Performance

Report

**1800 951 822**

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| Name of service: | Kolora Aged Care |
| Service address: | 8 Prisk Street GUYRA NSW 2365 |
| Commission ID: | 0359 |
| Approved provider: | McLean Care Ltd |
| Activity type: | Site Audit |
| Activity date: | 7 February 2023 to 9 February 2023 |
| Performance report date: | 18 April 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 Kolora Aged Care (**the service**) has been prepared J Durston 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 13 March 2023 and report attachment: Plan for Continuous Improvement, received on 15 March 2023.

# 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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

* Requirement 3(3)(a) – the approved provider ensures each consumer gets safe and effective personal and clinical care in the areas of wound management and pressure injury prevention, diabetes management and blood glucose monitoring, pain management and responsive behaviour support, psychotropic medication management and restrictive practices.
* Requirement 3(3)(d) – the approved provider ensures effective processes for staff to be able to recognise and respond in a timely manner to deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition, and discussion is held with the consumer and/or consumer representative, and the medical officer is alerted when deterioration or change occurs for a consumer.
* Requirement 3(3)(g) – the approved provider ensures the minimisation of infection related risks by implementing standard and transmission-based precautions to prevent and control infection in managing shared equipment, disposal of chemical waste and correct use of personal protective equipment.
* Requirement 5(3)(b) – the approved provider ensures the service environment is safe, clean, well maintained with effective processes to identify maintenance and cleaning needs, and checks they are completed; safe smoking signage is placed in the designated consumer smoking area and consumers in all areas can move freely indoors and outdoors.
* Requirement 5(3)(c) – the approved provider ensures there is a process to monitor furniture, fittings and equipment including furniture in consumer communal areas and care and support equipment, to ensure it is safe, clean and well-maintained; and action is taken when cleaning, maintenance or replacement is required.
* Requirement 7(3)(a) – the approved provider ensures each consumer is the number and mix of members of the workforce enables the delivery of safe and quality care and services to ensure consumers are provided the care they need, consumers are not waiting extended periods for care, and there are sufficient staff on duty to meet the needs of consumers who require more than two staff to assist with their care.

# 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 six of the six specific requirements are compliant.

Consumers and their representatives interviewed said they are treated with dignity and respect and their culture, identity and diversity are valued. Staff handover meetings include a ‘resident of the day’ discussion to familiarise staff with each consumer’s background, culture and preferences. Staff are trained in person-centred care, and demonstrated a good understanding of consumer’s cultural preferences, how consumers are supported to maintain friendships and relationships, and how they provide care and services aligned to their care plans.

Consumers and representatives confirmed their care and services are culturally safe and they felt staff respect their cultural preferences. The service has policies, processes and training to guide staff to provide culturally safe and inclusive care and services. Care plans showed consumers are assessed during the admission process, their care plans are regularly reviewed and include their individual preferences including cultural, religious, social activities and community services such as the NDIS, and care services.

Consumers and their representatives said they felt supported to exercise choice and independence, including how their care and services are delivered and their privacy is respected. The service demonstrated consumers are supported to make connections and maintain relationships of choice.

The Assessment Team found the service supports consumers to take risks in line with their choice to live their best life and to engage in activities they enjoy. Documentation showed signed consent forms contain evidence of discussions with consumers and representatives about risks and mitigation strategies associated with their chosen activities.

Consumers and representatives said they receive regular, clear and timely communication to make informed decisions about their care and services. They advised the service provides opportunities through resident meetings, case conferences and surveys to provide feedback and participate in decisions about their care and services. The Assessment Team identified information for consumers is easy to understand, readily available in various languages, and staff use a range of communication aids to effectively communicate with consumers who have communication impairments.

Consumers and representatives advised they feel their privacy is respected and confirmed staff knock on doors before entering their rooms and shut doors and curtains when providing personal care. The Assessment Team observed staff knocking on doors and asking consumers their preferences before providing personal care.

# 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 five of five specific requirements are compliant.

The Assessment Team found the approved provider did not demonstrate assessment and planning, including consideration of risks to consumer’s health and well-being, their needs, goals and preferences informs the delivery of safe and effective care and services. Consumers and their representatives provided positive feedback in relation to assessment and planning of their care and services.

