Performance

Report

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| Name: | Koorooman House Nursing Home |
| Commission ID: | 3419 |
| Address: | 23 Sloan Avenue, LEONGATHA, Victoria, 3953 |
| Activity type: | Site Audit |
| Activity date: | 13 February 2024, 19 February 2024 to 21 February 2024 |
| Performance report date: | 28 March 2024 |
| Service included in this assessment: | Provider: 900 Gippsland Southern Health Service  Service: 2172 Koorooman House Nursing Home |

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 Koorooman House Nursing Home (**the service**) has been prepared by P. Wallner, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 25 March 2024.
* other information held by the Commission.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 2(3)(a) - Ensure assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* Requirement 3(3)(a) - Ensure each consumer gets safe and effective personal and clinical care, that is best practice, tailored to their needs, and optimises their health and well-being.
* Requirement 7(3)(d) - Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 8(3)(c) - Ensure effective organisation wide governance systems relating to regulatory compliance and workforce governance.

# 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 is assessed as Compliant as 6 of the 6 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 1(3)(b) was Not Met. The Site Audit found consumers did not receive culturally safe care. Evidence brought forward included:

* Three representatives expressed concern about the cultural safety of care due to a lack of language translation support and not enough meals reflecting consumers’ original national cuisine.
* Staff were aware of consumers’ cultural backgrounds although they could not specify how this influenced their daily care delivery.
* Documentation demonstrated the service celebrates a range of culturally significant days and some meals on the menu did reflect cuisines from consumers’ country of origin.
* Care planning documents did not always detail consumers’ cultural needs and preferences.
* Management said they were unaware some consumers/representatives had requested particular cuisines, or that staff did not understand how to access interpreter services.
* Management explained that all consumers could speak some English and they also supported communication through the use of language cards and assistance from family members.
* Management demonstrated new entries on the Plan for Continuous Improvement to provide additional education to staff about accessing language support and introducing monthly cultural food days in addition to the existing varied menu.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the provision of culturally safe care. The provider advised:

* The issues raised by representatives in the Site Audit had not been raised through other feedback mechanisms such as the Residents and Relatives meetings or the Resident of the Day reviews.
* While the weekly menu already included several meal options from the national cuisine requested, a calendar of food days has also been created to celebrate culturally diverse foods.
* The service has access to a provider of interpreter services in person and via telephone or video call. The relevant policies and Resident Handbook have been updated and staff training in relation to accessing these services has been scheduled.
* Staff training from Dementia Training Australia has also been booked to support staff in providing care to consumers with dementia whose first language is not English.
* The service is actively seeking volunteers with language skills to provide consumers with additional access to conversation and activities in their preferred language.

I have further considered issues related to consumers’ dietary needs and preferences under Requirement 4(3)(f). I acknowledge the gaps identified in the Site Audit and note the service immediately created improvement actions which included training staff in accessing language support and expanding the menu to include additional cultural meals, and celebrating cultural days. Given the provider’s improvement actions taken during, and since, the site audit, I am satisfied they have taken appropriate steps to address the issues identified and meet the cultural needs of consumers. Therefore, on the balance of the evidence before me, I find Requirement 1(3)(b) Compliant.

The Assessment Team recommended Requirement 1(3)(d) was Not Met. The Site Audit found the service was not able to demonstrate how they supported consumers to take risks to live the life they chose. Evidence brought forward included:

* While there was evidence of consumers taking risks, consumers and representatives could not enunciate ways the service supported them to understand and minimise the risks they took engaging in their chosen activities.
* One consumer identified as a falls risk was wearing ill-fitting slippers and another consumer with diabetes was eating non-diabetic food provided by their family. Consumers’ care planning documents did not include the benefits, risks, and mitigation strategies associated with their choice to take risks.
* Staff could not always explain how each consumer was supported to understand the benefits and possible harms when they were making decisions around taking risks.
* The service had a dignity of risk policy however, dignity of risk authorisations sighted did not clearly identify the risks, record the risk/benefit discussions with consumers/representatives, or detail the mitigation strategies.
* Management demonstrated a Plan for Continuous Improvement action (with a completion date of 19 March 2024) was created to strengthen the assessment and documentation of risks to include advantages/disadvantages, risk mitigation strategies, and discussion with consumers/representatives to ensure informed consent.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to supporting consumers to take risks to live the life they chose. The provider advised:

