Performance

Report

1800 951 822

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| Name of service: | Performance report date: |
| Jewish Care (Vic) Inc. Residential Homes, Windsor | 13 September 2022 |
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| Approved provider: | Activity date: |
| Jewish Care (Victoria) Inc | 18 July 2022 to 20 July 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 Jewish Care (Vic) Inc. Residential Homes, Windsor (**the service**) has been considered by Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 25 August 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 1(3)(a) - The Approved Provider ensures each consumer is treated with dignity and respect and their identity, culture and diversity is valued.
* Requirement 2(3)(a) - The Approved Provider ensures assessments and plans are completed and accurate in line with the organisation’s procedures, including risk assessments.
* Requirement 3(3)(a) - The Approved Provider ensures each consumer gets safe and effective personal care and clinical care which is in line with best practice and the consumers’ needs.
* Requirement 3(3)(b) - The Approved Provider ensures high impact and high prevalence risks associated with the care of the consumer are managed effectively
* Requirement (3)(g) - The Approved Provider ensures staff practice and actions to manage consumer infections is in line with infection control management procedures and guidelines.
* Requirement 4(3)(a) - The Approved Provider ensures each consumer receives effective services and supports for daily living that meets the needs, goals and preferences of the consumer and which optimises the consumer’s health, wellbeing and quality of life.
* Requirement 4(3)(f) - The Approved Provider ensures meals provided are varied and of suitable quality and quantity.
* Requirement 6(3)(d) - The Approved Provider ensures feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(a) - The Approved Provider ensures 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)(d) - The Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 8(3)(c) - The Approved Provider ensures effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.
* Requirement 8(3)(d) - The Approved Provider ensures effective risk management systems and practices, including but not limited to the following, managing high impact or high prevalence risks associated with the care of consumers.

# 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. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | 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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

The Assessment Team brought forward evidence from two consumer representatives regarding inadequate hygiene care they perceived impacted on consumer dignity. The Assessment Team further observed care documents which indicated one consumer had not received a shower in over a month and malodours in the consumer’s room. A representative who wished to remain anonymous described negative interactions with agency staff and the Assessment Team observed consumers in compromised, undignified positions on two occasions.

The Approved Provider’s written response of 25 August 2022, acknowledged some of the deficits identified by the Assessment Team and explained that challenging behaviours from consumers and refusing hygiene care impact on the ability of staff to provide care, however detailed the strategies used by staff to overcome this, the Approved Provider further explained that at times hygiene care, although provided, was not correctly documented.

The Approved Provider submitted additional supporting evidence of actions that have been taken since the Site Audit to address the deficiencies identified by the Assessment Team, which included a new internal work instruction relating to oral and dental care, additional staff training on hygiene care and updates to processes to ensure correct documentation is occurring.

I acknowledge the Approved Provider has implemented some actions to address the deficiencies identified by the assessment team, however based on the evidence brought forward by the Assessment Team in the Site Audit Report, at the time of the Site Audit the service did not consistently demonstrate that each consumer was treated with dignity and respect, therefore I find Requirement 1(3)(a) is non- compliant.

I am satisfied that the remaining five requirements of Quality Standard 1 are compliant.

Consumers reported that staff respected their needs and values and ensured care provided was culturally safe and staff described the ways consumers' differences are respected and celebrated.

Staff demonstrated how consumers are supported to make choices about their care and maintain relationships with those important to them and consumers explained the different was the service supports them to exercise choice and independence.

Consumers said they are supported to take risks and staff described how they assist consumers to understand risks and make decisions. Care planning documents contain risk assessments that include mitigation strategies. Consumers and representatives reported that they are kept updated by management on any changes to their care and services.

Consumers confirmed their privacy and confidentiality is respected. Staff outlined the practical ways they respect the personal privacy of consumers, such as, knocking on consumers’ doors prior to entry and closing their doors during the provision of care.

# 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. | 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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* 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.