The Assessment Team found that the organisation has policies and procedures for conducting assessments, and except for one named consumer whose falls management was reviewed, care and service documentation evidenced comprehensive assessment and care planning that considers risk to the consumer’s health and well-being.

Review of one consumer’s falls incident reports and progress notes showed they continued to have falls, their risk of falls was not comprehensively investigated for each incident, and the relationship between the consumer’s behaviour triggered by pain and the associated falls risk was not investigated. The Assessment Team observed the consumer to be on the floor and in pain. Their care documentation showed their regular pain relief had not been administered that morning because the service was out of stock. The service had re-ordered the medication to arrive that day. Regular pain checks were not attended as directed by the registered nurse. The consumer’s care documentation showed they placed themselves on the floor when in pain. However, that responsive behaviour was not recorded in their Responsive Behaviour Support Plan and there were no behaviour support strategies to mitigate the risk.

The approved provider responded to the Assessment Team report and advised the consumer’s falls risk assessment was updated following their first 2 falls to include the behaviour of placing themself on the floor, but not after the third fall. Prior to the Site Audit the service reviewed and updated the consumer’s Behaviour Support Plan (BSP) to include pain as a behavioural trigger, and the consumer’s care documentation has now been corrected to include relevant support strategies. The service acknowledged the gaps identified in risk assessment for the named consumer, but noted the other consumers reviewed by the Assessment Team showed comprehensive assessment and care planning had occurred, as stated in their report.

With these considerations, I find the approved provider’s findings to be more compelling regarding compliance with this requirement. I am satisfied that, overall, the service demonstrated assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care and services. Accordingly, I find Requirement 2(3)(a) is compliant.

The Assessment Team found assessment and planning does not identify and address the consumer’s current needs, goals and preferences. Consumers provided positive feedback in relation to their needs, goals and preferences being met and confirmed they had been included in discussions around end-of-life care. Staff interviewed were knowledgeable about consumers’ needs and were able to describe when conversations around end-of-life planning and advance care planning occurred. The Assessment Team identified one consumer whose behaviour support plan did not adequately address all their care needs, particularly risks associated with behaviours triggered by pain. This issue was considered in Requirement 2(3)(a).

In their response to the Assessment Team’s report the approved provider disagreed that the requirement was not met and advised the named consumer’s Behaviour Support Plan was completed prior to the Site Audit, and includes the assessment that pain was a trigger for their behaviours. The service noted this was the only area where the requirement was assessed as not met and described the multidisciplinary approach and regular reviews by other health professionals to effectively manage the consumer’s other health conditions.

I have considered the Assessment Team’s report and the response from the approved provider. I have placed weight on the positive consumer feedback received regarding their needs, goals and preferences being met, the positive action taken by the service to amend the named consumer’s Behaviour Support Plan, and the fact that the Assessment Team did not identify gaps in the care plans of other sampled consumers with respect to their needs goals and preferences. Accordingly, I find Requirement 2(3)(b) is compliant.

The Assessment Team found the approved provider has processes in place to ensure assessment and planning is based on an ongoing partnership with consumers, the people they wish to be involved in their care and other organisations and providers of care. Consumers and representatives confirmed they had been involved in their care planning, and their needs were being met.

The Assessment Team found the approved provider demonstrated the outcomes of assessment and planning are effectively communicated to consumers, documented in their care and services plan and readily available to consumers. Consumers and their representatives confirmed they had been involved in case conferencing to review care plans, were informed about the results of assessments and had been provided with a copy of their care plan.

The Assessment Team found the service demonstrated that care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Consumers and representatives confirmed they had been informed when changes in in the consumer’s condition occurred. Review of care documentation showed care plan reviews and assessments were up to date.

# 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. | 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. | Non-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

This Quality Standard has been assessed as non-compliant as three of the seven specific requirements are non-compliant

The Assessment Team found the organisation has policies and procedures to guide the delivery of safe personal and clinical care. Most feedback provided by consumers and representatives about their personal and clinical care was positive. However, feedback from some sampled consumers and representatives, and care documentation reviewed, showed their clinical care is not always safe and effective, in line with best practice and does not optimise their health and wellbeing. The Assessment Team identified wound management and pressure injury prevention were not managed in line with best practice. Documentation for a new wound sustained by one consumer was delayed, checks and dressing changes occurred less frequently than directed, and wound measurements were not documented in the wound chart for progress review. Gaps were also identified in diabetes management and blood glucose monitoring, pain management and responsive behaviour management, psychotropic medication management and restrictive practices