* Dignity of risk reviews are conducted by clinical managers rather than general clinical staff and the service uses different terms to those used by the Assessment Team in relation to consumers being supported to take risks. Some staff may have appeared confused about the risk assessment process because of this.
* The consumer identified as a falls risk was being supported to exercise their choice in relation to what, if any, footwear they wore. The consumer declined the offer of new footwear and has been assessed by both a podiatrist and physiotherapist. Staff respect the consumer’s changing footwear preferences, and the service disagrees that the documented risk assessment was inadequate.
* A Privacy, Dignity and Choice Authorisation form had been completed by the authorised representative of a diabetic consumer who chose to eat some non-diabetic food brought in by their family. While this consumer had not indicated a strong preference for meals reflecting their national cuisine their meal preferences will be supported.
* The service has strengthened the processes for managing dignity of risk, to ensure there is a documented risk assessment, a review of the privacy dignity and choice authorisation form.

While there were some gaps in documentation identified in the Site Audit, I consider there is evidence consumers were being supported to make choices involving risks and live the life they chose. I note the service immediately created improvement actions which included strengthening their documentation and processes for assessing and managing risks chosen by consumers. Given the provider’s improvement actions taken during and since the site audit, I am satisfied each consumer is supported to take risks to enable them to live the best life they can. Therefore, on the balance of the evidence before me, I find Requirement 1(3)(d) Compliant.

I am satisfied the remaining 4 Requirements in Standard 1 are Compliant.

Consumers and representatives stated staff treated them with dignity and respect. Staff were observed treating consumers with dignity and respect and addressing them by their preferred names. Care planning documents included information on consumer’s background, culture, and personal preferences. The Resident Handbook contained information about diversity, privacy and respect, and the Charter of Aged Care Rights, which was also displayed throughout the service.

Consumers said they were supported to make choices about their care and daily lives, and who is, or is not, to be involved in their care, and staff were aware of these decisions. Consumers and representatives felt supported to maintain their relationships. Staff showed they knew consumers well, and described how they supported them to make decisions about their care and make and maintain their chosen relationships. Care plans detailed consumers’ care and lifestyle choices and the involvement of others in their care decisions such as their next of kin.

Consumers and representatives said they were provided with regular and timely information that enabled them to make choices about their care and services, and what was happening at the service. Staff explained the various ways they provided current information to consumers and representatives to help them to exercise choice. Notice boards displaying information about activities, events and other issues were observed around the

Consumers and representatives confirmed their personal privacy was respected and their personal information kept confidential. Staff described how they maintained consumers’ privacy when providing care, and how they ensured consumers’ information was securely stored. Staff were observed interacting respectfully with consumers such as by knocking on doors, announcing themselves, and explaining to consumers what they were doing. The service had written policies and procedures to guide staff in maintaining privacy and confidentiality.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

This Quality Standard is assessed as Not Compliant as 1 of the 5 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 2(3)(a) was Not Met. While consumers felt they received safe and effective care, the Site Audit found the assessment and planning of care was not always completed with sufficient detail or adequate consideration of risks, to inform the delivery of safe and effective care and services. Evidence brought forward included:

* All consumers in the service had been classed as environmentally restrained, which was inappropriate for some consumers due to their inability to mobilise at all, or their ability to independently enter/ exit the service.
* Staff acknowledged risk assessments and behaviour support plans were not always fully documented and said time constraints and staff shortages contributed to risk assessments not being completed.
* Care documentation for consumers subject to restrictive practices did not always reflect appropriate risk assessment and risk management consultations had occurred and behaviour management plans documented, in accordance with the service’s restrictive practices policy.
* Management advised they had misapplied the legislative definition of environmental restraint and had been using the Restrictive Practice Authorisation forms to record risk assessments. Management raised Plan for Continuous Improvement actions to proactively review their current practices and ensure all consumers restraint status was assessed and correctly documented.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the assessment and planning of care. The provider advised:

* All 30 consumers in the service had a risk assessment in place relating to environmental restraint. The service acknowledges it was not correct to collectively assess all consumers as being environmentally restrained. Consumer’s individual mobility status has now been considered in their assessment.
* Additional staff education around restrictive practices was recently implemented with multiple sessions held in February. A follow up assessment will be implemented with the outcomes provided to the Older Persons Committee in May 2024.
* A review of all consumers’ care plans has been completed, including individualised risk assessments and review of their restraint status.