A review of care planning documentation by the Assessment Team found that multiple assessment and care plans were either not completed or insufficiently documented in the electronic care management system. The Assessment Team identified five named consumer’s whose care documentation were missing assessment and care plans, impacting staff’s ability to provide care and services and posing risks to consumer health and wellbeing.

The Approved Provider’s written response, received 25 August 2022, acknowledged the deficits identified by the Assessment Team and outlined the actions taken in response to the findings, which included review and update all current care plans to ensure all assessments reflect the consumers current needs, a review of policies and procedures to guide staff and additional staff training on documentation requirements.

Whilst I acknowledge the actions taken by the Approved Provider to address the issues identified by the Assessment Team, at the time of the Site Audit, the service did not consistently demonstrate that assessment and care planning, including risks to the consumer’s health and wellbeing, informed the delivery of safe and effective care and services. I find Requirement 2(3)(a) is non-compliant.

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

Staff described what is important to consumers in terms of how their personal and clinical care is delivered, and the approach used for advance care planning, this was supported by consumers who described being involved in assessment and planning of their care, including advance care planning.

Most consumers and representatives confirmed they were involved in the planning process and had direct input into their care planning, where required. There is evidence of involvement of other health professionals, including medical officers, in assessment and planning and resultant care directives being incorporated in the care plan for consumers.

Consumers confirmed that staff explain relevant information and that they have access to their care plan. Care planning documents reflected reviews occur when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. However, the Assessment Team noted that pain management needs are not always reviewed for effectiveness, I have considered this evidence further under Requirement 3(3)(b).

# 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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; is tailored to their needs; and optimises their health and well-being;
* Effective management of high impact or high prevalence risks associated with the care of each consumer;
* Minimisation of infection related risks through precautions to prevent and control infection and reduce the risk of increasing resistance to antibiotics.

The Assessment Team reviewed care documentation and found that clinical monitoring, attending to personal hygiene and best practice guidelines were not followed in areas of catheter care and restrictive practices. The Assessment Team identified inconsistent clinical monitoring and care for two consumers according to their care plans. Staff stated that staffing pressures meant they are unable to complete clinical tasks as required and stated they are often too busy to update documentation in line with organisational policy.

The Assessment Team found that restrictive practices were not always managed in line with best practice. Care planning documents reveal that review of psychotropic medications are overdue for consumers; and staff reported training and knowledge gaps regarding restrictive practices.

The Approved Provider’s response of 25 August 2022 provided supporting evidence of actions that have been taken since the Site Audit, which included staff education on pain identification, additional staff training and internal audits of catheter management, a review of restrictive practices including immediate medical officer reviews for three named consumers who were identified as being overdue for a review. And ongoing education training for all registered staff on restrictive practices including legislative requirements, practical application, and documentation requirements.

While I acknowledge the actions taken by the service to address the deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider that at the time of site audit the service did not demonstrate each consumer received safe and effective, personal and clinical care, I find the service non-compliant with Requirement 3(3)(a).

The Assessment Team identified the service was unable to consistently demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer particularly in relation to pain management and pressure area care. A review of care plans identified an absence of pain charting and pain management review for deteriorating wounds and ineffective communication of high impact risks between staff impacting consumer care.

The Approved Provider did not refute the Assessment Team’s findings in its written response of 25 August 2022 and provided information including supporting evidence of actions that have been taken since the Site Audit, which included staff education on pain management, pressure area care and wound management and an update to the electronic care management system to reflect residents’ current high impact risks which can be accessed by all staff.

I acknowledge the Approved Provider has implemented actions to address the deficiencies identified by the assessment team, however, at the time of the Site Audit the service did not consistently demonstrate that consumer high impact or high prevalence risks were managed effectively.  I therefore find requirement 3(3)(b) is non-compliant.

The Assessment Team identified deficits in relation to staff practices and training in relation to infection control and found that a pathology test is not always completed prior to commencement of antibiotics for suspected infections, a practice not in line with the service’s policy. The Site Audit report identified four named consumers who were suspected of infections and prescribed and commenced on antibiotics prior to a pathology test to confirm the infections.