The approved provider responded to the Assessment Team’s report and advised that prior to the Site Audit the service had commenced improvements to their electronic care planning system to ensure improved wound assessment and monitoring to be implemented in April 2023, and management of psychotropic medication and restrictive practices implemented in March 2023. All wounds have been reviewed, care plans were updated to include clinical specialist and medical advice, care changes were implemented, and wounds are being monitored by incident reporting, audits and feedback. Discussions were held with the consumes’ representatives and the medical officer to optimise consumers’ outcomes, and pain assessments are occurring as directed. All charts for residents with diabetes mellitus were reviewed, and staff training in glucose monitoring was completed. The Responsive Behaviour Support Plan and pain management for the consumer named in the Assessment Team report, were improved.

I acknowledge the actions taken by the service in response to the Assessment Team’s feedback, and improvements made to wound and psychotropic medication management systems prior to the Site Audit. However, I consider the identified gaps in clinical and personal care, particularly in clinical monitoring, did not demonstrate best practice care and posed a significant risk to some consumers’ health and safety. The service is still undertaking improvements, and I encourage them to embed those improvements into their usual practice. To ensure each consumer gets safe and effective care. Accordingly, I find Requirement 3(3)(a) is non-compliant.

The Assessment Team found the service did not demonstrate deterioration or change of mental health, cognitive or physical function, capacity or condition for all consumers is recognised and responded to in a timely manner. Some consumers advised they had not been reviewed by a medical officer when there was a change in their condition. Care documentation for 2 sampled consumers showed escalation and response to deterioration did not occur in a timely manner, including contacting the medical officer, when one consumer had several episodes of blood glucose levels outside the normal range, and when another consumer had several episodes of low blood pressure, whose condition continued to deteriorate up to and during the Site Audit when management advised they were waiting for medical to review the consumer.

The approved provider responded to the Assessment Team’s report and advised procedures for the management of deterioration have been re-distributed to staff ahead of training to be provided and monitoring of improvement will be managed by documentation audits and incident management processes. The service’s plan for continuous improvement states recent referral time frames were reviewed with the medical officer, who stated all escalations to them had occurred in a timely manner.

I acknowledge the approved provider’s actions show a commitment to improve recognition and responsiveness to deterioration and changes in a consumer’s condition. However, I note that it will take some time for these improvements to be embedded into usual practice. Accordingly, I find the Requirement 3(3)(d) is non-compliant.

The Assessment Team found the service has systems in place to manage an outbreak and minimise infection related risks. However, staff were observed breaching infection control protocols and some consumers with infections were not being managed appropriately. Some staff members were observed to be touching or wearing their face masks incorrectly. Staff were observed not following sanitising procedures for shared equipment after use, and antibiotics were prescribed and administered before pathology was confirmed for a consumer with a suspected urinary tract infection (UTI), that returned a negative test result. Clinical waste bins located in an area accessible to consumers were observed to be overflowing. Management said the waste contractor from the local council had not collected the bins for several weeks.

The approved provider responded to the Assessment Team report and acknowledged some staff were not wearing personal protective equipment correctly during the Site Audit, and their normal clinical waste removal timeframe was impacted by disruption to the services provided by the clinical waste removal contractor. The provider also noted its remote regional location of the service. The provider advised the prescription of antibiotics prior to obtaining pathology for the consumer named in the Assessment Team’s report, was not consistent with the service’s clinical pathway for suspected UTIs. The service advised urgent education has been delivered to staff on the correct infection transmission and control procedures, and all current infections and treatment have now been reviewed.

I acknowledge the actions the service has taken to improve its infection control practices. However, the service is responsible for ensuring safe storage and disposal of clinical waste and to have a contingency plan in place (which it now has) in the event of a disruption to collection services. The service did not demonstrate it took effective actions to minimise transmission-based precautions when this occurred, which posed a significant infection control risk to consumers and staff over an extended time period. I consider the improvement actions taken by the provider will take time to demonstrate effectiveness and sustainability. Accordingly, I find Requirement 3(3)(g) is non-compliant:

I am satisfied the remaining four requirements of Standard 3 Personal care and clinical care, are compliant.

