

**Performance Report**

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| Name: | Kanwal Gardens Care Community |
| Commission ID: | 2806 |
| Address: | 100 Wahroonga Road, KANWAL, New South Wales, 2259 |
| Activity type: | Site Audit |
| Activity date: | 10 December 2024 to 12 December 2024 |
| Performance report date: | 28 January 2025 |
| Service included in this assessment: | Provider: 3061 DPG Services Pty Ltd  Service: 1161 Kanwal Gardens Care Community |

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 Kanwal Gardens Care Community (**the service**) has been prepared by K Richards, 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 consumers, representatives, staff, management, and others; and
* the provider’s response to the assessment team’s report received 17 January 2025.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

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# 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 Quality Standard has been assessed as compliant as 6 of the 6 requirements have been assessed as compliant.

Consumers said staff understood their cultural backgrounds and personal circumstances and treated them with respect. Staff described how they respected consumers and supported maintenance of dignity, with information aligned to preferences within care planning documentation.

Staff described how they ensured care provided to consumers was culturally safe and considered specific preferences. Whilst sampled consumers did not consider they had cultural requirements, they provided examples of how their values and preferences influenced care and were understood by staff.

Consumers said they were informed of available options and encouraged to make their own decisions about care, services, and who was involved in care. Visitors were welcomed and consumers said they were encouraged to engage with people of importance to them.

Consumers detailed how their wishes and preferences were supported, even when this included risk. A dignity of risk assessment was undertaken for identified risks, including informed consent of the consumer or their representative and mitigating strategies.

Consumers said they received daily information in relation to activities, events, and meal options and could participate in monthly meetings to raise issues or learn about happenings.

Staff were observed respecting consumer privacy through seeking permission before entering rooms and recognising consumers who preferred to have their doors closed during the day. Whilst computers were password protected, one nurses’ station was observed to have been left open, providing access to consumer information within cupboards. In response, management reminded staff of their privacy and security responsibilities.

# 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. | 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 Quality Standard has been assessed as compliant as 5 of the 5 requirements have been assessed as compliant.

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

The assessment team recommended Requirement 2(3)(b) as Not Met. Assessment and planning captured end of life and advance care planning, with information known by staff, however, care planning documentation for 3 sample consumers did not reflect current needs and contained inconsistent information for falls management, skin integrity, repositioning, or hygiene care. Evidence brought forwarded included:

* a consumer’s falls management strategy included answering call bell immediately, however, the consumer had limited capacity to understand its use
* the care and services plan for a consumer with pain and skin integrity risks did not include guidance for staff to address the consumer’s needs, and a repositioning chart was not completed despite being a strategy for optimising skin and pain management
* one consumer’s needs and preferences for showering did not reflect their refusal, or inconsistent alternatives used, such as sponge wash.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant care planning documentation for named consumers. Where falls management information had been identified as inconsistent, bed sensor mats were in place to trigger an alert on the call bell system and although it was not in the care and services plan it was reflective in progress notes and discussed within handover. Staff were aware of the priority to answer these alerts, reflective in response times data. Further assessment and planning undertaken to understand falls included pharmacist review of medications to identify risks and review by physiotherapist and medical officer. The service had commenced improvement actions for falls management prior to the Site Audit, which included development of a falls committee, identification of high-risk consumers, and review of assessment and planning.

Consumers identified with risks to skin integrity and repositioning had assessment and planning to identify the risks and develop strategies. Where pain and skin integrity documentation had identified inconsistent repositioning, information is noted as a ‘preferred’ treatment and strategy for management of pain, rather than due to risk to skin integrity. As this intervention is not regular this strategy had not triggered the requirement for regular charting.

Where it was identified that care planning documentation recorded hygiene preferences for shower or a wash as an alternate, and the consumer was known to refuse care, strategies were documented in in the behaviour support plan. Furthermore, there was no evidence of signs and symptoms of poor hygiene, such as impact to skin.

