Performance

Report

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| Name: | Jonathan Rogers GC House |
| Commission ID: | 0821 |
| Address: | 124 Wallace Street, Nowra, New South Wales, 2541 |
| Activity type: | Site Audit |
| Activity date: | 30 July 2024 to 2 August 2024 |
| Performance report date: | 17 September 2024 |
| Service included in this assessment: | Provider: 643 RSL LifeCare Limited  Service: 5875 Jonathan Rogers GC House |

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 Jonathan Rogers GC House (**the service**) has been prepared by Therese Solomon, 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 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 29 August 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **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)

* Ensure 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 3(3)(a)

* Ensure 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 3(3)(b)

* Ensure 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.

# 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

This Standard has been assessed as compliant as 6 of the 6 Requirements have been assessed as compliant.

Requirement 1(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that each consumer is treated with dignity and respect, with their identity, culture and diversity valued. The service has policies, procedures and culturally diverse resources that outline what it means to treat consumers with dignity and respect. Care plans reflect the diversity of consumers, including information about their cultural and religious beliefs and preferences. Individualised well-being and meaningful engagement details are documented for each consumer.

Staff were observed interacting with consumers respectfully. Consumers and/or representatives confirmed consumers are respected and valued as individuals by the service. Staff were knowledgeable about consumer preferences and their cultural background and values, and described how they applied this when providing care to consumers, which was consistent with the service’s cultural diversity policies and procedures. The service has resources for staff to access about consumers cultural needs and considerations. Catering staff are aware of consumers’ cultural backgrounds and ensure they cater to them in accordance with their preferences.

The service demonstrated that care and services are culturally safe. Staff were able to identify consumers' cultural backgrounds and preferences, and this was reflected in care plans. Care plans reviewed included information on consumers’ individual care and service preferences and relevant cultural and religious beliefs. Care staff described how the consumer’s culture influenced the delivery of culturally safe care and services. Consumers are encouraged and supported to decorate their rooms reflecting their individual tastes and identity.

Requirement 1(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives described how consumers are supported to exercise choice and independence and maintain relationships of importance. Staff described how consumers are supported to make informed choices about their care and services. The organisation has policies on supporting consumers to maintain relationships of choice and to drive decision making, which staff were able to explain.

A review of primary representatives has been conducted and a new register has been generated to guide staff to ensure that it is clear who consumers’ legal representatives are and who they would like to be involved in the decision-making process. Consumers are supported to contact friends and family who are unable to visit regularly with electronic devices. Staff recognised the importance to consumers of making their own decisions and that those decisions must be supported and respected. Staff are aware of consumers’ friendships and support them to spend time with each other and will ensure consumers who have friendships sit together during meals and activities.

The service demonstrated that each consumer is supported to take risks to enable them to live the best life they can*.* Care planning documentation described areas in which consumers are supported to take risks in accordance with their preferences. Staff were able to provide examples where consumers are supported to take risks, and dignity of risk forms are completed in collaboration with consumers and/or representatives to document consumer preferences and risk-taking activities.

The service has a dignity of risk policy that recognises supporting the rights of customers to be treated with dignity and respect, and to make decisions about how they live their lives whilst balancing the organisation’s duty of care. Staff outlined the wishes and preferences of consumers engaging in risk taking activities and how they monitor and support consumers in these activities. Staff described how consumers are informed on the risks associated with their activity of choice and the strategies used to enable consumers to participate in the activity.

Information was available to consumers and/or representatives in a clear, easy to understand way to support decision making. Consumers and/or representatives described the information they receive to assist them with decision making, related to meals and activities. Staff described how information is provided to consumers, including consumers with a cognitive deficit or where language barrier is present. The service provided evidence of consumers' choices, including catering, lifestyle preferences and recreational activities.

Consumers and/or representatives stated they feel well informed, and that they receive information via newsletters, consumer meetings and meeting minutes, letters, emails and on noticeboards. Information was observed around the service relating to meals, activities, events, and management updates. The service has a residential handbook that provides information for consumers and/or representatives entering the service and is a reference to services provided and other general information.