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks in the care of each consumer. While at the commencement of the Site Audit management advised the Assessment Team there were no high impact or high prevalence risks for consumers at the service. However, review of a service benchmarking report showed there was a high prevalence of falls and urinary tract infections (UTIs). Care documentation did not show appropriate post fall assessments were completed for sampled consumers nor the frequency of post fall neurological monitoring met organisational requirements. The Assessment Team identified administration of pain medication was not always done by the registered nurse. Staff medication competence and qualifications have been considered in Requirement 7(3)(c).

The approved provider responded to the Assessment Team’s report and advised the service uses an incident management system to track, trend, analyse and address reasons for incidents such as UTIs and falls. Incident analysis for the period October 2022 to January 2023 did not show any specific reasons for the increase in falls rate but did identify the service’s falls prevention and management procedure and UTI clinical pathway were followed. Graphs from these reports were included in the provider’s response.

I acknowledge the Assessment Team’s report, and I have considered the approved provider’s response. The bench marking data showed falls in January minimally exceeded the benchmark number determined by national and international best practice. The number of UTIs fell significantly in both November and December 2022 demonstrating there was not a sustained increase from October 2022 to January 2023. There was no evidence of serious impact resulting from increased UTIs provided in the Assessment Team report, while the impact of multiple falls was noted for one consumer. I am not satisfied that overall, the increased number of UTIs and falls, without sufficient evidence of significant consumer impact, demonstrates ineffective management of high impact or high prevalence risks to consumers’ health, safety, and wellbeing, by the approved provider. Accordingly, I find Requirement 3(3)(b) is compliant.

The Assessment Team found the service has implemented effective systems for palliative care and end-of-life care. Care documentation for consumers receiving or who had received end-of life-care showed appropriate care was provided. Staff were knowledgeable regarding end-of-life care.

The Assessment Team found systems for communicating information about consumers’ care have not been effective for all consumers. Care documentation showed information about some consumers’ condition has not been shared with medical officers and information and orders from medical officers have not been shared with staff. The lack of documented evidence of communication/escalation to the medical officer when two consumers’ conditions changed and/or deteriorated has been considered in Requirement 3(3)(d). Management advised Some medical officers completed hand-written consultation notes kept in paper files rather using the provider’s electronic care planning system, resulting in multiple sources of information regarding consumers where important care information may be missed.

The approved provider responded to the Assessment Team’s report and advised it has addressed documentation issues as a matter of urgency. The service’s plan for continuous improvement notes the service continues to work with the town’s only medical officer on information sharing, including current discussions about the medical officer entering their notes directly into the electronic clinical records. Based on their evidence provided, I am satisfied the provider has taken significant steps to address communication issues with the medical officer.

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services is occurring in a timely manner. This was evident in care documentation, positive feedback from consumers and representatives regarding access to health professionals, and staff who were able to describe the processes for referring consumers to other health professionals. Gaps in referrals to the medical officer have been considered in Requirement 3(3)(d).

I find Requirements 3(3)(b), 3(3)(c), 3(3)(e) and 3(3)(f) are compliant.

# 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 seven of the seven specific requirements are compliant.

The Assessment Team found that the approved provider was able to demonstrate consumers receive safe and effective services that enhance and maintain their independence, well-being and quality of life. Consumers and representatives said they were satisfied services and supports for daily living meet their needs, goals and preferences. Staff demonstrated a sound knowledge of consumers individual needs and preferred activities and how they support consumers to meet their needs, goals and preferences. Care planning documentation reflected what is important to consumers and what they like to do.

The approved provider demonstrated that services and supports for daily living promote each consumer’s emotional, spiritual and psychological wellbeing. Appropriate referrals are made to external services when required. The organisation provides scheduled religious services for consumers to attend. Consumers described how staff support their needs. Staff were able to provide examples of supporting consumers with their emotional well-being and the services and supports to support consumers’ social, emotional and psychological needs.

The Assessment Team interviewed consumers who said they felt the service supported them to participate in their community within and outside the service, to engage in social and personal relationships important to them and to do the things of interest to them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer.

Consumers and representatives confirmed information about their condition, needs and preferences related to lifestyle is communicated within the service and with others where responsibility for care is shared. Staff demonstrated sound knowledge of individual consumers. The service demonstrated it has effective processes and systems in place to identify and record each consumer’s condition, needs and preferences, including changes as they occur.

