Performance

Report

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| Name of service: | Karingal Seymour |
| Service address: | 3 Bretonneux Street SEYMOUR VIC 3660 |
| Commission ID: | 3050 |
| Approved provider: | Seymour Elderly Citizens Hostel Inc |
| Activity type: | Site Audit |
| Activity date: | 6 December 2022 to 8 December 2022 |
| Performance report date: | 8 March 2023 |

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 Karingal Seymour (**the service**) has been prepared by K. Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Assessment Team’s report received 17 January 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 2(3)(e) – The Approved Provider ensures care and services are reviewed regularly for effectiveness including when incidents or changes occur and that appropriate updates are made to the plans to ensure consumers changed needs are met.
* Requirement 3(3)(a) - The Approved Provider ensures each consumer gets safe and effective personal care and clinical care, that is best practice; is tailored to their needs; and optimises their health and well-being.
* Requirement 3(3)(b) – The Approved Provider ensures high impact or high prevalence risks associated with the care of each consumer are managed effectively.
* Requirement 3(3)(c) – The Approved Provider ensures the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.
* Requirement 3(3)(g) – The Approved Provider ensures infection related risks are minimised through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.
* Requirement 7(3)(d) – The Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 8(3)(b) - The Approved Provider ensures the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Requirement 8(3)(c) – The Approved Provider ensures effective organisation wide governance systems relating to information management; continuous improvement and workforce governance; regulatory compliance; feedback and complaints.
* Requirement 8(3)(d) – The Approved Provider ensures effective risk management systems and practices, to manage high impact risks to consumers and to support consumers live the best life they can.
* Requirement 8(3)(e) - The Approved Provider ensures it has an effective clinical governance framework, including antimicrobial stewardship; minimising the use of restraint; and open disclosure.

# 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

Consumers said they were treated with dignity and respect. Staff knew how to preserve consumers’ privacy, dignity and cultural diversity, and staff knowledge of individual consumers aligned with care plan documents. Staff interacted with consumers in a respectful, polite manner.

Consumers said the service supports them to practice their beliefs and values and learning about their culture and staff were aware of consumers’ cultural beliefs. Care planning documents showed consumers’ individual religious, spiritual, and cultural needs and personal preferences. The service has a documented diversity and inclusivity framework that includes guidance for staff on cultural safety.

Consumers and representatives felt involved and supported to make decisions about their care and are able to freely choose who they want involved in their care planning. Consumers said the service supports them to make and maintain relationships, and that it encourages them to participate in activities that keep them connected.

The service kept risk assessments and evidence of consent on file, in line with its risk management policies. Consumers were satisfied the service supported them to take risks and they felt they had adequate knowledge to make informed decisions on their choices and felt that they were supported to live their best life.

Consumers and representatives were satisfied they received timely and accurate information, consumers stated they are involved in discussions and meetings and are encouraged to raise concerns or ask questions especially in the consumer meetings. Staff had processes to ensure they provided current, relevant information to consumers.

Consumers were satisfied the service maintained their privacy and said staff knocked and waited before entering their rooms. Staff closed consumers’ doors during personal care and locked computers after use.

# 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement 2(3)(e) is non-compliant.

Consumers and representatives raised concerns regarding how the service managed changing care needs following incidents or changes in circumstances. The Assessment Team identified two consumers who had experiences recent falls, a review of the care documents for these consumers did not include post falls assessments, their care plans were not reviewed and updated following these incidents and not all falls experienced by consumers were reviewed by the medical officer or physiotherapist. The service did not regularly review incident data and a review of the falls policy found there was no guidance for staff to ensure care plans are reviewed post falls.

The Approved Provider’s response of 17 January 2023 included a Plan for Continuous Improvement (PCI), to address the Assessment Team’s findings. Action items within the PCI included:

Developing tools to guide staff on post-incident care, post-incident reviews, care planning, and seeking input from allied health providers.

Additional staff training in palliative care, wound management, care planning and medication management.

Additional actions, such as reviewing all incidents in fortnightly clinical review meeting and physiotherapist review of all data and each consumer who experienced falls.