I note the service acknowledged gaps in staff knowledge around environmental restraint and completing and documenting individualised risk assessments. I accept the service moved quickly, during and since the site audit, to initiate various improvement actions which included staff education and a review of all care plans. While the service has taken improvement actions, it is too early to determine whether these actions are sustainably embedded in their processes and are effective in ensuring care planning includes an individualised assessment of risks with documented management strategies. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(a) Not Compliant.

The Assessment Team recommended Requirement 2(3)(b) was Not Met. While most consumers and representatives said staff knew their current and end of life care needs the Site Audit found documented assessments did not always reflect changes in consumer’s conditions and behaviours. Evidence brought forward included:

* Management and clinical staff explained the processes in place to identify the current needs, goals and preferences of consumers, and their end of life plans.
* Some consumers subject to environmental or chemical restraint did not have appropriate behaviour support plans in place.
* One consumer’s current pain assessment was not appropriately documented however, this was rectified during the Site Audit.
* Management acknowledged some gaps in the assessment of consumer’s care needs, and the need to complete detailed behaviour support plans with triggers identified and behaviour management strategies to use, prior to administering medication.
* Management advised the had created actions on the Plan for Continuous Improvement to review and update all consumer’s assessments and provide additional education on restrictive practices.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the assessment and planning of consumer’s needs, goals and preferences. The provider advised:

* The service acknowledges the Site Audit finding that most consumers and representatives said staff provide respectful care and knew consumers’ personal and clinical care needs, and their end of life care needs.
* All consumers’ care plans have been reviewed and updated, including their advanced care plans and behaviour support plans.
* The resident of the day procedure has been updated to schedule monthly reassessment and regular review of restrictive practice status.
* Additional dementia education has been scheduled to support staff in consistently documenting behavioural support plans.

I acknowledge the evidence brought forward in the Site Audit of gaps in the assessment and planning of consumers’ care. I note the service immediately created improvement actions which included reviewing and updating all assessments and scheduling staff training. Given the provider’s improvement actions taken during, and since, the site audit, I am satisfied they have taken appropriate steps to effectively address the issues identified. Therefore, on the balance of the evidence before me, I find Requirement 2(3)(b) Compliant.

I am satisfied the remaining 3 Requirements in Standard 2 are Compliant.

Consumers and representatives confirmed they were involved in assessment and care planning, and could choose who else was involved such as medical officers, allied health professionals and family members. Management and clinical staff confirmed consumers and representatives were involved in regular care evaluations and care planning documents showed the input of consumers, representatives and other health professionals.

Consumers and representatives confirmed they were involved in care evaluations, and the outcomes of assessments and any changes to care were communicated to them, and copies of care plans were offered. Staff and care documentation confirmed consumers and representatives were consulted when care was evaluated.

Consumers and representatives said the care and services were regularly evaluated and reviewed when incidents occurred, and when consumer’s care needs changed. Management and staff described the processes in place for scheduled care evaluations and reviews following a change in condition or circumstance. However, while care documentation of consumers sampled demonstrated care evaluations and review occurs in progress notes, gaps in the process for completing assessment plans have been observed and this is further discussed in requirement 2(3)(b).

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

This Quality Standard is assessed as Not Compliant as 1 of the 7 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 3(3)(a) was Not Met. While consumers and representatives were satisfied with the personal and clinical care provided, the Site Audit identified deficiencies related to restrictive practices, manual handling and the management of temperature sensitive medications. Evidence brought forward included:

* Consumers, representatives and clinical staff expressed concerns about the safe manual handling of consumers during transfers with examples of poor technique being described.
* Records indicated only 58% of staff had completed the mandatory annual training module Practical Handling Competency.
* Management agreed some of the manual handling examples described were not in line with best practice and stated they would include actions on the Plan for Continuous Improvement to improve staff education and the manual handling policy.
* Some lapses in procedures for the cold storage of temperature sensitive medications were identified. Temperatures were not always being recorded and excursions outside the correct temperature range not always documented and investigated.
* Management acknowledged the monitoring of the storage of temperature-sensitive medications was not in line with best practice and they provided a comprehensive Plan for Continuous Improvement action dated 14 February 2024.
* Gaps were identified in the assessment and documentation of consumers subject to restrictive practices and the management of behaviours. One representative expressed concern the service was not managing changing behaviours by not providing language support to address a behavioural trigger. These are further considered under Requirements 2(3)(a) and 2(3)(b).