The service demonstrated that each consumer’s privacy is respected, and personal information is kept confidential. Consumers confirmed that their privacy is respected, and staff described the practical ways they respect consumers' personal privacy, including knocking and waiting for a response before entering their rooms. There is an organisational policy on the protection of consumer personal information, hard copy consumer files are stored securely, and password protected. The Assessment Team observed staff respecting consumers’ privacy and dignity when delivering care and services, and staff were aware of the service’s policy on privacy and confidentiality.

# 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. | Not 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

This Standard has been assessed as non-compliant as 1 of the 5 Requirements have been assessed as non-compliant.

The service did not demonstrate 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.

The service has a process for assessment and planning which considers risks to the consumer’s health and well-being, however this does not always inform the delivery of safe and effective care. The process for initial assessments for new consumers includes an assessment and documentation schedule to be followed and documented in hard and soft copy files. The schedule indicates who is responsible for assessments and when assessments and progress notes are to be undertaken for new consumers. Staff advised the Assessment Team they use the hard copy guide when completing assessments for new admissions to the service.

However, consumer’s assessments are not always completed in a timely manner or by the assigned person responsible. Overall, the admission protocol has not been followed and risks are not always considered to inform care and services, including for diabetes, falls risks, pressure injuries and pain management.

Behaviour support plans did not consistently reflect assessed risks to consumer health and well-being to inform the delivery of safe and effective care.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including daily monitoring of assessment completion, support provided to the clinical team by the contracted care manager, and implementing a third registered nurse shift 6 days per week.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(a) has been found non-compliant.

Requirement 2(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated 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.

Assessment and care planning is being conducted at the service to identify consumer’s current needs, goals and preferences. In relation to advance care planning and end of life planning, the service has a relationship with the local health district palliative care in reach service. The palliative care service from the local health district visited the service and reviewed 2 consumers during the Site Audit. While some areas for improvement were noted in care plan documentation, overall care plans identified consumer’s needs, goals and preferences including advance care planning and end of life planning.

Requirement 2(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated assessment and planning is based on ongoing partnership with the consumer and others that the consumer wishes to involve, including other organisations, and individuals and providers of other care and services.

Consumers and/or representatives indicated involvement in care planning and review of the consumer’s care and services. However, areas for improvement were noted in representative involvement in assessment, planning and review of consumers related to weight loss and changes in wound management.

The service includes other organisations and providers of care and services in assessment and planning. The Assessment Team found consumers were satisfied they have input into their care and service provision and can communicate with the service about care planning and assessment.

The service demonstrated the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

The Assessment Team identified an area for improvement in relation to consumer and/or representative awareness of the consumer care plan and their ability to access the care plan. Feedback received from some consumers and/or representatives stated they had not received a copy of their care plan, and that they were not aware that a care plan was available for them to review.

Management advised the outcomes of assessment and planning are communicated to the consumer and/or representatives when the consumer is reviewed on their resident of the day procedure and during a case conference. They stated staff call the representative by telephone and give them an update and provide them with a copy of the consumer’s care plan. However, not all consumers and representatives could confirm they had received a copy of the care plan.

The Approved Provider responded with additional documentation and clarifying information, as well as a plan for continuous improvement containing actions to address the areas of concerns including adding a reminder in the monthly consumer newsletter encouraging consumers and/or representatives to access a copy of the consumer care and service plan.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(d) has been found compliant.

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated 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. Management advised that consumer care evaluations are being completed annually, quarterly and when needed, including if a consumer’s circumstances change or an incident occurs.

The service has a daily huddle, where the registered nurse meets with the care staff. The care staff can report any changes they have noticed in the consumer’s condition. The registered nurse will initiate further assessment and follow up if a change is reported. High risk consumers and care plan reviews are discussed at the weekly care planning meeting. When a consumer experiences a fall, they will discuss pain, medication and other contributing factors, and implement strategies to try and prevent reoccurrence.

The service has a resident of the day program which involves a review of each consumer’s care once per month and update accordingly. Part of the program includes contacting the consumers’ representatives to provide them with an update and informing and/or referring to the medical officer if there has been any identified change in a consumer. When a consumer or their representatives report a change in the consumer’s condition, a clinical review is triggered.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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

This Standard has been assessed as non-compliant as 2 of the 7 Requirements have been assessed as non-compliant.