I acknowledge the provider’s response and supporting documentation. Whilst the assessment team’s examples reflect potential improvement within documentation, some of which is acknowledged by the provider, the evidence before me does not demonstrate these issues are systemic in nature. In coming to my decision, I have also considered staff understanding and the impact on consumer care, including evidence brought forward in Standard 3. I find the overall evidence demonstrates the service is compliant with Requirement 2(3)(b).

Other Requirements within this Quality Standard have been assessed as compliant.

Staff explained how assessment and planning was undertaken and used to inform delivery of care and services. An entry process checklist guided staff through the 28 day process to complete assessments and develop care and services plans. Care planning documentation outlined individual risks for each consumer with mitigating strategies.

Consumers said they were able to include people and services of their choice in assessment, planning, and care. This was evidenced within care planning documentation, which included input from consumers, representatives, medical officers, allied health professionals, and specialist providers.

Consumers and representatives said they were informed of changes and had access to a copy of the care and services plan. Staff explained outcomes of assessment and planning were discussed with consumers and representatives, updates given in person or by telephone or email, and the care and services plan made available upon request.

Staff explained how and when care and services were reviewed, including following incident or change in health. Care planning documentation reflected assessments and outcomes were updated regularly or as required. Policies and procedures informed staff practice for evaluating care and services.

# Standard 3

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

Findings

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

The assessment team recommended Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) Not Met.

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

The assessment team reported the service did not demonstrate personal and clinical care needs were tailored and best practice in relation to hygiene care and medication administration. Evidence brought forwarded included:

* staff were not following documented care strategies for personal care. This resulted in consumers not being showered in line with preferences and reporting nail and skin care was not being attended, impacting consumer well-being
* one representative said a consumer wore the same clothing and innerwear for a week
* administration of time sensitive medications was not of best practice, with associated risks of late administration or omission due to stock shortages not identified or monitored.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant care planning documentation for named consumers. For a consumer reporting they were not receiving hygiene care aligned to needs and preferences, the provider explained medical management of complex health needs, including severe pain, did take precedence and for consumer safety a daily wash was provided instead of a shower. Following further consultation with the consumer, management have scheduled preferred shower times and coordinated sufficient staffing to meet mobility and transfer needs. The outcome has been evaluated, with the consumer posing some amendments, and an agreed schedule has been implemented. Ongoing monitoring is being conducted to ensure the consumer needs and preferences are being met.

Where a consumer was identified as refusing personal hygiene, the service has engaged specialists for tailored planning and detailed behaviour support strategies and undertaking staff training. The provider notes that consumers have the right to refuse care, with assessment and planning identifying alternate preferences for a wash in bed. The provider contends staff do know how to approach and engage consumers who refuse care, and this is evidenced in other documentation.

The provider reports best practice strategies for managing skin integrity were known by staff, with regular education from product specialists, displayed information posters, and preventative creams and sprays accessible in all nurses’ stations. Ongoing monitoring was undertaken, evidenced within progress notes, and changes discussed within handovers, huddles, and documented in wound charting.

In relation to repeated wearing of the same clothes, the provider has committed to engaging further with representatives for additional information to enable them to undertake further investigation, as the feedback is not supported within progress notes or previous care consultations.

The provider acknowledges the recorded incidents relating to medication administration times, however, a review of impacted consumers did not reflect a negative impact to their health from the delays. Improvement actions have been added to the Plan for Continuous Improvement (PCI) to ensure time sensitive medications are reviewed, along with administration times, and work will be undertaken with staff to raise awareness and ensure expectations are clear. The electronic system has been refined with administration times required to be within a 30 minute period, and heightened monitoring by management has been implemented. For the one incident relating to omission of insulin due to stock shortage, the provider has explained communication with the medical officer and additional monitoring used to ensure the consumer was stable until receiving supply ahead of the next dose.