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the provision of safe and effective personal and clinical care. The provider advised:

* The classification of consumers subject to environmental or chemical restraint has been reviewed and corrected, with individualised behaviour support plans put in place, where applicable.
* The service always trials non-pharmacological behaviour support interventions before administering chemical restraint with authorisation/consent.
* Additional staff education has been provided regarding restrictive practices. A follow up assessment of staff’s knowledge on restrictive practices will be implemented and the outcomes reported to the Older Persons Committee in May 2024.
* Senior Leaders also attended an education session on restrictive practices conducted by the Aged Care Quality and Safety Commission on Monday 26 February 2024.
* The service has now completed a range of Plan for Continuous Improvement actions to ensure temperature sensitive medications are stored and managed correctly.

I note the service acknowledged gaps in the provision of safe and effective personal and clinical care, and moved quickly to initiate improvement actions during, and since, the Site Audit. While the service has taken some improvement actions, it is too early to determine whether these actions are sustainably embedded in their processes and prove effective in ensuring each consumer gets safe and effective personal and clinical care, that is best practice, tailored to their needs, and optimises their health and well-being. Therefore, on the balance of the evidence before me, I find Requirement 3(3)(a) Not Compliant.

I am satisfied the remaining 6 Requirements in Standard 3 are Compliant.

Overall, consumers and representatives expressed satisfaction with the management of risks to consumers’ health and well-being. One representative expressed concern about staffing levels during the night, which I have considered under Requirement 7(3)(a). Management and clinical staff described effective practices for the management of high impact and high prevalence risks associated with the care of consumers. Care documents showed effective risk management strategies were implemented to support consumers’ health.

Consumers and representatives confirmed they had been provided with an opportunity to discuss their end of life wishes with clinical staff. Management and clinical staff explained the processes used to support end of life care, including the involvement of family, health professionals and external organisations. Care documentation demonstrated consumers’ end of life wishes and care needs were documented and followed accordingly.

Consumers and representatives were satisfied with how consumers’ condition was monitored, and their changing care needs responded to appropriately. Management and staff described how they recognised and responded to a deterioration or change in consumers’ condition. Care documentation confirmed staff responded to signs of deterioration or change in condition.

Consumers and representatives said information about consumers’ condition, needs and preferences was communicated between staff and with others responsible for providing care. Clinical staff described the processes for documenting and communicating information about consumers’ condition and needs throughout the service, and to others involved in providing care. Care planning documents confirmed current information about consumers’ condition, needs and preferences was documented and communicated effectively.

Consumers and representatives confirmed they were referred to other providers of care, including allied health professionals and external organisations, when required. Management and clinical staff described the referral process which considered consumers’ needs and preferences. Care documents demonstrated timely referrals to other organisations and providers of care.

Consumers and representatives expressed satisfaction with the infection prevention and control practices at the service. The service had an infection prevention and control lead and written policies and procedures providing guidance on outbreak management and antimicrobial stewardship. Staff described how infection risks were minimised and risks associated with antimicrobial resistance were mitigated.

# 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 is assessed as Compliant as 7 of the 7 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 4(3)(e) was Not Met. The Site Audit found not all consumers were provided with timely and appropriate referrals to other providers of care and services. Evidence brought forward included:

* Two representatives said the service had not met their requests for additional lifestyle supports such as bilingual volunteers and pastoral visits.
* Staff could not describe how they worked with outside organisations to provide additional activities and supports for consumers.
* Care planning documents did not reflect consumers being supported by external organisations.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to timely and appropriate referrals to other providers of care and services. The provider advised:

* The service has taken proactive measures to seek the additional lifestyle supports suggested by representatives including advertising for volunteers that speak different languages. This is further considered under Requirement 1(3)(b).
* The staff interviewed may not been involved in the Leisure and Lifestyle Program initiatives. The service already conducts church services and pastoral visits on site.
* The service’s lifestyle calendar confirms it does work with various external providers to deliver additional leisure and lifestyle activities including Vision Australia, Dementia Services Australia, and various local entertainers.
* The service has further strengthened the leisure and lifestyle referral process and provided additional education for staff.

I acknowledge 2 representatives had offered suggestions for additional in-house lifestyle services. I note the evidence demonstrating the efforts made by the service to meet the lifestyle needs and preferences of all consumers. I further note the service has identified and implemented additional initiatives aimed at strengthening the lifestyle program and the process for referring consumers to providers of other care and services. Therefore, on the balance of the evidence before me, I find Requirement 4(3)(e) Compliant.

I am satisfied the remaining 6 Requirements in Standard 4 are Compliant.