The service did not demonstrate that ach consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to their needs and optimises their health and wellbeing.

Review of consumer care and service records, observations made and interviews with management and staff did not show that safe and effective care is consistently provided for each consumer, specifically related to pain management, medication management, restrictive practices.

Medication incidents reviewed showed staff at the service are not using best practice methods to administer medications, including putting medications for multiple consumers in stacked cups to administer. Medications should be checked with the medication chart and the consumer to ensure the correct drugs are given to each consumer. When medication procedures are not followed consumers are at risk of receiving the wrong medication which can adversely affect their health and wellbeing.

The organisation’s medication policy states that time sensitive medication is to be given within half an hour of the scheduled time. If given out of this range, a Serious Incident Response Scheme incident should be completed. The policy direction is to follow best practice for safe and effective care for consumers due to risks experienced when these medications are administered at the wrong time. However, review of medication chart indicates some consumers are receiving time sensitive medications out of the scheduled time range.

Review of behaviour charting does not show safe and effective strategies are in place to manage changed behaviours, and does not identify triggers for the behaviour, or factors contributing to the behaviour.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including monitoring of time sensitive medications, reviewing pain assessment, support provided to the clinical team by the contracted care manager, and implementing a third registered nurse shift 6 days per week.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) has been found non-compliant.

The service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically related to skin integrity management and falls management.

Pressure injury risk have not been managed effectively for all consumers, with evidence of delays in the initial identification of a pressure injury.

While the management of falls injury risk and post fall assessment was demonstrated as effectively managed at the service, falls prevention strategies are not effective for all consumers.

Management reported the service manages high impact/high prevalence risks through conducting assessments on admission and having weekly care planning meetings where they discuss new admissions, incidents and changes in consumer’s condition. Incidents are reviewed every day and discussed in a collaborative stand up leadership meeting. A full review of the incident is then conducted, and assessments are updated. Changes in the consumer’s level of risk or changes to management of risk, is communicated at handover.

Significant risks are reported as Serious Incident Response Scheme incidents, which would involve a higher level of review and a follow up to identify strategies to be put in place to minimise the high level of risk. The service has recently implemented risk cards and ensure all staff understand risk.

The facility manager reported the service has been focusing on the identification of deterioration at the service. This area for improvement was identified during an audit done within the service in March 2024, where the service identified there were deficits in identifying, escalating and addressing clinical deterioration. Education was provided to staff and a stop and watch program was introduced. Stop and watch folders were put in each area and pocket cards to remind staff to escalate any change in a consumer.

Management advised they look at trends in risk at the service. They discuss these trends with staff and consumers and identify strategies they can implement to reduce or manage the risks.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the non-compliance, including the weekly review of all wounds by the care manager, support provided to the clinical team by the contracted care manager, and implementing a third registered nurse shift 6 days per week, skin integrity education provided to all clinical staff.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) has been found non-compliant.

Requirement 3(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

Management reported numerous staff at the service have attended palliative care training. Consumers and/or representatives stated they were happy with how the service managed end of life care and services. A pastoral carer is available to meet with consumers and their representatives to discuss their end of life wishes.

Details of consumer’s palliative status is documented in the advanced care plan section of their detailed care plan, to address the consumers current needs, goals and preferences in relation to their palliative trajectory. Consumer’s care plans are updated to detail an end-of-life plan, which contains their end-of-life wishes.

Requirement 3(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated 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.

Consumers and/or representatives did not indicate they had any concerns in relation to changes in consumer condition being identified and responded to in a timely manner. Management stated the registered nurses review alerts on the clinical documentation system during the day. Staff are aware to escalate any observations which are outside the normal parameters for a consumer for follow up.

Requirement 3(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated 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.

Consumers and/or representatives provided positive feedback in relation to communication with the service. Staff handovers were observed by the Assessment Team and information about consumer conditions, needs and preferences were communicated and discussed. Staff described the consumer’s condition, needs and preferences and consumer’s condition, needs and preferences were documented in their clinical files.

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services.