I acknowledge the provider’s response, including supporting documentation and improvement actions. The evidence before me demonstrates staff are adapting personal care to consumer needs and abilities, particularly at times where their documented preferences are not possible or there is a refusal of care. Whilst I am concerned by representative feedback about clothing being unchanged for a week, the evidence has not supported that this is a common nor recurrent issue, and I acknowledge the provider needs and plans to seek further detail to enable investigation.

Whilst I am concerned staff practices had not taken into account the importance of time sensitive medication administration and associated risks of irregular timeframes between dosing, the provider has implemented improvements and heightened monitoring. I note this includes adjustments to the electronic medication system. I would encourage the service to practice prompt identification of any overdue time sensitive medications for timely action, and staff are well informed of associated risks. In relation to the stock shortage, I note this was only identified to be on one occasion, with risk to consumer recognised and additional monitoring undertaken and I am satisfied this is not a systemic issue. Accordingly, I find the service demonstrates compliance with Requirement 3(3)(a).

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

The assessment team reported high impact or high prevalence risks, such as management of pain, falls, diabetes, medication, and skin integrity, were not effectively managed for each consumer. Evidence brought forwarded included:

* where pain was identified, there were inconsistencies in recording of pain interventions and evaluation with documented impact on the mental health of one of the named consumers
* consumer falls were not effectively managed, with generic fall risk management plans. Monitoring after falls was not always in line with policies and procedures
* two consumers with diabetes did not have evidence staff consistently reported abnormal blood glucose level readings to the medical officer in line with risk management directives
* the service did not have a process to monitor whether immobile consumers were repositioned, with charting only undertaken where there was a pressure injury. Staff reported they only undertook repositioning for consumers in beds, not in chairs, and acknowledged they had observed multiple consumers with red skin over bony prominences
* the service had not considered whether consumers who could not move freely through internal and external areas as being potentially environmentally restrained.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant care planning documentation for named consumers. Consumers experiencing pain were monitored and had management strategies applied. Where there was evidence of mental health changes this had been identified some months before changes to pain management, with explanation of referrals and supports already implemented and escalation of incidents. Pain was not a trigger to the prior incidents, but on the latter example had coincided with changes to pain management which had triggered additional monitoring.

As reflected in Requirement 2(3)(b), the service had previously identified an increasing trend in falls and developed improvement actions on the PCI to ensure appropriate and person-centred management strategies were in place. Investigations related to inadequate documentation of neurological observations following a fall, established that paramedics attended for assessment and treatment. Monitoring was completed by paramedics for the period they attended, and after their departure, recommenced in line with the organisational policy, evidenced within supplied charting.

The provider refutes that diabetes management plans for all consumers require immediate escalation of blood glucose level readings outside parameters but do provide directives to clinical staff for risk and symptom management. There is evidence of communication of abnormal readings with the medical officer through emails, although the provider acknowledges one occasion where this was more pressing, coinciding with consumer illness from a respiratory infection. Improvement actions have been developed to prevent recurrence, risk, or impact. The provider has acknowledged potential improvement in documenting the communication with the medical officer. They also recognise the confusion with recording blood glucose level readings in multiple places, such as charting and/or progress notes, but can demonstrate monitoring was undertaken.

All consumers have monitoring of skin integrity daily during personal care, with monthly head to toe assessment, and quarterly assessment and review. Repositioning charting and documentation is only by exception, but specifically implemented for consumers with a pressure injury or requests. The service had 48 consumers requiring repositioning, of which only one had a pressure injury, demonstrating effective practices.

In relation to environmental restraint, the provider explained their assessment process, with current number of consumers identified as environmentally restrained as being significantly higher than the national and organisational levels demonstrating effective practices.

I acknowledge the provider’s response, including supporting documentation and improvement actions. I consider evidence brought forward relating to falls management strategies and environmental restraint to be related to assessment and planning and have considered them within my findings for Standard 2. Examples brought forward are exceptions, rather than systemic failings of care provision, processes, or oversight. The provider acknowledges areas for improvement, some of which were identified prior to the Site Audit with corresponding improvement actions included in the PCI. Supporting documentation demonstrates named consumers were monitored for well-being and safety reflecting understanding of high impact risks and management pathways. Accordingly, I find the service has demonstrated compliance with Requirement 3(3)(b).