The Approved Provider has commenced some of these actions and will roll out additional tools and training throughout January and March 2023. Having considered the issues identified by the Assessment Team, I consider the Approved Provider’s response appropriate. However, I have also considered that some of the planned actions will take time to establish and measure for effect, such as the actions concerning staff training and embedding new processes. Therefore, I find that at the time of the Performance Report, the Service is non-compliant with Requirement 2(3)(e).

I am satisfied that the remaining 4 requirements of Quality Standard 2 are compliant.

Staff knew the service’s assessment and care planning processes, which included identifying risks to consumers’ safety, health and well-being. Consumers said the service considers their needs, preferences and risks as part of the care planning process. Care plans showed consumers had assessments in place.

Consumers said staff discussed their current care needs, goals, and preferences with them, including advance-care planning and end-of-life care, if the consumer wished. They said staff conduct assessments and planning in consultation with them and their care team. Consumers and their representatives said the service communicates the outcomes of assessment and planning effectively.

Care planning documents showed input from consumers, their representatives and other allied health professionals. The service’s electronic care planning system contained evidence of treatment directives from allied health professionals, and others involved in the consumers’ care.

Excluding the findings set out under Requirement 8(3)(a) concerning communication, documents showed the service maintained good communication with representatives.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirements 3(3)(a) 3(3)(b) 3(3)(c) and 3(3)(g) are non-compliant.

Requirement 3(3)(a)

The Assessment Team identified deficiencies in the service’s personal and clinical care delivery, care documents showed that service staff did not follow best practice guidelines for clinical monitoring of personal hygiene, wound management and restrictive practices. Evidence included:

Care plans for three consumers did not reflect the recommendations of external specialists and did not reflect the consumers’ current clinical care needs.

Care planning documents for two consumers with pressure injuries did not contain strategies to manage existing pressure injuries or prevent further ones.

For consumers who had sustained weight loss, there was no evidence the service identified, managed or implemented strategies to address the weight loss.

Consumers subject to restrictive practices did not have Behaviour Support Plans.

The Approved Provider’s written response of 17 January 2023 included its Plan for Continuous Improvement (PCI). The actions within the PCI included:

The Approved Provider commenced a thorough review of care plans and assessments for all consumers, which covered their personal, clinical, and complex care needs. As of 17 January 2023, 24 plans were still under review.

For consumers with identified pressure injuries, the Approved Provider conducted additional assessments and introduced supports, such as an air mattress, to better manage these pressure injuries.

In relation to consumer weight loss, the Approved Provider has reviewed and updated its weight loss management policy to ensure the policy is in line with best-practice and established systems. This ensured the service tracked monthly changes and alerts clinical staff for follow up. The service actioned all outstanding dietician referrals by the end of January 2023.

The service undertook a review of all Behaviour Support Plans following the Site Audit and, where necessary, developed new plans. This included consumers subject to restrictive practices. The service finalised this initiative on 13 January 2023.

Staff training in reviewing and developing assessments, and additional ongoing wound management training.

I have considered the Assessment Team’s evidence and the Approved Provider response. While the Approved Provider’s response is appropriate, it includes multiple larger-scale interventions such as care-plan review and staff training initiatives, that will take time to finalise and measure for effect and I have given weight to the potential impact to consumers while these processes are embedded. On balance of the evidence provided, I find the service non-compliant with requirement 3(3)(a).

Requirement 3(3)(b)

The Assessment Team found the Service did not consistently manage high impact or high prevalence risks associated with the care of each consumer. Specifically, the Assessment Team found:

Where consumers experienced a fall or pressure injury, the Service did not manage these incidents effectively, post incident. For example, medical officers or physiotherapists did not consistently review fall events and staff did not consistently document pressure injuries in care plans or identify and implement strategies to manage the pressure injuries.

While management was able to describe the high impact and high prevalence risks as they related to consumers within the service and produce data in relation to falls, injuries, wound and behaviour incidents. The Service did not analyse that data to identify trends for falls risks nor did it have strategies to minimise those risks.