Consumers and/or representatives reported consumers have been referred to other providers of care and services and have been happy with the care and services they have received. Management advised consumers with a decline in their mobility or transferring ability are referred to the physiotherapist for review. Consumers with a general decline in their health are referred to their medical officer and the geriatrician when required, and consumers experiencing weight loss are referred to the dietician for review. Documentation showed there is evidence of referrals to the physiotherapist, podiatrist and the local palliative care team. Consumers have been referred to Dementia Support Australia and reports were uploaded into consumer care files.

Requirement 3(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated minimisation of infection related risks.

The organisation has processes in place to monitor infections and antibiotic use. Staff demonstrated sound knowledge in relation to infection prevention and control and demonstrated practices within the service to minimise infection related risks, promote the principles of antimicrobial stewardship and preparedness in the event of an outbreak.

The service has policies and procedures to guide staff in relation to infection control management, the management of an outbreak and antimicrobial stewardship. Staff confirmed they received training in infection control strategies, infectious diseases and the principals of antimicrobial stewardship. The service has 2 infection prevention and control leads. Infections and antimicrobial stewardship are standing agenda items at the medication advisory committee meeting. Consumers and/or representatives stated they are satisfied with how the service manages the minimisation of infection related risks, including during outbreaks.

# 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. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Standard has been assessed as compliant as 7 of the 7 Requirements have been assessed as compliant.

Requirement 4(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives were satisfied that services and supports for daily living meet consumer needs, goals, and preferences. Consumers receive safe and effective services that enhance and maintain their independence, well-being, and quality of life. Staff demonstrated a sound knowledge of individual consumers’ needs and preferred activities and how they support consumers to engage in chosen activities. Lifestyle staff explained how they partner with consumers and/or representatives to create a lifestyle profile that includes individual preferences, past and current interests, and social, cultural, and spiritual needs and traditions that are important to them. Care planning documentation reflected what is important to consumers and what they like to do, and staff knowledge were in line with those preferences.

The lifestyle team described how they develop and evaluate the activities calendar according to each consumer’s needs and preferences. This is formally discussed at consumer meetings and in smaller groups with common interests. Lifestyle staff have generated meaningful activities and topics of interest for each consumer. These have been documented as a reference for one-on-one activities with consumers and for staff in general. Each consumer also has their own individualised activities box with items of interest to them.

Requirement 4(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives described services and supports available to promote each consumer’s emotional, spiritual, and psychological well-being. Consumers stated they felt connected and engaged in meaningful activities that are satisfying to them. Staff provided examples of supporting consumers for their emotional and psychological well-being. Care planning documentation recorded consumers’ individual emotional support strategies and how these are implemented. Staff were observed providing effective emotional support to consumers.

The lifestyle team meet with all consumers and/or representatives when a consumer enters the service. This interview generates a social and leisure assessment that provides information about their preferred names, consumer’s background, life history, emotional, spiritual, and psychological well-being and describes things that are important to them and that they value. This information is incorporated into their care plan. The lifestyle team have identified which consumers choose not to participate in group activities and prefer to self-isolate. The lifestyle officers described that they provide one on one individualised well-being and meaningful engagement visits in the morning and afternoon each day. Each consumer has details of activities and topics for discussion documented in each area as a guide on consumers’ preferred activities.

Consumers felt supported to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do the things of interest to them. The service supports consumers to maintain social and personal connections that are important to them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer.

Consumers who are returned service members or war widows are supported to visit the Shoalhaven veteran’s well-being centre. The veterans centre provides access to practical support services to help support veterans with their finances, mental health and physical well-being. The service engages with other aged care services virtually to participate in competitions and activities. Consumers are currently involved in an Olympics competition as part of their activities program. This involves competing virtually with other services in various sporting activities. Consumers are given medals when they win an event.

Requirement 4(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives confirmed that the information about the consumer’s condition, needs and preferences is communicated within the organisation and with others where responsibility for care is shared. Staff demonstrated sound knowledge of individual consumers and stated consumer care and other needs are well communicated during handovers and documented in the electronic clinical care system, which is accessible to all staff. The service has effective processes and systems in place for identifying and recording each consumer’s condition, needs and preferences, including changes as they occur.

