Luson The Vue

Performance Report

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**Commission ID:** 4571

**Provider name:** Luson Aged Care Pty Ltd

**Site Audit date:** 26 April 2022 to 28 April 2022

**Date of Performance Report:** 16 June 2022

# Performance report prepared by

Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this 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 Site Audit report received 24 May 2022
* other information and intelligence held by the Commission in relation to the service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

Consumers and representatives considered staff understood and respected their individual values, knew their life story and background and provided examples to the Assessment Team of how staff assisted them to participate in cultural activities. Staff were able to describe how consumers’ culture and diversity influenced the delivery of care and services. The Assessment Team observed care, lifestyle and clinical staff providing care and interacting with consumers in a respectful and gentle manner.

Consumers were satisfied that they were supported to exercise choice and independence, had the ability to make their own decisions and maintain personal relationships. Staff demonstrated an understanding of how the service encouraged the consumers to maintain relationships inside and outside of the service, through zoom calls and visits within the service. The Assessment Team observed the service’s organisational policies promoted a commitment to consumers ability to exercise choice and to receive clear and accessible information about their rights and the care and services they receive

Care planning documentation evidenced the completion of risk assessments in consultation with allied health professionals and consumers. Consumers confirmed the service supports them to life they choose and engage in activities that are important to them. Staff demonstrated an awareness of activities that included an element of risk to consumers and could describe the strategies in place to mitigate these risks. For example, staff described to the Assessment Team consumers who chose to self-manage medications or mobilise without the use of aids and explained how the service assessed and managed those associated risks. Consumers and representatives indicated they received information that was current, accurate and timely, and communicated clearly, easy to understand and enabled them to exercise choice and control.

Consumers expressed the service was considerate of their personal privacy and the confidentiality of their personal information. Staff described the practical ways they respect the privacy of consumers, such as knocking on consumers’ door as prior to entering and keeping doors closed when providing personal care. The Assessment Team noted privacy policies that detailed how personal information should be stored and protected.

The Assessment Team found the service did not meet Requirement 1(3)(a) regarding the delivery of care within the service. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Compliant. I have provided reasons for my finding in the relevant Requirement below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

Most consumers and representatives confirmed they were treated with dignity and respect, with their identity, culture and diversity valued. Staff spoke of consumers in a respectful manner and demonstrated a shared understanding of consumer’s identity, culture and diversity. However, the Assessment Team spoke with three consumers and one representative that brought forward evidence in conflict with this information, relevant summarised evidence included:

* One named consumer and their representative who stated they were reluctant to press the call bell buzzer late at night as they were unsure how staff would respond and stated they had been refused assistance with toileting
* One named consumer who stated that staff did not respect their privacy when interacting with them and left the door to their room open, despite requests for it to remain closed.
* One named consumer who advised that it is sometimes difficult to communicate with staff due to hearing loss and difficult to hear staff entering the room when they knock

In its written response, received, 24 May 2022, The Approved Provider provided additional context and explanation of the issues raised specifically.

* In response to the named consumer and their representative who was reluctant to use the call bell and stated they had been refused assistance toileting. The Approved Provider provided evidence that this historical issue had been addressed by the service, with additional staff education, reallocation of duties and direction provided by Management at the time. There is no evidence of further recent occurrences of this issue.
* In response to the consumer who reported they were not afforded privacy as requested, the Approved Provider gave further clarification around the issues raised and evidence that Management had engaged with the consumer to find alternate solutions and preferences to providing care
* In response to the consumer who stated privacy was an issue due to hearing difficulties, the Approved Provider advised they had not been made aware of this issue previously, however provided evidence of process and actions implemented to overcome the consumer’s concerns

I acknowledge the evidence brought forward by the Assessment Team and the actions, both planned and executed by the Approved Provider. On the balance of evidence brough forward under this Requirement I am satisfied the service is meeting its obligations. I therefore find the service Compliant with this Requirement.