Overall, staff did not demonstrate an understanding of how to manage high impact or high prevalence risks.

In its written response of 17 January 2023, the Approved Provider detailed the actions it took in response to the Site Audit. These actions included:

A physiotherapist reviewed all falls data in December 2023.

From December 2023, the Service began recording high prevalence risks on an alert board, to prompt management and staff.

The Service scheduled additional training for staff on risk processes, resources and handling procedures, due for completion in March 2023.

The Service formed a clinical review forum that meets once per fortnight to assess and manage risks across the service.

The Service made various resources available to staff, including about wound management, pressure injury prevention, and best practice care strategies, to ensure staff provide appropriate care.

The service planned further document reviews for February 2023.

I have considered the Assessment Team’s evidence and the Approved Provider’s response, while I am satisfied the Approved Provider’s response is appropriate to address the identified issues, I am of the view that some of the planned actions such as developing additional resources, training of staff, and forming and optimising clinical groups are planned to implement over longer periods and will take time to measure for effect. I therefore find requirement 3(3)(b) non-compliant.

Requirement 3(3)(c)

The Assessment Team found deficiencies in how the service delivers care for consumers nearing end-of-life. Specifically, the Assessment Team found that one recently deceased consumer did not receive effective end-of-life care. They found that the consumers’ representative had trouble communicating with the service, and the consumers’ other providers. Care documents for this consumer did not include an end-of-life care plan and care records showed the service did not identify the consumers’ initial deterioration, and delays in the referral of the consumer to a medical officer. For another recently deceased consumer, the Assessment Team found the service did not develop a palliative care plan or communicate with the consumers’ representatives at the time.

In response to these findings, the Approved Provider’s PCI included initiatives and actions planned to address these deficiencies. The service scheduled training in responding to deterioration, symptom management and palliative care throughout December 2022 and January 2023 to upskill staff within the service. It also increased the number of registered staff within the Service and adjusted its end-of-life care pathway, such that staff initiated the pathway sooner than they previously did. The service has additional training scheduled for later in 2023.

In assessing the Service against Requirement 3(3)(c), I acknowledge the Service has acted to address the Assessment Team’s findings. I have also considered the impact to consumers and the timeframe for the Service to fully implement its planned remediation activities. I have formed the view that there has been insufficient time for the service to fully implement its planned interventions, and to demonstrate the sustainability and effectiveness of those interventions. I therefore find the service non-compliant with Requirement 3(3)(c).

Requirement 3(3)(g)

The Assessment Team found that the service did not have documented policies concerning anti-microbial stewardship, and staff did not demonstrate sufficient knowledge of anti-microbial stewardship when interviewed during the site audit. The Assessment Team also found that staff did not manage consumer infections appropriately. For example, the service’s records showed that, prior to the site audit, two consumers tested positive to urinary tract infection (UTI). To manage the UTIs, staff arranged for medical officer reviews, which involved a delay of 5 to 10 days. In both cases, staff did not monitor the consumer’s infections adequately in the intervening period, and they did not attempt to clear the infection by encouraging the consumers to increase their fluid intake, or by using other non-antibiotic strategies.

In response to these findings, the Approved Provider advised that it commenced toolbox talks about anti-microbial stewardship, and that it introduced a program to train staff to test for UTIs. It also restructured its UTI testing procedures and scheduled future clinical meetings to workshop solutions to its management of UTIs. The actions commenced in December 2022 and are planned to be delivered and reinforced through further staff training throughout early 2023.

I have considered the information the Assessment Team brought forward, and the Approved Provider’s response. The Approved Provider’s response demonstrates it is acting to train staff, adjust its processes and review its infection management practices. While I acknowledge that the service has used the finding against Requirement 3(3)(g) to initiate improvements, I have also considered that the actions are ongoing and not yet fully realised. I therefore conclude that the service is non-compliant with requirement 3(3)(g).