Catering staff spoke positively about clinical staff at the service and confirmed that communication is always appropriate and timely to ensure that consumers receive the correct meal. The lifestyle team stated they are involved in developing behaviour support plans for consumers, and that they are satisfied with the information shared about consumers individual needs and preferences to ensure they continue to be safe and well cared for during activities.

The service demonstrated timely and appropriate referrals of consumers to other organisations, individuals and providers of other care and services. Consumers’ care planning documentation provided evidence that the service collaborates with external providers to support the diverse needs of consumers. Consumers and/or representatives stated if the service is unable to provide suitable support, they are confident they would be appropriately referred to an external provider. Staff provided examples of consumers being referred to other providers of care and services in the provision of lifestyle support.

The organisation uses the services of the aged care volunteer visitors scheme to support consumers at the service. The scheme involves volunteers visiting to provide friendship and companionship to consumers. Lifestyle staff explained when a new consumer enters the service, they communicate with the consumer and their representatives to determine what organisations the consumer affiliates with as a matter of priority. They will engage with that organisation to provide support to consumers within the service.

Requirement 4(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives stated the service provides a range of meals which are varied and of suitable quality and quantity. The service has processes in place to include consumers in the development of the menu and to provide feedback on the quality of the food provided. The catering staff explained how they review feedback from consumers and amend catering for consumers accordingly.

Meals are cooked fresh in a central kitchen and transported to each dining room in hot boxes where they are plated and served to consumers in the dining room or their rooms. Seasonal fresh fruit is always available including cut fruit platters. Consumers are offered an alternative hot meal option for lunch and dinner and/or sandwiches, soups, and salads. Catering and care staff described specific dietary needs and preferences of consumers and how these are accommodated in the menu or individualised meals.

There are established processes to ensure that meals and drinks are served according to consumer identified dietary needs and preferences, including texture modified meals and thickened fluids. The kitchen and dining rooms were observed to be clean, and the service showed evidence of recent food safety audits.

The service provides meals 24 hours a day to consumers. Each area has grazing boxes which include snack foods such as yogurts, desserts and cups of soup. Sandwiches are also available to consumers outside of mealtimes. The service holds cultural events which includes catering. The cultural events are determined according to the cultural backgrounds of the consumers at the service and cultures that are of interest to consumers.

Consumers confirmed they felt safe when using the service’s equipment and said it was easily accessible and suitable for their needs. Consumers and/or representatives stated they were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items were replaced when necessary. There was sufficient equipment available to support lifestyle activities. Equipment was observed to be safe, suitable, clean, and well maintained.

# 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

This Standard has been assessed as compliant as 3 of the 3 Requirements have been assessed as compliant.

The service environment was observed to be welcoming and comfortable. Furniture is positioned appropriately, and artworks and other furnishings provide a home like environment. The building has an easy to navigate design with signage to support consumers with cognitive impairment. Consumers and/or representatives confirmed the environment is safe, clean, and well maintained. There are adequate private areas, both indoors and outdoors for consumers and visitors to utilise when socialising. Consumers and/or representatives stated they have suitable equipment and resources to support their independence and enjoy activities.

The service is well presented and has a home like ambience. Consumer rooms and the common areas were observed to be safe, clean, clutter free, well maintained, and comfortable. Consumers and/or representatives confirmed they were satisfied with the cleanliness of their rooms and the common areas of the service. The maintenance staff demonstrated effective preventative and corrective systems in place to ensure all areas of the service are safe and well maintained and attended to within an appropriate timeframe. The service promotes consumer independence to move freely both indoors and outdoors.

Cleaning staff were observed maintaining consumer rooms, communal areas, and high touch points. Cleaning staff had sound knowledge of infection prevention and control measures and how it relates to their duties.

Requirement 5(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Furniture, fittings, and equipment were observed to be safe, clean, well maintained, and suitable for consumers. Consumers and/or representatives were satisfied with the maintenance of furniture, fittings, and equipment. Management and staff demonstrated effective systems in place for the cleaning and regular maintenance of the furniture, fittings, and equipment.

# 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

This Standard has been assessed as compliant as 4 of the 4 Requirements have been assessed as compliant.