Consumers said their needs, goals, and preferences for daily living were being met and they were supported to do the things they wanted to do. Staff described how they supported consumers to live the life they chose, and do what was important to them. Care plans described consumers’ lifestyle needs, goals and preferences, and how the service could support their independence and well-being. Consumers were observed actively participating in activities.

Consumers said their emotional, spiritual, and psychological well-being was supported by the service. Staff described how they supported consumers’ emotional, spiritual, and psychological well-being through individualised strategies, activities of interest, and one-to-one support. Care plans provided information on consumers’ religious and spiritual needs and preferences, and how they wanted to be supported emotionally.

Consumers said the service encouraged them to have personal and social relationships and do things of interest to them. One consumer said they would like to go on more bus trips into the community. Management demonstrated they were actively recruiting volunteers to facilitate more bus trips as part of the activities schedule. Staff described how they supported consumers to engage in activities of interest and maintain important relationships. Consumers’ care plans contained a detailed lifestyle assessment.

Consumers and representatives said staff were aware of their current needs and preferences and provided support accordingly. Consumers said they were comfortable communicating changes to their needs and preferences to staff. Staff described how they checked consumers’ care information daily and were notified of any changes to their care needs. Care documentation showed up to date information about consumers’ needs, goals or preferences for daily living.

Consumers and representatives said they were very satisfied with the meals provided which met their needs and preferences. Consumers said they enjoyed the mealtime experience, and they provided feedback to the service about the food. Two representatives said they had requested more Italian meals some time back however, the kitchen staff were unaware of this request and said they already provide some Italian meals but would be happy to accommodate these requests. Kitchen staff explained how they knew each consumer’s dietary needs and preferences, and ensured they were met. Care plans and dietary documents included the dietary needs and preferences of the consumers and their preferences for mealtime location. Consumers appeared to enjoy the dining experience and socialised with other consumers and staff, who assisted consumers when needed.

Consumers and representatives said the equipment was safe, clean, and well maintained. Staff described the procedures used to ensure equipment was safe, clean and available for consumers when they needed it. Equipment appeared to be safe, clean, and well maintained with staff using it appropriately.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard is assessed as Compliant as 3 of the 3 Requirements have been assessed as Compliant.

Consumers stated they felt welcome and at home in the service. Staff and management explained how they ensured the environment was welcoming and supported consumers’ independence, interaction and function. Consumers’ rooms were personalised, and the service environment was observed to be clean and tidy, with wide clear hallways, and handrails to support mobility.

Consumers and representatives said the service environment was safe, clean and well maintained, and they could move around the service as they chose. Cleaning and maintenance staff described effective scheduled processes in place for cleaning and maintenance. The service environment was observed to be safe, clean and well maintained with consumers moving freely around, both inside and outside.

Consumers and representatives confirmed the furniture, fittings and equipment were safe, suitable, clean, and well maintained. Staff described how maintenance requests were made and attended to promptly. The furniture, fittings and equipment throughout the service appeared to be safe, suitable, clean, and well maintained.

# Standard 6

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

Findings

This Quality Standard is assessed as Compliant as 4 of the 4 Requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 6(3)(d) was Not Met. While some consumers and representatives reported their complaints were responded to and some actions taken, the Site Audit found feedback did not always result in improvements being made. Evidence brought forward included:

* The Site Audit identified some consumer/representative feedback or complaints which had not been recorded on the feedback register.
* Two representatives said they had made suggestions about lifestyle activities and supports which had not been actioned, and one consumer said their feedback about disliking the gravy had not resulted in change.
* Management acknowledged some feedback had not been adequately recorded and addressed in line with their policies and procedures. Management advised a Plan for Continuous Improvement action dated 21 February 2024, would provide additional staff education regarding the complaints recording and management process.
* Consumer and Representative meeting minutes and the feedback register confirmed consumer feedback has led to improvements, such as the establishment of a men’s group.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to feedback and complaints informing improvements at the service. The provider advised:

* The service already provides chaplaincy, art and music activities regularly through the leisure and lifestyle program and is actively seeking bilingual volunteers in addition to the existing translation services.
* The service was actively implementing improvements to their feedback processes including reintroducing an onsite paper-based system, providing additional staff training and communicating with consumers and representatives.