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

Requirement 3(3)(f),

The Assessment Team found the service was unable to demonstrate it made prompt, appropriate referrals to other providers in relation to consumer weight loss. Under the Service’s policy on weight loss, where it identified that a consumer had lost 2kg or more of weight, its care coordinator was responsible for intervening. Despite this, the assessment team found three consumers who experienced significant weight loss between February and October 2022, a review of each consumers care records showed no referrals to dieticians or speech pathologists occurred for these consumers.

In response to these findings, the service formed a plan to address them and embedded this within its Plan for Continuous Improvement (PCI) provided on 17 January 2023. The plan included:

Reviewing all consumers for weight loss.

Consulting the service’s dietician about its weight loss policies.

Redesigning the service’s weight loss policies to require staff to escalate all weight fluctuations of 1kg or more to the service’s Management Alert Board.

Training staff in their obligations under the revamped weight-loss referrals policy.

Based on this information, I have reasoned that the service has acted appropriately to address the Assessment Team’s findings. It has used the findings as an opportunity to initiate improvement in the care it provides and it has reinforced its framework for consumer referrals, specifically as this relates to weight loss. Its training initiatives will also up-skill its staff, to ensure they are more vigilant going forward. Staff will be more alert to fluctuations in consumers’ weight, and they will respond more rapidly to such situations. Based on the Approved Provider’s response I am satisfied the service is compliant with requirement 3(3)(f).

Care planning documents and progress notes showed that, with the exception of the cases identified under Requirement 3(3)(c), the Service generally identified and responded to deterioration and changes in consumers’ conditions. Staff knew which signs to look for to identify deterioration, including changes in mobility, appetite, interest in activities, mood and behaviours.

Staff shared and documented information through staff meetings and handovers. Care documents showed staff notified consumers’ General Practitioners and representatives when the consumer experienced a change in condition, a major clinical incident, was transferred or when staff requested a change in medication.

# 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

The Assessment Team found that the Service was non-compliant with Requirement 4(3)(f).

I have reviewed the evidence brought forward in the Site Audit report and the Approved Provider’s written submission and come to a different view. I provide further information about my reasoning below.

The Assessment team spoke with consumers who generally said the Service’s meals were not nutritious and that its menu had insufficient variety. They said the service did not involve them in menu planning or ask them whether they liked the service’s food. Other findings included:

The presentation of food was not appealing. This included food such as pumpkin and potato served with skin that consumers found hard to remove.

The menu did not change over longer periods of time, with the food being the same ‘week in, week out’.

The quality of food had deteriorated over the preceding five years.

The Service conducted its last food survey prior to the Site Audit in late 2021.

The Service’s food ordering system required residents to select either a hot or cold meal one week in advance without knowing what the specific meal options were.

The Approved Provider’s response indicates the service has committed to improving the quality of food within the service. Actions taken by the Approved Provider include:

Arranging for the chef to attend the service’s monthly resident meetings to discuss the service’s food and directly capture feedback.

Restructuring consumer meal offerings by including more varied, better prepared and more flavourful meals.

Ordering two additional cooktops to support its kitchen staff.

Changing the way staff present and serve food. For example, by coordinating food service using trolleys.

Improving the amenity of the service’s dining area by playing music and delaying intrusive clean-up procedures.

Enrolling its food preparation staff in training courses.

Planning visits to other facilities to investigate food cooking and presentation techniques.

I have considered information from the Site Audit Report and the Approved Provider’s response. I have formed the view that the number and range of the service’s interventions shows a substantive response. Moreover, a number of the service’s interventions will have immediate effect to improve the dining experience and food quality within the service. The service will continue to gain improvements from its planned interventions over the long term. I am satisfied that the Service is compliant with Requirement 4(3)(f).

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

Consumers were satisfied with the services and support they received for daily living. Care planning documents showed consumers’ choices and provided information about the support consumers need to do the things they want. Staff knew consumers’ interests, and their information aligned with information from consumers and that within care planning documents.

Consumers said staff supported them when they were feeling low. Care planning documents showed information on how to support consumers’ emotional, spiritual and psychological well-being.

