled for completion by the 1 July 2022. However, it was noted at the time of the site audit, progress of the plan was unable to be identified due to unavailability of a full team.

I acknowledge the actions taken by the service to address the deficiencies identified in relation to 2 named consumers and overall lifestyle activities. As no further named consumer examples was brought forward in the Site Audit report, the evidence presented under this Requirement is insufficient alone to support that the service does not provide each consumer with safe and effective services and support for daily living. Therefore, on the balance of the evidence before me, I find Requirement 4(3)(a) compliant.

Regarding Requirement 4(3)(d), the Site Audit report identified several deficiencies. I consider the following deficiency relevant to Requirement 4(3)(d): Two examples of named consumers where they were served meals that were not suitable to their dietary needs and not consistent with care planning documents. This deficiency is more relevant to Requirement 4(3)(f) and is considered there.

The evidence presented under this Requirement is insufficient alone to support that the information about the consumer’s condition, needs and preferences in relation to their supports for daily living are not communicated effectively or its ongoing impacts to the health and safety of consumers. Therefore, on the balance of the evidence provided, I find Requirement 4(3)(d) compliant.

Regarding Requirement 4(3)(f), the Site Audit report identified the following deficiencies:

* Most consumers and representatives had negative feedback about the quality and consistency of the meals provided at the service. For example, 2 consumers said the food was bland.
* Most consumers and representatives said there were a number of instances where consumers were served meals that were not suitable to their dietary needs and preferences. For example, one named consumer is on a gluten free diet however the consumer said they have been served gluten food despite requesting not to be served such foods. Another consumer said they tell staff not to bother serving them food as they do not like the food and despite raising concerns, no change has occurred. Management advised the consumer order food online and has it delivered to them at the service.
* Staff were observed plating up meals, not referring care planning documents, as they said they had worked at the service for some time and were aware of consumers meal preferences. The Site Audit report states this could be contributing to feedback from consumers that they are not served meals suitable to their dietary needs and preferences.
* Observations where meals served were not completely in line with the menu displayed, for example by not including 2 types of vegetables as stated on the menu.
* For the meals being delivered on food trolleys, sticky notes listing consumers room numbers and did not have any labels identifying the consumers’ name or specify their dietary requirements.

The provider’s response detailed work undertaken with consumers to obtain their feedback and implement improvements in the month preceding when the Site Audit was conducted, including creating a new menu. However, the response does not evidence if improvements has resolved consumer concerns generally and those raised in the Site Audit report.

While I acknowledge the service has taken appropriate actions to address the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. I have given greater weight to negative feedback from consumers and find the service did not demonstrate that meals provided are of suitable quality. Therefore, based on the evidence before me, I find Requirement 4(3)(f) non-compliant.

I am satisfied that the remaining 4 Requirements of Quality Standard 4 are compliant.

Consumers said there are services and supports for daily living that promote their emotional and spiritual well-being. Care planning documents outlined consumers’ emotional and spiritual needs and strategies to support these needs. Staff explained how they identify when consumers are feeling low and what they do to support them.

Consumers said they are supported by the service to participate in their community within and outside the service environment as they choose. Staff described the supports in place for individual consumers to enable them to participate in the wider community and maintain personal relationships. Care planning documents identified activities of interest for the consumers and how they are supported to participate in these activities and also in the wider community.

Care planning documents evidenced the service collaborated with appropriate external services in a timely manner to support the needs of consumers. Staff gave examples of consumers who have been referred to other providers of care and services. Consumers said the service offers to refer them to external providers to support their care and service needs.

Consumers said, consistent with observations, equipment which supported them to engage in lifestyle activities was suitable, clean and well maintained. Staff described the process for reporting faulty equipment.

# 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

The service environment was observed to be welcoming and safe, well-lit with appropriate signage to assist consumers with navigating around the service environment. Consumer rooms were observed to be personalised to optimise a sense of belonging and independence. Consumers said they feel safe and comfortable at the service.