In relation to some of the specific feedback, I have further considered issues related to food preferences under Requirement 4(3)(f), cultural support under Requirement 1(3)(b) and lifestyle activities under Requirement 4(3)(e). I acknowledge the Site Audit identified some gaps in documenting verbal suggestions however, there is evidence these suggestions had been considered by the service. While not all consumer and representative feedback has resulted in changes being implemented, I consider there is evidence the service reviews feedback and complaints and uses them to identify opportunities to improve the quality of care and services. The provider’s improvement actions taken during and since the site audit provide further evidence of consumer feedback driving improvements at the service. Therefore, on the balance of the evidence before me, I find Requirement 6(3)(d) Compliant.

I am satisfied the remaining 3 Requirements in Standard 6 are Compliant.

Consumers and representatives said they were comfortable raising feedback or making a complaint to the service when required. Management described various processes and pathways available to consumers and representatives to provide feedback and complaints to the services. Posters, brochures and forms for the independent complaints service were observed around the service and staff were seen seeking consumer and representative feedback at a Consumer and representative meeting. Management addressed issues raised around the anonymity of the complaints process and staff training during the Site Audit.

Consumers and representatives stated they were aware of advocacy and external complaints services. One representative expressed concern about staff not utilising interpreter services however, management advised staff had access to phone interpreter services and they were informed how to access these services if they were required. The service’s Plan for Continuous Improvement included actions related to improving staff knowledge and access to interpreter services. The service had policies, procedures and resources for staff about accessing translation and advocacy services. Information pamphlets for the Aged Care Quality and Safety Commission and various advocacy organisations was displayed around the service.

Consumers and representatives who had made complaints said the service dealt appropriately with their complaints and they were satisfied with the outcomes. Management and staff described the complaints management process and how open disclosure process was used when an issue or concern was raised. Complaints documentation reflected the involvement of the complainant, clear actions implemented, and an apology provided. The service had written policies and procedures to guide staff in the management of feedback and 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. | 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

This Quality Standard is assessed as Not Compliant as 1 of the 5 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 7(3)(a) was Not Met. The Site Audit found staffing numbers, particularly during night shifts, did not adequately cater to the needs of consumers and led to increased risks associated with manual handling, management of behaviours, incomplete care planning and reduced ability to facilitate consumers’ participation in their community. Evidence brought forward included:

* While no specific negative impacts on consumers were identified, consumers and representatives expressed concerns about the adequacy of staffing numbers, particularly at night.
* Staff said a lack of staff impacted on their ability to provide safe, quality care, and complete care planning, assessments and reviews. Staff advised there were not always sufficient staff available to support consumers requiring 3 person assists.
* Management outlined a comprehensive range of incentives and strategies to attract, recruit and retain staff, and advised they were currently actively recruiting for staff locally and internationally.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the adequacy of the workforce. The provider advised:

* Records provided during the Site Audit clearly demonstrated there were adequate staffing levels for the number of residents at all times, during the relevant period.
* The service uses a variety of strategies to plan the workforce and ensure it is sufficient to meet the needs of consumers including staff working additional shifts and use of agency staff to cover unplanned leave. As the service is co-located with a hospital, additional support can be called in from the hospital staff, such as for manual handling, medication rounds, or to manage heightened behaviours of concern.
* The service also maintains a roster of 24/7 after-hours coordinators who can provide clinical advice and hands-on care, as required. At times, baseline staffing is also supplemented with additional personal care attendants and registered undergraduate students of nursing.
* The service meets or exceeds the staff patient ratios prescribed in the Safe Patient Care Act (2015) and complies with the 24/7 registered nurse requirements and exceeds the care minutes.
* Incident records do not show that a lack of staff or the use of agency staff at night have exacerbated behaviours of concern, or adversely impacted their management.
* The service will communicate further with consumers and representatives to improve their understanding of the processes in place for providing additional staff, when required.
* The service acknowledges some staff expressed the view there were inadequate staff numbers. Management will communicate further with staff about the strategies in place and reiterate how they can access additional support through the after-hours coordinator.

I acknowledge most consumers and staff felt there should be more staff however, there was minimal specific evidence brought forward of adverse impacts to consumers. I further note the service had self-identified the issue of staffing adequacy and had already initiated corrective actions which included the recruitment of more staff. Given the provider’s improvement actions taken before and since the site audit, I am satisfied the service recognises the importance of having a planned and sufficient workforce and has taken appropriate action, which is ongoing. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(a) Compliant.