The Assessment Team also observed training records that showed not all staff had completed infection control training, which I have considered further in Requirement 7(3)(d).

The Approved Provider’s response of 25 August 2022 addressed each of the named consumer’s circumstances and advised that in all instances the consumers were under the care of a medical officer, however acknowledged that there were some occasions that antibiotics were commenced prior to results being received. The Approved Provider further advised that a review of infection control practices is underway at the service as part of the clinical governance framework for best practice in infection control. The response states the service immediately commenced competency training as a result of the feedback.

I acknowledge the service has taken appropriate action following the Assessment Team identifying and raising concerns with the management. However, at the time of the site audit the suspected infection did not result in appropriate practices to reduce the risk of increasing resistance to antibiotics. I therefore find requirement 3(3)(g) is non-compliant.

I am satisfied the remaining four requirements of Quality Standard 3 are compliant.

Care plans provide guidance and directions for staff on how to assess for palliative care needs such as pain, breathing difficulties, agitation and corresponding interventions in place to promote comfort and minimise pain. Staff were able to describe the care requirements for consumers receiving end of life care.

Consumer representatives confirmed that any changes to a consumers’ care needs is recognised and responded to in a timely manner. Clinical staff described commencing clinical monitoring to assess the deterioration in a consumer’s condition, before implementing strategies and escalating to other allied health professionals as required.

Staff reported that they are informed of changes to a consumer’s care needs through the handover process and described how they update the handover sheet, assessments and care plans where there are changes to a consumer’s care needs. Staff described how the input of other allied health professionals directs care and services.

# 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. | 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

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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;
* Where meals are provided, they are varied and of suitable quality and quantity.

The Assessment Team spoke with seven consumers and representatives that described the activities offered by the service as very limited and not interesting. Consumers stated that was a general lack of activities offered by there service and some wings that did not receive any communication or updates of the daily offerings. The Assessment team also found some activities were held in areas that were not accessible by all consumers due to mobility issues.

The Assessment Team spoke with care staff who explained part of their role, included conducting lifestyle activities with one care staff reporting, it is difficult to fit in around care duties.

The Approved Provider’s response of 25 August 2022 evidenced actions that have been taken since the Site Audit, which included a review of lifestyle activities offered and an updated activity calendar to reflect a broader and more frequent activity list. The Approved Provider also stated they had recruited an additional lifestyle assistant to coordinate activities, who commenced in February 2022.

I have considered the Assessment Team’s findings; the evidence documented in the Site Audit Report and the Approved Provider’s response and while I acknowledge the actions taken by the Approved Provider, I find that at the time of the Site Audit the service did not demonstrate each consumer received effective support for daily living and to optimise their quality of life. I therefore find Requirement 4(3)(a) is non-complaint.

The Assessment Team spoke with eight consumers or representatives who raised concerns in relation to the quality of food and meal service offered by the service. Specifically, consumers stated the food quality was low, the taste and texture of the meals was not enjoyable, portions were oversized and often went to waste and food preferences and dietary requirements were not followed by the kitchen staff.

The Approved Provider’s response of 25 August 2022 explained that the service had employed an independent food consultant since April 2021 in response to feedback received by consumers, staff, and representatives about the food quality. In response to a review undertaken by the consultant, the service had unsuccessfully attempted to change food contractors before deciding to move to an in-house food service model, which was endorsed by the Board on 27 July 2022. The Approved Provider stated that throughout this process the service ensured the meals offered always met the nutritional needs of consumers.

I acknowledge the service has implemented appropriate actions to address the deficits and is committed to improving the dining experience for consumers. However, at the time of the site audit the service could not demonstrate that suitable quality meals were provided to consumers. Therefore, I find the service non- compliant with Requirement 4(3)(f).

I am satisfied the remaining five requirements of Quality Standard 4 are compliant.

Staff described how they ensure the well-being of consumer, which includes a program for volunteers who provide emotional and social support to consumers through regular visits. Care plans listed religious and spiritual preferences for all consumers and consumers said that they can always reach people important to them and connect with their family and friends.