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

The assessment team recommended Requirement 3(3)(d) as Not Met, as consumer deterioration was not consistently identified, escalated, or responded to in a timely manner. Evidence brought forwarded included:

* stage 1 pressure injuries were not documented, despite care staff saying they ensured changes to skin integrity were reported. A representative said skin excoriation was not always identified in a timely manner
* one care staff said clinical staff did not always respond in a timely manner when they reported pain
* where abnormal blood pressure or blood glucose levels were recorded, they were not always monitored or escalated to medical officers
* the service had not identified changes to emotional health of a consumer in relation to their personal care not aligning with preferences.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant care planning documentation for named consumers. Clinical indicator data, provided to the assessment team, evidenced identification and reporting of stage 1 pressure injuries demonstrating effective recognition and assessment of skin changes. Comments from a staff member reporting consumer pain was not responded to does not contain sufficient detail to enable investigation and effective response, and there is documentation in progress notes and discussion within handover, huddles, and shift reports disproving this statement.

Information related to monitoring blood glucose levels was the same as submitted for Requirement 3(3)(b). For the consumers with abnormal blood pressure readings, for one consumer this was an isolated incident. The other named consumer had recently returned from hospital, with the discharge summary noting blood pressure had been elevated in hospital, but not containing directives for management. The frequency of monitoring had been increased due to use of antibiotic, and the medical officer was advised of elevated readings despite them being within parameters outlined in guidance protocols.

The provider had acknowledged potential improvements in management of clinical deterioration, having identified this and developed improvement actions added to the PCI in May 2024. The PCI record includes contemporaneous records of actions, evaluations, and ongoing reviews.

I acknowledge the provider’s response, including supporting documentation and improvement actions. The matters of skin excoriation and emotional well-being have been considered within my findings for Requirement 3(3)(a). I also consider there is insufficient evidence brought forward to corroborate staff statements about stage 1 pressure injuries and pain management, as there was no evidence of affected consumers. Staff were aware to escalate skin changes and pain, pressure injuries were recorded and monitored.

I have identified sufficient evidence within the provider’s overall responses of recognition and response to deterioration or change of consumer health. Documentation shows escalation to medical officers and paramedics following change of condition or incidents. For one consumer, abnormal blood glucose level readings coincided with an acute illness with assessment identifying reduced oxygen saturation levels which resulted in transfer to hospital. Evidence brought forward in Requirements 3(3)(a) and 3(3)(b) demonstrates additional monitoring was undertaken in relation to incidents or adverse events. My decision also places weight on the ongoing improvement actions, identified in May 2024, and monitoring for positive changes in staff. Accordingly, I find Requirement 3(3)(d) is Compliant.

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

The assessment team reported the service did not have effective internal communication processes to share information about consumers, although it was effectively shared with external organisations when care was transferred. Evidence brought forwarded included:

* systems through which information was recorded and shared had not always been completed resulting in information on diet preferences, allergies, and falls risks not being communicated to care staff
* care staff said important information about consumers was not shared during handovers, giving examples of dietary needs for two consumers
* consumers and representatives were not always sure that staff understood the specific care needs of consumers, impacting consumer health and well-being. Representatives added concerns about staff inability to answer questions about care.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant care planning documentation for named consumers. Representative comments were addressed, explaining proactive and regular communication with one representative to offer a clinical well-being update and discuss ongoing refusals of care and the impact. The provider acknowledged potential improvement in communication between one consumer and the clinical team, considered in Requirement 3(3)(a) along with current actions.

Food allergies and sensitivities were recorded under allergies on the summary care plan and within the dietary needs and preferences assessment. The handover procedure is a ‘by exception’ reporting, discussing changes rather than pre-existing matters for consumers. This was discussed during the Site Audit but was not reflected in the assessment team’s report. The provider also contends there has not been any feedback about receiving the incorrect diet type.