Consumers said they are free to move around the service indoors and outdoors. Maintenance logs demonstrated repairs and maintenance were completed promptly and in a timely manner.

Staff reported they can readily access equipment as required to meet consumers’ needs. Consumers said the furniture, fittings and equipment are safe, clean, well maintained and suitable for use. Documentation demonstrated testing and maintenance is conducted and issues are addressed in a timely manner.

# Standard 6

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

Findings

The Assessment Team recommended Requirements 6(3)(a) and 6(3)(c) were not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 6(3)(a), the Site Audit report identified the following deficiencies:

* Some consumers and representatives were not comfortable raising complaints directly, however no examples of named consumers was provided. The report provided one example where a consumer’s representative relied on a letter from a health specialist to raise concerns about the care the consumer was receiving.
* One anonymous consumer’s representative was worried about the consumer safety and well-being at the service if they raised a complaint.

The provider’s response outlined the various ways the service encourages consumers and representatives to provide feedback and make a complaint, including emails, feedback forms and meetings with consumers. The response provided examples of how the service responds to complaints. I have considered this information under Requirement 6(3)(c) where it is relevant.

The Site Audit report stated most consumers and representatives felt safe to provide feedback and make complaints directly to staff or management. While I acknowledge the concerns raised by consumer’s representatives as listed above, I have given greater weight to the positive feedback from most consumers and representatives. The evidence presented under this Requirement is insufficient alone to support that consumers and representatives are not encouraged and supported to provide feedback and make complaints. Therefore, on the balance of the evidence before me, I find Requirement 6(3)(a) compliant.

Regarding Requirement 6(3)(c), the Site Audit report identified the following deficiencies:

* One named consumer, who is gluten intolerant, said they complained that gluten food continues to be served to them.
* One named consumer said they raised concerns regarding their meals however nothing has changed.
* The feedback register showed for the month of August 2022 there were 3 complaints, all relating to care. One complaint regarded one consumer who was reviewed by an external specialist and recommendation by the specialist to involve the consumer in a social group was not implemented. The Site Audit report evidence the other 2 complaints made in the month of August 2022 was adequately actioned and responded to.

In relation to the consumer who is gluten intolerant but continues to be served gluten food, the response stated the consumer is not allergic to gluten, thus the reason for the consumer choosing to have gluten desserts on occasion. This is not consistent with information in the Site Audit report where the consumer said, when interviewed, they have requested not to be served food containing gluten. Due to inconsistent information, I am unable to form a view and hence have not considered this example.

In relation to complaints surrounding food, the response evidenced the service has recorded and responded to feedback by implementing improvements. Issues around the effectiveness of those improvements resulting in ongoing food concerns is relevant to Requirement 4(3)(f) and considered there.

In relation to the complaint regarding lack of implementation of specialist recommendation to involve the consumer in a social group, the response evidenced attempts to initiate the social group. This is outlined and considered under Requirement 4(3)(a) where is it relevant.

The evidence presented under this Requirement is insufficient alone to support that the service does not take appropriate action in response to complaints. Therefore, on the balance of the evidence before me, I find Requirement 6(3)(c) compliant.

I am satisfied that the remaining 2 Requirements of Quality Standard 6 are compliant.

Staff described how they would contact advocacy and language services if they identified consumers who wanted to discuss issues or make a complaint via advocates or interpreters. Information on internal and external complaints and feedback processes and advocacy services was observed on noticeboards and brochures were available in shared areas of the service.

The service’s Plan for Continuous Improvement reflected common concerns raised by consumers such as staffing levels, calls bell response times and lifestyle activities. Management said they actively pursue continuous improvement through a range of methods including survey’s, meeting forums, audits and direct feedback from consumers and representatives.