The Assessment Team found the approved provider demonstrated timely and appropriate referrals are made to individuals, other organisations and providers of other care and services. Consumers advised when the service is unable to provide suitable support, they are confident they will be appropriately referred to an external service. Staff provided examples of consumers being referred to other care providers for lifestyle support. Care plans showed the service works with external providers to support the diverse needs of consumers.

The Assessment Team found the approved provider demonstrated that where meals are provided, they are varied and of suitable quality and quantity. Sampled consumers said the service provides a range of meals which are varied and of suitable quality and quantity. The service has processes in place to include consumers in the development of the menu and to provide feedback on the quality of the food provided.

Th Assessment Team identified that where equipment is provided, it is safe, suitable, clean and well maintained. Consumers and representatives confirmed they feel safe when using the service’s equipment and it is easily accessible and suitable for their needs. They said they were comfortable to report required repairs and that equipment was replaced when necessary.

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Non-compliant |

Findings

The Quality Standard has been assessed as non-compliant as two of the three specific requirements are non-compliant.

The Assessment Team found several areas of the service environment were not safe, clean and well maintained and did not enable consumers to move freely both indoors and outdoors. There were several locked doors around the service that consumers were unable to open, containers of chemicals were observed stored in the smoking area, carpeted areas throughout the service had multiple stains. The Assessment Team observed there was, and there were insufficient fire-fighting equipment at the service. The issue of exposed clinical waste was considered in Requirement 3(3)(g).

Consumers and representatives provided positive feedback about maintenance and cleanliness of the service. Maintenance records showed cleaning and preventive maintenance schedules are being followed. However, the maintenance officer confirmed maintenance of certain items required council approval because the building is leased from council, and it can take considerable time for Council to address maintenance issues.

The approved provider responded to the Assessment Team’s report and agreed with the Assessment Teams recommendation the requirement was not met. The service advised it has the council had not removed the bins for 3 weeks despite multiple calls by the service. The provider has undertaken immediate actions to remedy the issues raised, including review of all cleaning schedules, modification of the environmental audit program, urgent collection of clinical waste bins by a new contractor and changes made to the clinical waste contingency plan. An urgent meeting has been arranged with council to expedite required repairs, and signage has been placed in smoking areas. The service noted its fire-fighting equipment meets safety and legislative requirements as per the Annual Fire Safety statement. I have considered the provider’s response and commend the actions it has taken to address the Assessment Team’s findings. However, I understand that it will take some time to reflect compliance with this requirement. Accordingly, I find Requirement 5(3)(b) is non-compliant.

The Assessment Team found the service did not demonstrate furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. Most sampled consumers and representatives confirmed they were satisfied with the equipment, furniture and fittings at the service. However, the Assessment Team observed some furniture and fittings were not clean or well maintained. Several armchairs and couches had stains or ripped upholstery. Several wooden outdoor chairs appeared unsteady, and one chair was broken. An oven in a cottage servery area was observed to be dirty underneath the oven door.

The approved provider responded to the Assessment Team’s report and agreed with the Assessment Teams recommendation the requirement was not met. The service advised it has undertaken immediate actions to remedy the issues raised, including removal of all broken furniture, replacement furniture has been ordered and is expected to arrive in 6 weeks, and the environmental audit program has been improved to ensure increased oversight of this requirement. I acknowledge the provider’s response and improvements it has put in place to resolve the issues identified. However, I understand it will take some time to reflect compliance with this requirement and to ensure the improvements are sustained. Accordingly, I find I find the Requirement 5(3)(c) is non-compliant.

I am satisfied the remaining requirement of Standard 5 Organisation’s service environment is compliant.

The Assessment Team found the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. Consumers said there are enough indoor and outdoor private areas for them to socialise with visitors, and said they had enough equipment and resources of suitable quality to support their independence and enjoy activities. The doors to consumers’ rooms had pictures to aid recognition.

# 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 Quality Standard has been assessed as compliant as four of the four specific requirements are compliant.

The Assessment Team found that the service was able to demonstrate consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. Consumers and representatives confirmed they felt comfortable and safe to provide feedback and complaints and that the service takes appropriate action in response to their concerns. Staff described how they encourage consumers to make complaints. Complaints and feedback are captured through surveys, complaint forms and resident meetings.