Where the assessment team stated staff were unable to identify specific information, the provider suggests this could be naming conventions and understanding of what was being requested at the time.

I acknowledge the provider’s response. The evidence before me, including within other Quality Standards, supports effective communication practices and sharing of consumer information. The provider acknowledges some potential improvements on understanding consumer needs and preferences, but this is not the same as failing to effectively share information nor does it demonstrate current processes are not effective. Accordingly, I find the service has demonstrated compliance with Requirement 3(3)(e).

Other Requirements within this Quality Standard have been assessed as compliant.

Staff described palliative care practices for consumers nearing end of life, including prioritising comfort. A representative discussed the involvement of palliative care specialists and care meetings to ensure consumer needs and choices were understood and respected.

Care planning documentation reflected timely referrals to a range of providers where needs were identified. Staff demonstrated awareness of referral methods for a range of allied health providers and external organisations.

Consumers and representatives said they observed infection prevention and control measures used by staff, such as hand washing and use of personal protective equipment. Policies and procedures, including an outbreak management plan, supported minimisation of infection related risks. Staff received mandatory training on infection control practices and could explain how antimicrobial usage, including antibiotics, was minimised.

# 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 Quality Standard has been assessed as compliant as 7 of the 7 requirements have been assessed as compliant.

Care planning documentation recorded information to support consumers’ well-being and quality of life. Staff were knowledgeable about consumer’s needs and preferences. Consumers gave positive feedback on the services and supports provided to them.

Consumers and representatives said staff provide emotional and psychological supports to enhance their well-being. Staff described actions for supporting consumer emotional and spiritual well-being aligning with care planning documentation, spending additional time with consumers who did not want to socialise with others.

Consumers gave examples of how they were supported to participate in the community, maintain relationships, and pursue interests. Staff explained how the service coordinated community outings to local areas, including schools, and for scenic drives. Care planning documentation included interests of each consumer and preferred activities.

Service and support staff described methods of sharing information about consumers, seeking updates, or raising concerns about changes.

Staff gave examples of referrals made for consumers and described the network of organisations and providers available to support the well-being of consumers. Consumers confirmed they were supported by other organisations and providers.

Consumers and representatives provided positive feedback on the quality and variety of meals. Meals were prepared freshly on site, following a menu which had been reviewed by a dietitian for nutritional balance. Choices were available and communicated to consumers on the menu with verbal reminders from staff.

Staff explained cleaning and maintenance processes. Most consumers said they had access to necessary equipment, although some reported delays in care whilst waiting for equipment for hygiene care. This was discussed with management who advised they would respond to the concern through their complaint system.

# 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 Quality Standard has been assessed as compliant as 3 of the 3 requirements have been assessed as compliant.

**Requirement 5(3)(b)**

The assessment team recommended Requirement 5(3)(b) as Not Met. Whilst the environment was clean, the property was not well maintained, and consumers could not move freely. Evidence brought forward included:

* consumer rooms had damage to walls, railings, doors and door jambs.
* common doors to the outside and external doors for shared rooms were always locked, impacting free movement of consumers who needed to seek staff assistance for access. Some consumers expressed frustration with the limits to accessing outdoor areas, including the need to wait for staff availability and seek permission.

Management advised maintenance had been impacted by change of personnel, however, there was progress towards a refurbishment project. In relation to accessing garden areas, they said they would review the relevant policies and procedures.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant documents. Improvements to the environment and consumer rooms had been identified, with actions added to the PCI detailing all work. The provider acknowledges a copy of this was not provided during the Site Audit and have submitted a copy for review within their response. The provider reiterates the impact of the poor performance of the person responsible, resulting in cessation of employment, and delays experienced.

The provider explains a number of courtyards were accessible to all consumers, and activities scheduled in outdoor areas. Following feedback about courtyard doors being locked, a maintenance request was lodged and quote obtained to replace all locked door hardware. Whilst the provider was unaware of the impact to consumers, they will communicate progress on the work done to change locks and improve access.