Consumers and representatives reported information about their daily living choices was effectively communicated and staff understand their needs and preferences.

Care planning documents reflect the external involvement for lifestyle support. Management demonstrated an understanding of organisations, services, and supports available in the community if required.

Staff could describe the process to report maintenance issues. Maintenance logs reviewed confirmed appropriate maintenance for the equipment and inspections to ensure operational integrity and safety of all equipment.

# Standard 5

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| Organisation’s service environment | | 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. | 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 Assessment Team recommended the following requirement was not met:

* Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The Assessment Team observed an adequate standard of care and cleanliness of the furniture, fittings and equipment throughout the service but noted some consumers had raised concerns about lengthy call bell wait times. The call bell system integrates directly with cordless phones, provided to staff while on shift. The Site Audit report identified two named consumers who spoke of significant delays in call bell responses, the Assessment Team observed some staff not carrying their phones to receive the notifications and some consumers calling for assistance verbally, rather than using the call bell system during the Site Audit.

The Approved Provider’s response of 25 August 2022 provided call bell data in relation to the two named consumers to demonstrate there were no instances that consumers were left unattended. The Approved Provider submitted further evidence to show recent upgrades to the connectivity of the system have been undertaken and additional staff education that has been delivered in relation to call bell responses.

Whilst I acknowledge the evidence brought forward by the Assessment Team, based on the totality of evidence provided in the Site Audit report and Approved Providers response, don’t find these examples alone are sufficient to indicate systemic deficits of the call bell system or a failure of equipment under this Requirement. I therefore find requirement 5(3)(c) is compliant.

I am satisfied that the remaining two requirements of Quality Standard 5 are compliant.

Consumers said they felt safe and at home at the service and were supported to personalise their spaces. The Assessment Team observed consumers socialising in common areas of the service with the service environment supporting interaction with other consumers and visitors. The indoor area was observed to be a safe environment encouraging independent movement of consumers assisted with wide corridors, hand railing and walkways equipped with signs.

Most consumers and representatives stated they were happy with the cleanliness of their room and a review of maintenance requests demonstrated that maintenance issues are addressed in a timely manner. Cleaning staff explained the daily cleaning routine that each consumer’s room receives and advised of the process for more detailed clean as necessary, cleaning staff also described the checklists and inspections of common areas they undertake each day.

**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. | 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. | Non-compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team identified that feedback and complaints were not reviewed and used to improve the quality of care and services. A review of the service’s complaint register indicated the re-occurrence of similarly themed complaints regarding the quality of meals provided, the lifestyle activities on offer and staff shortages. Feedback from consumers and representatives indicated that the service does not have enough staff, and the care staff workload included items that were time consuming and took staff away from caring for consumers. The Assessment Team found the service actions feedback and complaints on an individual basis without an appropriate overall analysis, nor long term actions being implemented to prevent issues from re-occurring.

The Approved Provider’s written response, received 25 August 2022, included additional information regarding the issues identified by the Assessment Team. In response to consumer feedback indicating complaints were not always actioned in a timely manner, the service has developed a Feedback Management Flowchart to outline the response timeline and management requirements in line with the service’s feedback management process. In addition, the service has committed to continuous improvement projects, such as, a transition to in-house food services, an external review of the model of care and the establishment of two new positions.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues with the review feedback and complaints. At the time of the Site Audit, the service did not demonstrate that feedback and complaints were used to improve the quality of care and services. I therefore find Requirement 6(3)(d) is non-compliant.

I am satisfied that the remaining three requirements of Quality Standard 6 are compliant.

Consumers, representatives and staff, are encouraged and supported to provide feedback and were informed of ways to make a complaint. Staff were aware of the avenues available to consumers and representatives to provide feedback and could describe the ways they support would support a consumer to lodge a complaint.

The Assessment Team observed posters of advocacy services, language services and the Commission are displayed throughout the service. Staff were able to describe the advocacy and language services available to consumers and knew where to direct consumers and representatives for further information.