Requirement 6(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it has various ways consumers can provide feedback and make complaints. Consumers and/or representatives stated they are aware of the complaints and feedback process, and they would have no hesitation in making a complaint and feel supported by management to do so. Management advised they provide consumers with the opportunity to provide feedback and make complaints through consumer meetings, feedback forms and consumer surveys.

The Assessment Team observed a consumer meeting, which was well attended by consumers. The meeting was chaired by the lifestyle co-ordinator in an open forum style. The lifestyle co-ordinator provided updates on improvements being made at the service, upcoming events and actively requested feedback from consumers and representatives. Consumer meeting minutes of 28 March 2024 were reviewed and included feedback from consumers with regard to food and catering, clinical issues, activities, housekeeping and staffing.

The service provides information to consumers and/or representatives regarding advocacy services and language services. Consumers and/or representatives stated they were aware of advocacy services and did not have any concerns about accessing these services. The service demonstrated different ways it promotes advocacy services, including displaying advocacy services posters and brochures around the service. These include Senior Rights Services, Older People’s Advisory Network and the Commission’s feedback information in various languages.

The service demonstrated appropriate action is taken in response to complaints and feedback.

The service has policies and processes around open disclosure and how it is used in complaint management. Some consumers and/or representatives reported there had been some recent improvement in communication around complaints management. However, feedback from some consumers and representatives indicates responses to complaints are unsatisfactory for those consumers and their representatives.

The Assessment Team identified an area for improvement in relation to the evaluation of implemented actions to ensure they are effective and sustainable. The service’s complaints management system includes an open disclosure process where items are closed once actions and open disclosure have taken place. Review of the feedback and complaints register indicates that actions are not consistently completed or evaluated for effectiveness before the complaint is closed as outlined in the feedback and complaint handling and resolution policy and procedure.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the areas of concern, including engaging a temporary care manager with extensive experience in aged care to support the registered nurses with complaints management.

Although not all consumers and/or representatives felt their complaints had been resolved to a satisfactory level, the Approved Provider demonstrated they took appropriate action to address the feedback and complaints, and provided reassurance that the service will continue to collaborate with the consumer to address any ongoing concerns.

Based on the information provided by the Assessment team and the Approved Provider, Requirement 6(3)(c) is found compliant.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has systems and processes for the review of feedback and complaints and uses this information to improve the quality of care and services provided. The service trends its complaints and feedback and records issues into its plan for continuous improvement.

Consumers and/or representatives were satisfied that their complaints were resolved and that improvements have been made. Management is aware of the trends in complaints but reported most feedback received were compliments rather than complaints. Monitoring of feedback occurs weekly through the care planning meeting. Complaints are trended and the governing body receive a copy of the feedback register as part of their board documentation each month. Management provided an example of a recent improvement in the quality of care and services in response to feedback.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(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. | Compliant |

Findings

This Standard has been assessed as compliant as 5 of the 5 Requirements have been assessed as compliant.

The service demonstrated that 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 service has systems and processes for workforce planning and to enable the number and mix of staff. However, some consumers and/or representatives stated there are not sufficient staff to meet their needs and preferences. The service acknowledged it has experienced significant staff turnover, including in the management team during 2024, resulting in some staff working overtime and resulting in fatigue. The organisational structure at the service includes a facility manager, one care manager, registered nurses, enrolled nurses and care staff. All catering, laundry and cleaning staff are employed by the service.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the areas of concern, including moving to a centralised rostering team where the roster will be monitored and managed by an experienced rostering team based in the organisation’s head office.

Although not all consumers and/or representatives felt the service had adequate numbers of staffing to ensure care and service delivery, the Approved Provider demonstrated they systems and processes in place to enable the number and mix of staff to meet consumer needs and preferences.

Based on the information provided by the Assessment team and the Approved Provider, Requirement 7(3)(a) is found compliant.

Requirement 7(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives commented that staff are kind, caring and respectful. Observations of workforce interactions with consumers were respectful and caring, with staff having a good knowledge of consumer needs and preferences.

The service demonstrated that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The service has systems and processes to ensure staff have qualifications and training for their roles. However, the staff do not always demonstrate they have the skill and knowledge to effectively perform their roles. Consumers and/or representatives stated staff have the knowledge and skills to perform in their roles, however some representatives have indicated that certain staff members are not always competent in their roles.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the areas of concern, including checking overdue competencies and following up with staff to ensure completion, ongoing monitoring of staff competencies and training.