I acknowledge the provider’s response, including supporting documentation and improvement actions. I note the PCI action for improved environment was opened on 31 May 2024 with ongoing editing, potentially to expand items, but this does contain reference to all identified issues and other planned work. The intended finish date is 31 March 2025.

I do not find the evidence before me demonstrates consumers were unable to freely move indoors and outdoors, only that the most direct route may not enable access. The assessment team’s evidence explains courtyard access from shared bedrooms was not available from the room door but does not discuss other available passageways. The provider has acknowledged their ability to improve access, with quotes obtained to update locks, but I find this is not the same as impeding access to outdoor areas. Accordingly, I find the service compliant is Requirement 5(3)(b).

Other Requirements within this Quality Standard have been assessed as compliant.

Communal areas supported interactions between consumers and visitors. Signage was in place to assist independent wayfinding. Consumers said they were supported to make the service their home, personalising and maintaining their rooms as they wished.

Consumers reported furniture and equipment was safe and well maintained. Staff described cleaning and maintenance processes, including inspections and servicing where indicated. Staff acknowledged potential improvements in monitoring of fittings and the service environment, with intended review to implement an effective system.

# 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 Quality Standard has been assessed as compliant as 4 of the 4 requirements have been assessed as compliant.

Consumers and representatives said they were comfortable to raise complaints with staff and management. Staff explained that consumers were encouraged to provide feedback or make complaints, and all staff received necessary training on this. The organisation has programs to actively seek consumer feedback.

Information on advocacy services were displayed throughout the service. Consumers and representatives said they were informed of supports for complaints prior to entering the service, with contact details in the handbook. Staff said they could assist consumers access language services or external complaint options and advocates.

Most consumers and representatives said appropriate action was taken in response to complaints. Representatives for one consumer expressed frustration with the management of their complaint, however, management explained they were aware of the complaint, and it remained open with ongoing review. The provider’s response also addresses this and a further action, as one of the raised elements had not been communicated to the service, either by representative or the assessment team. Staff received training on complaint management and open disclosure.

Actions and outcomes of complaints were recorded in the complaint and incident management system. Management explained this information was reviewed, trends identified and used to develop actions within the continuous improvement plan.

# 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 Quality Standard has been assessed as compliant as 5 of the 5 requirements have been assessed as compliant.

Most consumers and representatives said there were enough staff to meet consumer needs and respond to call bells in a reasonable time. One consumer and one staff member said there were not enough staff early in the morning, resulting in rushed care. Management described monitoring undertaken to ensure consumer needs were met in a timely manner. Documentation demonstrated shifts were filled, and the service met legislated care minute and nursing requirements.

Consumers and representatives described staff as kind, caring, and respectful of identity and diversity. Interactions between staff and consumers were observed to be respectful.

Recruitment processes ensured staff were qualified and competent. Consumers described staff as knowledgeable, however, one stated new staff would benefit from more education and support. Management monitored and reviewed staff for competency in performing their roles.

Staff received mandatory and skills-based education through a variety of delivery methods, including online and face-to-face sessions. Management described how training gaps were identified, such as through feedback, observations, and incidents. Documentation evidenced monitoring of training requirements, visa status, security checks, and professional registrations.

Staff explained the performance review process was a supportive process in which they could raise issues or request further education. Whilst some staff said their annual review was overdue, management described processes in place to address this. Ongoing monitoring of staff was undertaken through observations, and processes available to address poor performance.

# 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 Quality Standard has been assessed as compliant as 5 of the 5 requirements have been assessed as compliant.

The assessment team recommended Requirements 8(3)(c) and 8(3)(d) Not Met.