Consumers and representatives indicated that management generally respond to feedback and complaints in an appropriate manner. Management displayed an understanding of the open disclosure policy, how it is relevant to complaints, and how it is practised by following up with the complainant and discussing the actions taken to remedy the issue.

**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. | 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. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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 workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Consumers and representatives expressed to the Assessment Team they felt the service did not have enough staff to assist consumers with their personal care needs and did not have enough time to engage with consumers. Consumers described the negative impacts to their care because of staff shortages, these impacts included lengthy waits for assistance, insufficient meal and hydration assistance and a lack of meaningful engagement with staff. In addition, feedback from staff outlined they did not have enough support to complete their tasks or deliver care and services adequately. These issues were raised with management, and they advised they are reviewing the service’s model of care and have engaged a consultant to undertake this process. Management provided the Assessment Team evidence of a consultant engagement brief as well as evidence indicated agency staff usage being identified as an area for improvement and is on the service’s continuous improvement plan.

The Approved Provider’s written response of 25 August 2022 included additional information regarding the issues identified by the Assessment Team. The service responded to the feedback made by consumers and representatives to provide further clarity and outlined the service improvements that have arisen from this feedback, which included additional recruitment and roster management and a review of areas of responsibility. The service provided additional current and planned improvement activities referenced within their continuous improvement plan.

I acknowledge the additional information provided by the Approved Provider, however, have also given weight to the feedback from consumers, representatives and staff that indicates impacts to care due to staffing levels. Based on the feedback provided by consumers, representatives and staff, the service did not demonstrate 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. I therefore find requirement 7(3)(a) is non-compliant.

The Assessment Team identified that the service was unable to demonstrate the workforce is recruited, trained, equipped and support to deliver the outcomes required by these standards. A review of training records identified not all staff have completed their mandatory competencies to perform their roles and the service did not have an adequate way to monitor completion of mandatory training.

The Approved Provider’s written response, received 25 August 2022, committed to undertake extensive training sessions across all the key areas identified by the Assessment Team during the Site Audit, including the completion of mandatory training competencies. The service indicated the training register is now managed and monitored by the Residence Manager to maintain closer oversight and follow up with individual staff to ensure compliance with required education and training.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues. At the time of the Site Audit, the service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. I therefore find requirement 7(3)(d) is non-compliant.

The Assessment Team recommended the following requirement was not met:

* The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team brought forward evidence that staff did not consistently complete their mandatory training and management do not have a system in place to effectively manage training requirements. Some consumers and representatives have outlined they have to remind staff, especially agency staff, of their care preferences and needs.

The Approved Provider’s written response, received 25 August 2022, advised that a new Residence Manager has been recruited and is reviewing the training register to commence the rollout of mandatory education in conjunction with the People & Culture team and refresher updates for all clinical care staff, in line with identified risks. The Approved Provider acknowledged the gaps in the training records at the time of the Site Audit and in response, has updated the training matrix and will be redesigning the training register to ensure management oversight.

Whilst I acknowledge there have been knowledge gaps in staff, these examples alone were not sufficient to indicate significant deficits in the qualifications or competence of the workforce. I therefore find requirement 7(3)(c) is compliant.

I am satisfied that the remaining two requirements of Quality Standard 7 are compliant.

Consumers and representatives expressed that workforce interactions are kind, caring and respectful of each consumer’s identity, culture and diversity, this feedback was consistent with observations made by the Assessment Team. Staff interviewed demonstrated an in depth understanding of the needs and preferences of consumers.

Staff indicated during the probationary period, performance is assessed on their third and sixth month at the service, following this period, regular performance assessment occurs on a yearly basis. Management indicated that where staff performance is identified as not up to standard it is addressed immediately.

**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. | 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. | 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. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.
* Effective risk management systems and practices, including but not limited to the following, managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, managing and preventing incidents, including the use of an incident management system.