The Assessment Team recommended Requirement 7(3)(c) was Not Met. While management described how they ensured staff were competent and knowledgeable in their roles, the Site Audit found gaps in compliance with some mandatory training requirements, resulting in poor manual handling techniques and incorrect use of personal protective equipment by some staff. Evidence brought forward included:

* Staff records confirmed staff had appropriate qualifications, registrations, security checks, and experience for their roles.
* Some staff indicated other staff used poor practices in relation to manual handling and use of personal protective equipment.
* Some consumers and representatives reported concern around staff training in areas including manual handling.
* Management detailed how the recruitment and induction process ensured staff were competent and knowledgeable to perform their roles. Management advised staff retention was also a challenge faced by the service.
* Management were aware completion rates for mandatory training was low and they had raised a Plan for Continuous Improvement action dated 27 December 2023, to encourage staff to complete mandatory training modules.

I have considered evidence related to the training and support of staff under Requirement 7(3)(d) where it is more relevant. I note the documentary evidence showing the service’s recruitment and induction processes ensured staff had the appropriate qualifications, registrations, security checks, and experience for their roles. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(c) Compliant.

The Site Audit brought forward evidence related to the training and support of the workforce which I have considered under Requirement 7(3)(d). Evidence brought forward included:

* Consumers and representatives provided mixed feedback about the adequacy of staff training and identified managing changed behaviours, use of personal protective equipment, safe lifting, and accessing interpreter services as areas where training is required.
* Clinical staff had gaps in their knowledge around restraint and did not describe completing behaviour support plans or documented risk assessments for restrictive practices which included identifying triggers for behaviours and (non-pharmacological) strategies to manage these behaviours. Clinical staff also expressed concern about staff’s understanding of changing behaviours and said that additional training would be valuable.
* Management described the training and education offered by the service both face-to-face and online, and how they supported staff throughout orientation and ongoing employment to maintain skills and provide opportunities for learning.
* Mandatory training records showed only a moderate rate of completion (70-80%) for multiple modules.
* The monthly education calendars showed an extensive range of training was offered however, the Site Audit found the enforcement of staff attending mandatory training was not effective.
* Management explained staff received regular reminders about mandatory training and are alerted to any overdue training.
* Staff expressed feeling under pressure and said they did not always have sufficient support to provide safe, quality care, and complete care planning, assessments and reviews. Staff also expressed concerns about having sufficient staff to safely lift some consumers and manage escalating behaviours.
* While staff were satisfied with the extent of training offered, they said they did not have enough time to complete it.
* Management responded to findings brought forward by the Assessment Team by introducing actions on the Plan for Continuous Improvement to run additional training.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the training and support of the workforce. The provider advised:

* The service acknowledged the gap in mandatory training compliance identified in the Site Audit and advised corrective actions on their Plan for Continuous Improvement are well underway.
* The service confirmed the continuous improvement initiatives had resulted in 90% staff compliance with patient handling training and 81% of staff up to date with personal protective equipment training.
* The service provided evidence of further staff education around accessing language support services.

I acknowledge the service conducted mandatory and voluntary training however, the evidence shows staff lacked knowledge in key areas and compliance with the mandatory training schedule was unsatisfactory. Staff did not feel supported to deliver safe and effective care and meet their training obligations. While the provider has taken improvement actions, during and since the site audit, to bolster the training program, management needs to ensure staff are supported to participate and that training is ultimately effective. I consider it too early to determine whether these improvement actions are sustainable and effective in ensuring the workforce is trained and supported to deliver the outcomes required by these Standards. Therefore, on the balance of the evidence before me, I find Requirement 7(3)(d) Not Compliant.

I am satisfied the remaining 2 Requirements in Standard 7 are Compliant.

Consumers and representatives confirmed the workforce was kind, caring and respectful to consumers. Management and staff were observed addressing consumers by their preferred name and using respectful language when assisting consumers. For example, a staff member was observed spending time with a comfort chair-bound consumer, using touch and a soft voice to communicate with them.

Management described how the performance of the workforce was assessed, monitored, and reviewed through regular performance appraisals and feedback from staff, consumers and representatives. Staff reported having regular performance appraisals and felt supported by management in their roles. Staff records showed the service had processes in place to monitor, assess and review the performance the workforce, and identify their training needs.

# 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. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

This Quality Standard is assessed as Not Compliant as 1 of the 5 Requirements have been assessed as Not Compliant.