The Assessment Team found there is consumer advocacy information in the consumer handbook and consumer agreements, and there are signs and brochures throughout the service in various languages. There are also advocacy and language resources available on the Seniors Rights Service, OPAN and Telephone Interpreting Service (TIS). The service demonstrated how it supports consumers living with hearing impairment to communicate their concerns using communication support devices.

The Assessment Team found the approved provider takes appropriate action in response to complaints and an open disclosure process is used when things go wrong. Complaints documentation showed and consumer and representative feedback confirmed management responds and takes action in relation to their concerns. The service uses an open disclosure process when things go wrong. The service has documented policies on open disclosure and staff were able to demonstrate an understanding of the open disclosure process. Consumer feedback confirmed the service practices open disclosure.

The approved provider demonstrated complaints and feedback are reviewed by the management team and used to inform continuous improvement at the service. The electronic complaints system showed complaints are tracked and trended to implement actions and initiate continuous improvements. Documentation shows complaints are investigated and analysed to understand and improve the quality of care and services. Complaint data is analysed to identify trends from information captured through complaint forms, surveys, monthly resident meetings, and verbal complaints.

# Standard 7

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

Findings

The Quality Standard has been assessed as non-compliant as one of the five specific requirements are non-compliant.

The Assessment Team found the service has an insufficient number and mix of staff to provide timely, safe and quality care and services. Half the sampled consumers and their representatives interviewed said the service has insufficient staff, noting impacts such as not receiving showers, or not being showered at their preferred time, concern about safety if they fell at night, and difficulty getting help from staff on weekends.

Seven out of eight staff interviewed advised they consistently felt the impact of insufficient staffing especially during the afternoon and night shifts, and morning shifts are regularly short staffed. Impacts mentioned by staff included providing rushed personal care, unable to spend quality time with consumers, sometimes they were unable to effectively assess clinical needs, not documenting progress notes, and needing to leave consumers while providing personal care to attend to other consumers. Two care staff are allocated on night shift with no registered nurse on site. Management advised that for clinical emergencies care staff contact a registered nurse at one of their other services, who has access to care plans and systems or to call an ambulance. Management said there are 6 consumers who require assistance from 2 or more care staff. The service has a casual pool of 6 staff who are trained to perform as care staff, lifestyle, and kitchen staff.

Call bell response times showed the majority were less than 5 minutes, but some exceeded one hour. Staff advised they regularly attend call bells quickly to find out what the consumer needs and then ask the consumer to wait while they attend to other consumers.

The approved provider responded to the Assessment Team report and agreed that the requirement was not met. The service advised it has experienced unprecedented workforce challenges over the past 10 months. It has a strategic workforce plan, ongoing partnerships with education providers and an ongoing on-the-job training program to increase its workforce capacity.

I acknowledge the recruitment and retention challenges faced by the service. However, I place weight on the extensive feedback received from consumers and staff about the negative impacts of insufficient staffing on consumer health, safety and wellbeing, particularly on the night shift. Two care staff rostered on night shift, with 6 consumers requiring 2 or more to assist, poses the risk that care needs of all consumers cannot be met in a timely manner if an incident occurs and/or multiple consumers require assistance at once. I encourage the approved provider to continue to maintain their focus on the attraction and retention of skilled and qualified staff to ensure safe and quality care and services. Accordingly, I find Requirement 7(3)(a) is non-compliant.

I am satisfied the remaining four requirements of Standard 7 Human resources are compliant.

The Assessment Team found the service demonstrated workforce interactions with consumers are kind and caring and respectful of each consumer’s identity culture and diversity. Consumers and representatives consistently stated staff are kind and caring and treat them with respect. Staff were familiar with consumers’ backgrounds and preferences and adjusted their support to suit consumer’s needs. The service demonstrated it regularly reviews and updates care plans including consumers identity, culture, and diversity preferences.

The Assessment Team identified that over all the service demonstrated staff are regularly monitored and assessed to ensure they have skills, qualifications and knowledge required to effectively perform their roles and provide quality and safe care and services. Consumers and representatives advised they feel staff are competent and provide quality care. Staff demonstrated an accurate understanding of policies and processes covered in training on SIRS, restrictive practices, infection control and clinical care. Records are maintained for clinical staff members’ clinical registration, medical and Certificate IV competencies and transcripts.