The Assessment Team brought forward evidence the service did not demonstrate how they implemented an effective governance system relating to continuous improvement, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team identified a number of significant continuous improvement initiatives remain unresolved, impacting on the delivery of quality care and services. Similarly, staffing numbers and competency have impacted negatively on consumer care. Restrictive practices deficiencies were identified as reviews for psychotropic medication use were not undertaken in line with legislation. Complaints were not used to improve the quality of care and services, nor were they reviewed with the view to finding long term solutions to prevent similarly themed complaints arising.

The Approved Provider’s written response, received 25 August 2022, included additional information regarding the issues identified by the Assessment Team. The service referred to the improvement initiatives previously discussed within this performance report, including a review of the staffing model and food services to address consumer feedback and complaints and a review of the training register to ensure mandatory staff training is monitored and completed. The service’s continuous improvement plan provided additional current and planned improvement activities regarding continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues, at the time of the Site Audit, the service did not demonstrate effective organisation wide governance systems. I therefore find requirement 8(3)(c) is non-compliant.

The Assessment Team identified that the service was unable to demonstrate the effective risk management systems and practices. The Assessment team noted that not all risks, such as pain, are identified, assessed and documented. While staff had knowledge of risk minimisation strategies, these were not always applied due to staffing levels impacting on the ability of staff to respond to requests for assistance, rushing consumers or not attending to care or clinical needs and completing documentation as required. The Assessment Team further noted the call bell system does not currently support consumers who may be assessed at risk due to compromised mobility, or of increased care needs. The Assessment Team observed poor infection control practises throughout the audit period with staff wearing gloves inappropriately and wearing long-sleeved shirts whilst providing care.

The Approved Provider’s written response, received 25 August 2022, included additional information regarding the issues identified by the Assessment Team. The service has reiterated their planned improvement initiatives relating to staffing levels, clinical care, mandatory training requirements, model of care and food services. The Approved Provider has acknowledged the implementation of significant projects has been delayed due to the current pandemic environment, however, have since commenced. The Board and the new Chief Executive Officer have completed a comprehensive Board review to establish a Board Operating Rhythm and improved governance across the whole organisation, resulting in an Improving Governance Implementation Plan.

Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues, at the time of the Site Audit, the service did not demonstrate effective risk management systems and practices. I therefore find requirement 8(3)(d) is non-compliant.

The Assessment Team recommended the following requirement was not met:

* Where clinical care is provided - a clinical governance framework, including but not limited to the following, antimicrobial stewardship, minimising the use of restraint, open disclosure.

The Assessment Team brought forward evidence that staff are not promoting antimicrobial stewardship, for example, pathology tests are not always conducted prior to the administration of antibiotics. The Assessment Team further indicated that whilst the service has a clinical governance policy, however, the service’s monitoring system has not identified the deficits in clinical care.

The Approved Provider’s written response, received 25 August 2022, included additional information regarding the issues identified by the Assessment Team. The service asserted their recognition of the importance of anti-microbial stewardship which is evidenced by the appointment of newly established Chief Medical Officer role as well as the reviews undertaken by the independent pharmacist. The service acknowledged their documentation could be improved to substantiate clinical care and are committed to improving their care and services. The service’s continuous improvement plan provided additional current and planned improvement activities regarding their clinical governance framework.

Whilst I acknowledge the service has demonstrated discrepancies with service’s clinical governance framework, on the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate systemic non-compliance. Therefore, I find the service is compliant with Requirement 8(3)(e).

I am satisfied that the remaining two requirements of Quality Standard 8 are compliant.

Consumers and representatives were confident the service is run well and are satisfied with their level of engagement in the development, delivery and evaluation of care and services. Management and staff described the ways in which consumers are encouraged to be engaged and involved in decisions about changes to the service, and the development, delivery and evaluation of care and services they receive.

The service was able to demonstrate that the governing body is working towards promoting a culture of safe, inclusive and quality driven culture. The service has developed a new clinical governance framework which it is in the process of rolling out through the service, which the service says will further increase engagement of consumers in the development of care and services.

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