Although not all consumers and/or representatives felt the service had adequate numbers of staffing to ensure care and service delivery, the Approved Provider demonstrated they systems and processes in place to enable the number and mix of staff to meet consumer needs and preferences.

Based on the information provided by the Assessment team and the Approved Provider, Requirement 7(3)(c) is found compliant.

The service has systems and processes in place for staff recruitment and orientating them into their roles. Ongoing training is provided on a regular and ad hoc basis depending on staff training needs. Consumers and/or representatives generally felt staff were well trained in their roles. Orientation and induction training is provided to all new staff.

The regional education coordinator provides ongoing regular and mandatory education either online or face to face in toolbox talks. They advised they scan attendance sheets and follow up any missed training the next time they attend the service. The quality coordinator attends the service 1 to 2 times per week as required. Education compliance is monitored by the facility manager at the service.

Staff reported they have received a lot of mandatory training in the last few months including online training in restrictive practices, antimicrobial stewardship, manual handling, open disclosure and Serious Incident Response Scheme. Training and education records reviewed indicate online education has been provided to most staff on mandatory training with fire training at 78% completed and manual handling online at 93% completed.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has systems and processes in place to ensure regular assessment of staff performance. Staff appraisal records indicated that these have been completed in 2024 and are up to date. Several staff stated they had undertaken a performance appraisal in the last twelve months. The facility manager advised the organisation has a system in place to manage and monitor staff performance. The quality coordinator for education monitors this process and provided the Assessment Team with a document detailing the escalation process for staff performance management. The Assessment Team were shown staff records which included a performance improvement plan clarification letter and a notice to attend a formal meeting. The service has a policy on managing underperformance.

# 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. | 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

This Standard has been assessed as compliant as 5 of the 5 Requirements have been assessed as compliant.

Requirement 8(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The organisation has commenced actions to develop a consumer advisory committee at regional level and issued expressions of interest in January 2024. The inaugural meeting was held on 12 March 2024. The regional manager advised that since the inaugural meeting the organisation has decided that there is insufficient diversity in the committee and would seek wider representation.

The organisation currently engages with consumers through a variety of avenues, including regular surveys, newsletters, consumer meetings, verbal and written feedback, analysing trends and maintaining a feedback register.

The Service conducts a Consumer Engagement Survey and a Quality of Life and Consumer Experience Survey each quarter as per the requirements of the National Mandatory Indicator Program. Results of these surveys are documented in the consumers medical record with responses followed up by clinical and lifestyle staff where appropriate for individual residents. The results are displayed across the organisation and these results are reported to the Clinical Governance Committee at the end of the reporting period.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The organisation’s governing body and its sub-committees are responsible for overseeing the service’s strategic direction and policies to meet the Quality Standards. The governing body is accountable for the delivery of safe, inclusive and quality care and services. The board has a diverse membership of independent directors including members with experience in clinical governance. The governing body has 4 sub-committees which report monthly to the board.

The executive leadership team advised the governing body sets expectations and communicates them to management and staff in relation to safe, inclusive and quality care and services. They advised the organisation meets the Quality Standards through organisation wide governance, audits, risk based independent review, the implementation of policies and procedures and monitoring of incidents and hazards.

Information from the governing body, such as changes to policies or legislative updates, are provided to the service’s staff through training and education, handover and staff meetings. The service provides regular notifications to consumers and representatives via emails and phone communications.

The executive leadership team advised the organisation has several electronic data-based systems for trending and benchmarking information. Monthly reports are provided to the governing body via the board’s sub-committees, including the quality audit and risk committee. This committee overseas internal audits at the service and has a 3-year audit plan. The service’s plan for continuous improvement includes improvements and actions as a result of internal audits in 2024. The regional manager advised that audits are undertaken based on clinical indicator results.

Reports to the board include information on recruitment, rosters, education and training, continuous improvement, clinical indicators, audits, risk register, incidents, Serious Incident Response Scheme reports and feedback and complaints.