The service supported consumers to participate in the wider community and maintain their personal relationships. Care planning documents showed the consumers’ activities of interest, and strategies to supported them to participate in these activities and in the wider community.

Staff shared information and kept informed of the changing conditions, needs and preferences of consumers during shift handovers.

Care planning documents showed the service collaborated with external providers. Consumers said the service referred them to external providers to support their care needs.

Equipment used for activities of daily living was suitable, clean and in good condition. Staff ensured shared equipment was clean and they knew how to make maintenance requests when equipment needed fixing.

# 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

Consumers said they feel at home at the service and consider it a nice place to live. Staff explained how they support consumers to customise their rooms and promote a sense of belonging and independence. The service environment had adequate signage, and easy-to-navigate indoor and outdoor areas, which consumers were observed utilising.

Consumers said the service was clean and well maintained and that they could move freely inside and outside the service. Cleaning staff had a daily regimen, with set cleaning schedules for their areas of responsibility. The service has processes and systems in place for identifying and recording hazards, maintenance issues and cleaning, and those requests are completed in a timely manner.

Most consumers said furniture, fittings, and equipment were safe, clean, well maintained, and suitable. Maintenance schedules showed regular maintenance of the service environment, with no overdue planned or periodic maintenance. Staff demonstrated awareness of how to report any maintenance issues and the preventative maintenance schedule.

# Standard 6

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

Findings

The Assessment Team found that the Service was non-compliant with Requirement 6(3)(d).

I have reviewed the evidence brought forward in the Site Audit report and the Approved Provider’s written submission and come to a different view. I provide further information about my reasoning below.

The Assessment Team found the service did not consistently document or review feedback, or consistently use it to improve the quality of its care. Much of this feedback concerned the service’s food and food service. Care documents showed that staff did not consistently enter feedback into the service’s feedback log or interrogate the feedback sufficiently to identify how to prevent issues from reoccurring. The Assessment Team found a core reason for this, was that staff actioned feedback as isolated cases, without appropriate systemisation or strategy to prevent issues from re-occurring. As at the Site Audit, the service’s Plan for Continuous Improvement did not show any improvement initiatives arising from feedback trends or clinical analysis. When presented with this finding, Management said that the service’s systems were less suited to identifying trends in complaints data.

The Approved Provider’s response of 17 January 2023 indicates the service has committed to streamlining its feedback and complaints processes. The service’s response includes the following:

Improvements to the meal options, delivery and presentation through chef attendance at meetings, additional kitchen resources and staff training, commenced from January 2023.

Management engagement with consumers and representatives to discuss how feedback is used to improve services

Additional feedback reporting to the Board, with data analysed and trended

The inclusion of consumer feedback in the Plan for Continuous Improvement and actions to address the feedback

I have considered the Assessment Team’s and the Approved Provider’s submission. I acknowledge the Approved Provider has deployed a range of initiatives intended to address the Assessment Team’s findings. These initiatives are highly targeted and relevant to the findings. The service has devised and implemented a number of solutions to address the various findings concerning its food, and it has devised a system to ensure it fully incorporates feedback into its long-term improvement activities. Given this, I have reasoned that the service has adequately addressed the deficits identified during the Site Audit. I therefore find the service compliant with requirement 6(3)(d).

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

Consumers said staff supported them to make complaints and that the service addresses their complaints in a timely manner. Staff knew which channels were available to consumers to raise complaints and how to support them to do so, including how to help consumers living with cognitive impairment or poor vision. The service had a process to support consumers in raising complaints or feedback.

Consumers said they felt comfortable speaking directly with staff and management about their concerns. The service displayed information about its feedback and complaints process in various locations around the facility. This included information on advocacy services, along with its feedback forms. The service also gave consumers information about its complaints and feedback processes in its consumer onboarding booklet.

Consumers said the service responded to any complaints they raised. The service used a process of open disclosure when things went wrong, and care staff knew the complaints management process and how to apply open disclosure when addressing complaints and incidents.