The Assessment team identified medication competent staff on the evening shift were acting beyond their scope of practice and legislative requirements by administering Schedule 4D and Schedule 8 medications to consumers. However, in their response the service confirmed medication competent staff administer those medications on the evening shift under the supervision of an RN based at one of their other facilities which is consistent with NSW health legislation for hostel services with aged care residents.

The Assessment Team found the approved provider demonstrated it has recruitment policies and processes in place and staff are provided with training and education in all areas related to the delivery of safe and quality outcomes for consumers in line with the Quality Standards. However, clinical care shows staff are not providing the clinical outcomes required by the Quality Standards, in the areas of wound management, pain management, and management of blood glucose monitoring. Deficits in these areas of care for some sampled consumers were considered in Requirement 3(3)(a).

The Assessment Team found the approved provider demonstrated regular assessment, monitoring and review of the staff performance in line with the Quality Standards and best practice is undertaken. Records reviewed showed performance reviews are up to date. Documentation shows performance review feedback is sourced from consumers and representatives, surveys, audits, and incident data and is provided to staff members to aid their professional development and support staff to achieve results

I find Requirements 7(3)(b), 7(3)(c), 7(3)(d) and 7(3)(e) are compliant.

# 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

The quality standard has been assessed as compliant as five of the five specific requirements are compliant.

The Assessment Team found the approved provider was able to demonstrate it supports consumers to engage in the development, delivery and evaluation of care and services. Consumers and representatives confirmed the service encourages feedback about their care and services through surveys, audits, verbal and in writing and resident’s meetings. The board incorporates feedback and data from consumers and representatives into the annual and 3-year strategic plan. The board has online consumer engagement forums to receive feedback. Board members make a yearly visit to the service and host a meeting with consumers and representatives to obtain first-hand feedback.

The approved provider’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Chief Executive Officer disseminates board communications to staff and management via email and other digital systems. Organisational values statements are displayed in multiple areas. Staff confirmed they regularly receive communications from the board and the management team relating to values and relevant organisational information. Consumers and representatives advised they feel safe, the place is run well, and they are happy with the quality of care and services provided by the management team and staff members.

The Assessment Team found the approved provider had effective organisation wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The Assessment Team found the approved provider has risk management systems and practices that incorporates current legislative requirements and reflects best practice. However, it did not demonstrate effective management of high impact, high prevalence risks in relation to wound care and falls management. The service benchmarking report shows a high prevalence of falls with a significant increase in falls from none at the start of July 2022 to 19 by the end of the January 2023. The falls increase were considered in Requirement 3(3)(b) and management of wound care risks were addressed in Requirement 3(3)(a). Accordingly, I find Requirement 8(3)(d) is compliant.

The Assessment Team found the service has an incident management system, investigates incidents, and implements and reviews mitigation strategies. The board receives incident reports, quality audits and management reports identifying risks to consumers and providing recommended mitigation strategies. The board supports the service to support consumers to take risks and live their best life through policies and processes and review of risks. Care documentation showed consultation with consumers and representatives about risks and signed consumer/representative consent forms containing risk mitigation strategies. Serious Incident Reporting Scheme (SIRS) reports demonstrated the service is identifying and responding to incidents correctly and there is a low number of SIRS incidents. Training records showed staff received training in SIRS policies and processes, and they were able to explain them.

The approved provider responded to the Assessment Team’s report and suggested the evidence in the report was supportive of a recommendation of met against the requirement. The service provided further information about its risk governance system, noting it has both internal and external reporting of incident rates that monitor performance, and provide reports to the staff, management and the governing body. I acknowledge the approved provider’s response and have considered the Assessment Report. I find the service’s evidence to be more compelling. Accordingly, I find requirement 8(3)d) to be compliant.

The Assessment Team found the approved provider has a clinical governance framework to provide safe and quality outcomes in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure. The board promotes a culture of continuous improvement in relation to clinical safety and quality through communication of clear accountabilities and expectations to management and staff. The board reviews clinical data and trends from audits and reporting at monthly meetings with the management team. The management team review clinical matters such as antimicrobial stewardship and provide recommendations to the board. However, care documentation for one named consumer did not demonstrate all staff have a good understanding of antimicrobial stewardship and the precautionary measures recommended prior to using prescribed antibiotics. This issue regarding gaps in antimicrobial stewardship was considered in requirement 3(3)(g).

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