# Standard 7

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

Findings

The Assessment Team recommended Requirements 7(3)(a), 7(3)(d) and 7(3)(e) were not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 7(3)(a), the Site Audit report identified several deficiencies. I consider the following relevant to Requirement 7(3)(a):

* As outlined under Requirement 3(3)(a), consumers were not receiving hygiene care according to their preferences due to staffing shortage.
* As outlined under Requirement 4(3)(a), consumers were not provided lifestyle activities according to recommendations and their interest due to staffing shortage.
* Feedback from staff that, due to staffing shortage, consumer care is compromised and they do not receive hygiene care in line with their preferences.
* An internal staff survey identified majority of staff said staffing was their main concern.
* Review of rosters identified vacant shifts and call bell data evidenced wait time of over 10 minutes for several calls each month.
* One named consumer said, and their representative agreed, that staff do not spend a lot of time with them and to assist them get out of bed as per their wish.
* One named consumer’s representative said staffing levels have decreased and this has impacted on the care of the consumer. Review of complaints from the consumer showed all complaints were regarding the consumer being left unattended in common areas of the service for long periods of time.
* One named consumer said they no longer participate in a social group at the service as staff loss meant the service was unable to hold the social group. Staff said they have been unable to start the social group again due to difficulties getting appropriate staffing.

The provider’s response provided:

* A master roster for the period of 15-28 August 2022 that evidenced the planned staffing level and the actual number of staff worked which was less than the number of planned staff shifts.
* Clarifying information that only 4 percent of call bell response times in August 2022 were over 10 minutes long.
* Several strategies in place to address staffing shortfalls.

While I acknowledge the service has taken some appropriate actions to address the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Further, I have given greater weight to negative feedback from consumers and representatives and find the service did not demonstrate that the workforce is planned to enable the delivery of timely and appropriate support and services to consumer’s satisfaction.

Therefore, based on the evidence before me, I find Requirement 7(3)(a) non-compliant.

Regarding Requirement 7(3)(d), the Site Audit Report identified the following deficiencies:

* Mandatory training records for 2021 showed that not all staff completed training and for 2022 mandatory training, staff completion rate for most training topics was less than 50%.
* Management stated that an internal audit conducted in April 2022 identified training needs for staff as an area for improvement and that management have since prioritised training.
* Management said the clinical staff who completed the psychotropic register did not have training on how to complete the psychotropic register and that training was provided on 18 August 2022.

The provider’s response agreed that not all mandatory training was completed for 2021 however staff were on track to complete mandatory training for 2022. The Site Audit report provided feedback from consumers and representatives that they were confident with staff abilities and practices. Staff also described mandatory training sessions available to them. The Site Audit report did not bring forward evidence on the impacts lack of staff training had on consumers.

The evidence presented under this Requirement is insufficient alone to support that the workforce is not trained to deliver the outcomes required by the Quality Standards. Therefore, on the balance of the evidence provided, I find Requirement 7(3)(d) compliant.

Regarding Requirement 7(3)(e), the Site Audit report identified deficiencies around regular assessment, monitoring and review of staff performance not occurring. For example, in 2021 only 38 of 102 staff had completed a performance appraisal and no appraisals have occurred in 2022. The Site Audit report stated that management provided evidence that staff performance was being monitored through disciplinary processes.

The response acknowledged the evidence in the Site Audit report of incomplete staff appraisals due to change of the provider of the service and management who usually complete the appraisals. The response confirmed processes have been revised and provided a schedule to evidence that all staff performance appraisal will occur in 2022.

While I acknowledge the provider’s commitment to addressing the deficiencies, the service did not demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Therefore, based on the evidence before me, I find Requirement 7(3)(e) non-compliant.

I am satisfied the remaining Requirements in Quality Standard 7 are compliant.

Consumers and representative’s said staff are kind, caring and respectful with delivery of care and services. Staff demonstrated understanding of needs and preferences of consumers.

Consumers and representatives felt confident staff are suitably skilled to meet their care needs. Management described the process of ensuring staff members are competent and capable in their roles. Review of documentation demonstrated staff have appropriate qualifications, knowledge, and experience to perform their duties.