# 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

I have assessed the service as non-compliant as I am satisfied that Requirement 7(3)(d) is non-compliant.

Requirement 7(3)(d)

The Assessment Team found some staff did not have adequate training in key clinical domains, including in care charting, anti-microbial stewardship, wound care, weight loss, falls management and restrictive practices.

Some staff did not have training in relevant procedural domains, including in the Serious Incident Response Scheme, and in the Aged Care Standards.

The service’s training material did not include content on anti-microbial stewardship, high-impact, high-prevalence risks or open disclosure.

While the Assessment Team was on site, management reported to it that the Service planned to arrange structured training and education sessions on weight loss, wound care and falls. The Approved Provider’s written response included detail of the service’s training initiatives from August to October 2022 covering areas of care such as falls prevention, infection and outbreak control and restrictive practices.

In its response of 17 January 2023, the Approved Provider further stated that it had scheduled, or was in the process of planning, the following training packages; wound dressing best practice for nursing staff, dedicated wound training for the service’s care manager, toolbox talks on antimicrobial stewardship and further training related to open disclosure, high impact, high prevalence risks, and behaviour support plan due to be delivered throughout early 2023.

I have considered the Assessment Team’s and the Approved Provider’s response for Requirement 7(3)(d). I acknowledge the planned and commenced actions of the Approved Provider in delivering training to address the gaps identified during the site audit, however, have also considered that delivering training and embedding new process in staff will take time to roll out and measure for effect and have considered the potential impacts to consumers while staff receive additional skills training. I therefore find the service non-compliant with requirement 7(3)(d).

The Assessment Team found the service non- compliant with Requirement 7(3)(e).

I have reviewed the evidence brought forward in the Site Audit report and the Approved Provider’s written submission and have come to a different view. I provide further information about my reasoning below.

Requirement 7(3)(e)

The Assessment Team found that the service did not undertake staff performance appraisals consistently. At the time of Site Audit, the service had not completed 50 per cent of staff performance appraisals and three staff said they could not remember when they last had a performance appraisal. This Assessment Team identified incidents between 1 June 2022 to 31 December 2022 involving staff errors with no evidence the service had attempted to performance manage the involved staff.

In its formal written response to these findings, the Approved Provider confirmed that the service had completed the lapsed performance appraisals and updated its continuous improvement plan. Concerning the identified incidents and performance management issues, the Approved Provider stated its staff had completed additional staff training in the 2022 and staff directly involved will be coached further, which was documented and formalised and commenced in January 2023.

I have considered the Assessment Team’s information and the Approved Provider’s response; I am satisfied that the Approved Provider has demonstrated all outstanding appraisals have now been brought up to date and the inclusion in the PCI will ensure ongoing appraisals on an annual basis. I have also considered the additional training and staff coaching initiatives commenced by the Approved Provider to address individual skills gaps and ongoing training will ensure future incidents do not occur or will be managed appropriately. Based on the evidence available to me I am satisfied that Requirement 7(3)(e) is compliant.

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

Consumers said they were satisfied with the service’s staffing levels and that staff generally answered call bells promptly. During the Site Audit, staff were available when consumers needed them and staff said they worked together to ensure they meet consumers’ care needs.

Consumers said staff engaged them in a respectful, kind, and caring manner. Staff understood the consumers they cared for, including their needs and preferences. Care plans accurately depicted consumers’ care needs. The service monitored staff interactions through observations, and feedback and complaints processes. Staff were caring and respectful when they interacted with consumers.

Consumers said staff were sufficiently skilled to meet their care needs. The service had policies and processes to ensure its workforce was competent and qualified, which included documented position descriptions setting out key qualifications and knowledge requirements for each role at the service. Staff members said they felt competent to perform their roles.

# 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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Assessment Team brought forward evidence to suggest the service did not meet all 5 Requirements in Standard 8.

I have reviewed the evidence brought forward in the Site Audit report and the Approved Provider’s written submission and come to a different view in relation to Requirement 8(3)(a). I provide further information about my reasoning below.