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

The assessment team recommenced Requirement 8(3)(c) as Not Met in relation to ineffective processes for information management, continuous improvement, and regulatory compliance. Evidence brought forward included:

* documentation practices about consumer condition and care did not support effective communication or staff understanding, with impact to consumer care and services
* continuous improvement planning did not include record of issues identified relating to service environment maintenance, consumer access to outdoor areas, or accountability of staff for the delivery of care and services
* the service did not support free movement of consumers in line with legislative requirement, and therefore did not demonstrate effective regulatory compliance.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant documents. Staff are required to document by exception, or through specific request, rather than record routine episodic care consistent with care and services plans. Furthermore, they contend ongoing recording of care, or absence thereof, does not reflect the quality of care provided to consumers which is monitored through reviewing and analysing clinical data. Continuous improvement planning was available for a number of cited issues, and whilst this was viewed by the assessment team it was not reflective within the report. In relation to access to outdoor areas, there were a small number of external spaces which did not permit access, which was being rectified, but alternate areas and access were available. Assessment and planning processes were used to identify whether consumers were environmentally restrained and were based upon the Commission’s guidelines.

I acknowledge the provider’s response, including supporting documentation and improvement actions. In making my decision on whether the service had effective governance systems, I have considered the evidence and outcomes within the other Quality Standards. As reflected within my determination for Requirement 2(3)(b), systems for capturing and sharing information were effective. I am satisfied the service had an effective continuous improvement process and plan, noting the provided copies of relevant action items pre-dated the Site Audit and reflected ongoing evaluation and amendments. I am also satisfied that consumers had access to outdoor spaces, albeit not always through the most direct or obvious access, and the organisation was aware of legislative obligations. The assessment team brought forward evidence reflective of effective governance frameworks and practices for finance, workforce, and feedback and complaints. I find the evidence before me sufficient to determine Requirement 8(3)(c) compliant.

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

This requirement was recommended as Not Met as the assessment team was not satisfied high impact or high prevalence risks were effectively managed, including addressing of incidents to ensure recurrence was prevented. Consumers were not being supported to live their best lives. This was associated with assessment and planning deficiencies outlined in Requirement 2(3)(b), and care delivery in relation to personal and clinical care deficiencies brought forward within Standard 3. Issues relating to medication management for time sensitive medications and absence of medication stock were not identified as risks. Risks associated with the environment, including potential for restricting free movement of consumers, had not been recognised or assessed.

The provider states they believe that they demonstrate they meet the requirement, offering clarifying information and relevant documents. The provider has referred evidence already brought forward for each circumstance raised. They contend they have effective systems and processes in place to identify and manage risks, including, but not limited to, reporting and analysis, monitoring and management meetings, improvement actions, policies, and procedures.

I acknowledge the provider’s response, including supporting documentation. The provider has acknowledged improvements in documentation for the examples brought forward in Standards 2 and 3, however, I consider the evidence does not reflect a systemic failing in processes, nor a failure to identify risks. Instead, I find the service had already identified issues which were used to develop improvement actions. Documentation from the provider demonstrates PCI actions were comprehensive and ongoing, with evaluations used to make enhancements.

In coming to my decision, I have considered all the evidence before me and find the organisation uses an effective risk management framework to identify, manage, and monitor consumer risk and this has effective for consumer examples brought forward. Accordingly, I have determined Requirement 8(3)(d) is compliant.

Other Requirements within this Quality Standard have been assessed as compliant.

Consumers and representatives said they were supported to participate and be involved in the evaluation of care and services through feedback, surveys, and case conferencing practices. Minutes of the consumer advisory body meeting demonstrated their engagement through consultation.

The organisation has a strategic plan and maintains oversight of care and service delivery and improvements. The governing body comprises a Board and subcommittees. Reporting structures, including outcomes from internal and external auditor reviews, enable the governing body to monitor performance and remain accountable.

The clinical governance framework outlines staff and management roles and responsibilities within clinical care delivery. Antimicrobial stewardship, including use of antimicrobial medications, was reviewed within medication advisory committee meetings. Policies and procedures informed the use of restrictive practices, with monitoring of reviews of consent and authorisations. Staff were aware of roles and responsibilities when things went wrong, including application of an open disclosure process.

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