# Standard 8

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

Findings

The Assessment Team recommended Requirements 8(3)(c), 8(3)(d) and 8(3) (e) was not met. I have considered the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 8(3)(c), the Site Audit Report identified several deficiencies. I consider the following relevant to Requirement 8(3)(c):

* For one consumer, the service was unable to provide evidence that informed consent was obtained prior to use of the psychotropic medications as chemical restraint, as per regulatory requirements.
* The service did not have BSPs in place for all consumers receiving chemical restraint medication, as per regulatory requirements.
* Two staff did not have current police checks, as per regulatory requirements.
* An incident of consumer-to-consumer aggression was not reported through SIRS, as per regulatory requirements.

The provider’s response addressed some of the deficiencies. However, the response did not address all the specific deficiencies listed above. The service did not address and demonstrate compliance with regulatory requirements, including restrictive practices. Therefore, based on the evidence before me, I find Requirement 8(3)(c) is non-compliant.

Regarding Requirement 8(3)(d), the Site Audit Report identified several deficiencies. I consider the following relevant to Requirement 8(3)(d):

* As outlined under Requirement 3(3)(b), the service did not demonstrate effective management of high impact or high prevalence risks of named consumers. I have considered this information under Requirement 3(3)(b) where it is relevant and found to be compliant.
* In relation to supporting consumers to live the best life they can, one consumer did not have risk assessments in place for smoking and self-harm tendencies. I have considered this information under Requirement 2(3)(a) where it is relevant. Additionally, this appears to be an isolated event and no evidence of further occurrences was brought forward to suggest systemic issues of ineffective risk management.
* Not all incidents were not identified by or reported to management to action. The report provided 2 examples of this:
* One consumer’s fall incident was not reported.
* An incident of consumer-to-consumer aggression was not reported, including through SIRS. This appears to be an isolated event and no evidence of further occurrences was brought forward to suggest systemic issues of ineffective risk management. I have considered this information under Requirement 8(3)(c) where is more relevant to show deficiency in complying with regulatory requirements.

The provider’s response provided clarifying information, in relation to the incident of a consumer’s fall not being reported. The response evidenced that there was an error made by the external staff and that in fact the consumer did not have a fall so no incident needed to be reported. The provider’s response outlined meetings that take place to ensure discussion of consumers’ care and service needs, including the service’s incident reporting system.

The evidence presented under this Requirement is insufficient alone to support that the service does not have effective risk management. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(d) compliant.

Regarding Requirement 8(3)(e), the Site Audit report identified several deficiencies, including deficits in relation to restrictive practices which has been addressed under Requirement 8(3)(c). I consider the following relevant to Requirement 8(3)(e):

* Pharmacy medication review records for one named consumer recommended reducing the use of psychotropic medication, these are not necessarily taken up by the service.
* The service’s psychotropic register did not record all psychotropic medication administered to consumers and did not capture all chemical restraints.

The provider’s response provided the following clarifying information:

* In relation to not reducing psychotropic medication in line with recommendations, the response stated that every effort is made to support implementation of recommendations however it is for the relevant medical officer to ensure recommendations are followed up and reviewed. The Site Audit report and response did not bring forward sufficient information to demonstrate that the service is not minimising restrictive practices and no further named consumer examples were brought forward.
* In relation to the incomplete psychotropic register, I have not considered this information as no impacts on consumers was brought forward. Further, no evidence was brought forward to suggest that an incomplete psychotropic register resulted in the service not being able to minimise the use of restraint.

The evidence provided in the Site Audit report in this Requirement does not sufficiently support that the service is not minimising the use of restrictive practices. Therefore, based on the evidence before me, I find Requirement 8(3)(e) compliant.

I am satisfied the remaining 2 Requirements of Quality Standard 8 are compliant.

Consumers said the service is run well. Management and staff described ways consumers are encouraged to be involved and engaged, such as through resident meetings.

Various reports are generated and consolidated and received by the governing body on a regular basis. The governing body used this information to identify compliance with Quality Standards and to initiate improvements to enhance performance or monitor care.

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