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

The current clinical information management systems include an electronic medical record for each consumer and an electronic incident management system. Both are effective in providing current information to advise management and staff on providing quality care and services. An electronic medication management system will be implemented over the coming weeks and months with implementation plans in progress.

The organisation’s clinical governance systems capture data from both systems providing data for trending and analysis. Clinical indicator reporting is conducted at a service level via a monthly facility leadership team meeting, attended by the facility manager, care manager, quality coordinator, regional manager and regional quality advisor.

The service identifies opportunities for continuous improvement through the analysis of information gathered from internal audits, feedback and complaints, clinical indicators and consumer meetings. Management advised that review of the plan for continuous improvement takes place in leadership team meetings.

The organisation provides financial reports for internal and external review. The executive team provided an example of how the board supports the service when additional funding outside the service’s budget is required. In the last twelve months the organisation has addressed issues at the service regarding security, and funding was approved by the board to increase security monitoring at the service with increased closed-circuit television.

The organisation has systems for receiving information with regard to regulatory obligations from a range of sources. The chief risk officer advised they receive information internally from general council, legal reports, communication and regular updates via the intranet.

The organisation has processes to ensure policies and procedures are up to date including documentation control. The chief risk officer advised that individual officers are responsible to ensure their policies and procedures are updated and reviewed at least every 2 to 3 years or as required. The Assessment Team identified that policies reviewed were mostly reviewed in the past twelve months.

The organisation has processes to identify, document and report significant incidents. The organisation has systems and processes to capture and record feedback and complaints from consumers and representatives.

The organisation demonstrated effective risk management systems and practices in place at the service.

The organisation has systems and practices in place to document risks at the service. A risk register is maintained, and regular reviews take place. Consumers are generally supported to live the best live they can. Consumers receive safe and effective care and service that assist them with independence, well-being and quality of life. Each consumer is supported to take risks in accordance with their preferences.

However, the Assessment team identified areas for improvement in relation to the effective management of high-impact and high-prevalence risks in association with the care of each consumer.

Deficits were identified in the management of unplanned weight loss, falls and pressure injuries. Pain is not consistently assessed or considered when attending to wound reviews. The admission protocol is not consistently followed, and risks are not always considered to inform care and services, including diabetes, falls risks, pressure injury and pain management. Behaviour support plans did not consistently reflect assessed risks to consumer health and well-being to inform the delivery of safe and effective care.

The organisation’s incident management system is not effective in managing and preventing incidents. Routine comprehensive analysis is not evident to identify contributing factors and to inform the development of preventative strategies. Strategies put in place have not always been sufficient to minimise the high level of risk for some consumers with pressure injuries, wounds and changing behaviours and have not been evaluated for effectiveness.

The Approved Provider responded with additional documentation and a plan for continuous improvement containing actions to address the areas of concern, including engagement with an experienced quality coordinator to support the service with quality audits, meetings and data analysis.

Although areas for improvement were identified related to high impact/high prevalence risks, the non-compliance was mostly related to staff practices and not adhering to organisational policies and procedures. I would encourage the Approved Provider to ensure all staff are aware of and adhere to organisational policies and procedures to ensure the delivery of safe and quality care and services to all consumers.

Based on the information provided by the Assessment team and the Approved Provider, Requirement 8(3)(d) is found compliant.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated a clinical governance framework, including but not limited to antimicrobial stewardship, minimising the use of restraint, and open disclosure.

The organisation has a clinical governance framework, and a new draft framework is due for review by the board in the next week. The service has clinical policies and procedures to guide management and staff to deliver safe and quality clinical care including those relating to antimicrobial stewardship, minimising the use of restraint and open disclosure.

The regional manager advised the organisation had completed an internal audit of the psychotropic register in July 2024. This resulted in identifying deficits in consent for chemical restraint. Some Serious Incident Response Scheme incidents were submitted, and processes put in place to ensure relevant parties were contacted and the register updated, and education was provided to relevant staff, to improve staff understanding of consent and of restrictive practices.

Staff stated they had training in antimicrobial stewardship and were able to describe how the policy is implemented.

The service was able to demonstrate that it has systems and processes in response to complaints, including implementing open disclosure.

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)