The Assessment Team found that consumers and their representatives did not know what a care plan was, and the service had not offered them a copy of their care plan and did not feel like partners in the planning of their care. As at the Site Audit, the service had not held ‘resident and representative meetings’ since 11 March 2022 and had not conducted a consumer survey since late 2021, resulting in an overall lack of engagement with consumers.

In response to these findings, the service took the following actions:

Immediately contacted residents and their representatives and offered them a copy of their care plans.

Displayed information about this finding inside the facility, in accordance with open disclosure principles.

Updated its consumer onboarding package and information booklet to include information about access to care documents.

Held a consumer forum on 9 December 2022 to discuss the service’s menu.

Scheduled regular meetings commencing from 27 January 2023, during which the service’s food will be discussed and a member of the Board will attend these meetings.

Implemented consumer and representative interviews and surveys.

I have considered the Assessment Team’s evidence and the Approved Provider’s response, I consider the response substantive and involves a wide range of interventions that address the Assessment Team’s findings. I am satisfied that, the actions implemented by the Approved Provider will ensure ongoing consumer engagement about their care and incorporate their feedback into its care offerings. Based on the evidence available to me, I find the service compliant with Requirement 8(3)(a).

Requirement 8(3)(b)

The Assessment Team found the service did not show that its board promoted a culture of safe, inclusive care. The specific findings included:

The Board said it determines whether the service meets the Quality Standards based on reports the service makes to it. However, the reports did not include sufficient information for the Board to make accurate judgements. For example, the reports omitted feedback trends, clinical incident trends and information about deficiencies that should have been flagged for continuous improvement activity. The reports Management sent to the board did not always give a clear picture of incidents within the service. For example, one report did not include data about falls, medication incidents or injuries. Another included information about falls and medications but not wounds, pressure injuries, or use of psychotropic medication.

The Assessment Team found no evidence that the Approved Provider monitored the service’s care data to ensure it followed its policies and frameworks and the Approved Provider did not initiate improvement action in response to identified adverse trends.

The Assessment Team found no evidence that the Board communicated directly to the rest of the organisation through such channels as a newsletter or monthly bulletin. When presented with these findings while on site, management acknowledged them and stated the service would commence training and review its processes as required. The Assessment Team was also advised that the Board was undergoing training to better communicate with consumers.

In its formal response, the Approved Provider stated:

The service will report data trends to the Board on a quarterly basis.

The service will commence reporting all clinical incidents to the Board, on a monthly basis.

The service will detail all Serious Incident reports to the Board on a monthly basis.

The Board will review the service’s Continuous Improvement Plan on a monthly basis.

The CEO has launched the Aged Care Quality and Safety Commission Governing for Reform board kit to the service’s Board, which is intended as an ongoing training platform.

An additional Care Manager commenced at the Service on a part-time basis, increasing its care manager hours by 45 hours a fortnight.

The Board has implemented engagement initiatives, such as direct email to enable easy communication with consumers and staff.

The Board has worked with the Service to restructure the Service’s monthly newsletter. From 14 December 2022, it featured a section ‘What’s happening with the Board?’.

I acknowledge the Approved Provider has made effortful attempts to address the findings. However, given that cultural change occurs over longer periods, and the effects of some of the proposed interventions have not yet been fully embedded, I have also considered that it will take time to measure these changes for effect. I find the service non-compliant with Requirement 8(3)(b).

Requirement 8(3)(c)

The Assessment Team found the service’s systems did not effectively manage information, support continuous improvement, govern its workforce, ensure it was compliant with regulations, or manage complaints. A summary of the key elements is as follows:

* Concerning information management:
  + The service did not have a unified system for capturing feedback and incidents. This hindered its ability to share information between tiers of management within the service and approved provider organisation.
  + Under its own advice, the service should have held consumer meetings once per month. Prior to the December 2022 Site Audit, the previous consumer meeting was in July 2021.
* Concerning continuous improvement:
  + The Service had fragmented systems for capturing continuous improvement opportunities.
  + Staff did not enter all continuous improvement opportunities into the service’s Plan for Continuous Improvement
* Concerning workforce governance:
  + Staff were not familiar with concepts central to their roles, including antimicrobial stewardship, and minimising restraint.
  + The service’s education and training records showed that its staff had overdue mandatory training.
  + Management had not undertaken recent performance reviews for 50% of staff.
* Concerning regulatory compliance:
  + The service did not have an internal audit schedule to monitor staff compliance with policies.
  + Staff had not completed documents relating to regulatory compliance correctly
* Concerning feedback and complaints:
  + Staff did not analyse feedback data for trends
  + The service logged feedback data and complaints but did not follow them up

Given the range of findings against this Requirement, the service provided a large response to the findings. A summary of its various interventions is as follows:

* Concerning information management:
  + The service has adjusted its processes for capturing feedback, including training staff in applying its new processes.
* Concerning continuous improvement:
  + The service updated its digital system for recording continuous improvement initiatives such that it now has to identify a timeframe for resolution of continuous improvement items.
* Concerning workforce governance:
  + The service immediately commenced training and performance appraisals and scheduled future training initiatives.
* Concerning regulatory compliance:
  + The service scheduled various meeting and training initiatives to upskill its staff and improve their compliance knowledge.

I acknowledge the immediate and planned actions undertaken by the Approved Provider to address the Assessment Team’s findings. However, have also considered the scale and implications some of the actions have for the service’s ongoing performance, such as the establishment of new processes and ongoing training and have given weight to the time it will take to embed these. I therefore find the service non-compliant with Requirement 8(3)(c).

Requirement 8(3)(d)

The Assessment Team found that the service’s risk management systems did not adequately monitor or address instances of consumer weight loss or falls and identified related findings in that the service did not focus on risks during its organisational meetings. The Assessment Team additionally found:

The service had inadequate risk minimisation strategies to prevent consumers from falls incidents and experiencing later reoccurrence of similar falls.

Where consumers experienced weight loss, the service did not investigate the underlying causes or develop strategies to prevent it.

During interview, staff could not identify high impact, high-prevalence risks and they said they required more training to do so.

In response to these findings, the Approved Provider adjusted its risk monitoring process to include a greater focus on weight loss. It also made referrals to dieticians for all consumers found with weight loss. In addition, the service committed to re-evaluating its response to falls incidents, which included having physiotherapists review its falls data, and relevant consumers’ care plans, to assess how it needed to adjust its care going forward, the service has planned actions to be undertaken to address these deficiencies to commences immediately and be undertaken throughout early 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its response, I acknowledge that the actions planned and implemented by the Approved Provider may be sufficient to address the deficiencies, however, have also considered that some of the actions are ongoing and will take time to embed through processes. I therefore find the service non-compliant with requirement 8(3)(d).

Requirement 8(3)(e)

the Assessment Team found that, generally, staff at the service did not have adequate training in key clinical concepts. This included training in anti-microbial stewardship, minimising the use of restraint, and open disclosure. Other findings included:

The Board did not discuss relevant items during its meetings. For example, the service’s clinical governance framework set out that the Board should discuss antimicrobial stewardship, restraint minimisation and open disclosure but there was no evidence within meeting documents that the board discussed these items.

Concepts such as antimicrobial stewardship, quality standards, restrictive practices and open disclosure did not form part of the service’s mandatory training.

The service did not analyse trends in its infection data.

During interview care staff did not demonstrate knowledge of psychotropic medication or restraint practices.

The service had not maintained training records to show that it trained staff in minimising restrictive practises.

In its response, the Approved Provider reiterated that it planned various improvement initiatives relating to staff training, antimicrobial stewardship, toolbox talks, review of its care plan documents, and psychotropic medication. These initiatives were commenced following the Site Audit and are planned for delivery throughout early 2023.

Given the complexity involved in addressing all of the findings that overlap with this Requirement, I have concluded again that doing so will take significant time. I consider there has been insufficient time for the Approved Provider to realise the full range of planned improvements. I therefore find the service non-compliant with Requirement 8(3)(e).

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)