The Assessment Team recommended Requirement 8(3)(c) was Not Met. The Site Audit found the service had effective organisation wide governance systems related to information management, continuous improvement, financial governance, and feedback and complaints. However, gaps were identified in compliance with the regulatory requirements for restrictive practices and governance of the workforce. Evidence brought forward included:

* The Site Audit found a lack of staff impacted the safe manual handling of some consumers and the management of behaviours. Management had self-identified staffing as a risk and put in place various strategies for managing rosters and the recruitment and retention of staff, which were endorsed at Board and Committee meetings. I have considered this further under Requirement 7(3)(a).
* The service had robust systems in place for monitoring compliance with staff training compliance however, there was little evidence of enforcement of the staff mandatory training requirements.
* Records showed the organisation was aware of deficits in workforce competencies and training however, there was no documented clear plan to address the issue other than reminding staff to complete training.
* The service had multiple documented policies and procedures covering workforce governance which ensured the workforce was appropriately skilled, qualified and experienced to provide safe and effective care to consumers.
* Records confirmed the service effectively monitored and enforced the required security, vaccination and registration checks.
* Management described various ways the service kept informed of legislative changes and regulatory compliance was a standing item on the staff meeting agenda. Items discussed included, restrictive practice requirements, the use of behaviour support plans and the Serious Incident Reporting Scheme processes.
* The Assessment Team found the service did not comply with restrictive practices legislation, including not applying correct definitions and not completing individualised risk assessments and behaviour support plans. The Clinical Governance Framework (April 2023) sets out the responsibilities of the Clinical Quality and Safety Committee for overseeing clinical regulatory compliance.
* Staff and consumer representatives expressed concern regarding staff not utilising effective behaviour support strategies.

The provider’s response received 25 March 2024, provided additional clarifying information and evidence in relation to the efficacy of the organisation wide governance systems for regulatory compliance and workforce governance. The provider advised:

* The senior leadership and Board have made significant efforts to improve workforce competencies over recent months. Communications have been sent to staff explaining the requirements to complete mandatory training. Unfortunately, a weather event disrupted staff’s ability to complete their mandatory training over the February period where there was a large push to complete training competencies.
* The Board have been informed through the Clinical Quality & Safety Report for March 2024.

I have also considered the training and support provided to staff further under Requirement 7(3)(d) and the application of restrictive practices under Requirement 3(3)(a). I note the deficits identified in the Site Audit in relation to compliance with restrictive practices regulations and workforce governance. In relation to the sufficiency and training of the workforce, I consider the organisation had full visibility of these challenges and the existing governance systems had initiated reasonable corrective actions which were being monitored. In relation to regulatory compliance, I do not consider the organisation’s governance has been proactive and effective in ensuring the service is current and compliant with restrictive practices regulations. While the service has taken improvement actions, it is too early to determine whether these actions are sustainably embedded in their processes and are effective in addressing the deficits identified. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(c) Not Compliant.

The Assessment Team recommended Requirement 8(3)(e) was Not Met. The organisation had a clinical governance framework that included written policies, procedures and staff training addressing antimicrobial stewardship, minimising the use of restraint and open disclosure. However, the Site Audit identified gaps in staff knowledge and training in relation to the minimisation of restrictive practices and management of behaviours. I have addressed the issues related to the provision of clinical and personal care under Requirement 3(3)(a) and staff training and support under Requirement 7(3)(d). I consider there is evidence demonstrating the organisation has a clinical governance framework addressing antimicrobial stewardship, minimising the use of restraint and open disclosure. Therefore, on the balance of the evidence before me, I find Requirement 8(3)(e) Compliant.

I am satisfied the remaining 3 Requirements in Standard 8 are Compliant.

Consumers and representatives reported being engaged in the development, delivery and evaluation of care and services. Management described the various methods used to engage consumers such as consumer meetings, surveys and an independent feedback service. Documents showed consumers were engaged and supported in providing input regarding the delivery of care and services and ongoing improvements.

Consumers and representatives said the service was well-run however, they provided mixed feedback regarding aspects of the care and services which have been considered under the relevant Requirements. Management described the Board make up and structure and how it oversighted the operation of the service and was accountable for the delivery of safe, inclusive and quality care and services. Board and Committee meeting minutes demonstrated reporting of performance measures and discussion of incidents and other topics relevant to the delivery of safe and effective care and services.

The service demonstrated it had an appropriate risk management framework with documented policies and systems for managing high impact or high prevalence risks to consumers, identifying and responding to abuse and neglect, supporting consumers to live the best life they can, and managing and preventing incidents. While the Site Audit identified some minor deficits in staff practice these were not indicative of the risk management framework failing.

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)