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

The service demonstrated assessment and care planning processes that were implemented to inform the delivery of safe and effective care and services. Consumers and representatives expressed satisfaction with the service’s assessment and planning process. Staff were aware of the relevant risks to the health and well-being of each consumer and the strategies in place to ensure the safe and effective delivery of care. Care planning documentation was individualised and included specific risks to each consumer’s health and well-being such as falls, pain and skin integrity.

Care planning documentation evidenced that consumers and representatives were consulted throughout assessment and care planning, including advanced care planning. Consumers and representatives said they were consulted throughout assessment and care planning, and when required, input was sought from health care professionals.

Care planning documentation evidenced an ongoing partnership with the consumer and others that the consumer wishes to be involved in their care. Staff described to the Assessment Team, the assessment and care planning process, which involved partnership with the consumer and identified the services process including gathering information about the consumer’s life history, needs, goals and preferences.

Consumers and representatives confirmed the outcomes of assessment and planning had been communicated to them and they were able to access consumer care plans upon request. A review of care plans by the Assessment Team evidenced details of ongoing partnerships and indicated who was involved in the assessment and planning process including the consumer, the representative, staff and other providers. Consumers and representatives indicated that consumer’s care and services are reviewed on a regular basis, or when the consumer’s circumstances have changed.

Staff outlined that care plans were reviewed monthly or every three months and that they were aware of the incident reporting process and how these incidents may trigger a reassessment or review and care planning is reviewed if changes are required. For example, if a consumer has a fall, they are reviewed by the physiotherapist and medical officer.

Staff were able to describe how the assessment and care planning process identifies consumers’ goals, needs and preferences that inform the care plan development and delivery of care. The service had policies for palliative care planning to guide staff practice and documents consumers end of life wishes in the Advance Care Plan.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

Consumers and their representatives considered they received personal and clinical care that was safe and right for them and in accordance with their needs and preferences. Care documentation reflected individualised care that was safe, effective, and tailored to the needs and preferences of consumers.

Care documentation showed that high-impact and high-prevalence risks such as falls were appropriately identified, and appropriate interventions were documented to manage and minimise the risks for each consumer. Each consumer’s care documentation captured and described key risks such as falls, skin integrity, infections, and behaviours with corresponding strategies to manage the identified key risks. Staff had received training on risk management and could describe to the Assessment Team how to identify and report incidents with management actioning incidents through their quality, risk and safety system.

Care planning documentation specified individual consumer’s end of their life wishes and staff described the way care delivery changed for consumers nearing the end of their life and practical ways that consumers’ comfort is maximised.

Deterioration or changes to consumers’ condition were identified and responded to in a timely manner. Care plan documentation included behaviour care plans which outlined triggers of behaviour and corresponding alternative strategies to manage behaviours before resorting to medical intervention.

Staff described how information about the condition, needs and preferences of consumers was documented and shared within the service and with other professionals that share care of consumers. Care planning documentation demonstrated progress notes, and case conference notes that provided sufficient information to support effective and safe sharing of the consumer’s information. The service had a clinical governance framework and staff practice that was guided by work instructions that support staff in consumer handover processes.

Consumers and representatives said referrals to health professionals were timely and appropriate, and that consumers had access to relevant professions such as speech pathologists, dietitians, and medical specialists. Care planning documents showed referrals to allied health professionals where relevant, including external services such as Dementia Support Australia. Staff explained that referrals were made in consultation with the consumer and representative.

The service had policies and procedures to minimise infection-related risks, and staff provided examples of practices to prevent and control infections. The service provided training in infection minimisation strategies including hand hygiene, the use of appropriate personal protective equipment and cleaning processes.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*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.*

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

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

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 NON-COMPLIANTServices and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

Consumers felt supported to pursue activities of interest to them, individually and as part of a group. Care plans included consumers' lifestyle preferences and identified people important to them. Staff demonstrated knowledge of individual consumers’ interests, which were consistent with care plan records. Lifestyle staff explained that that due to the wide range of preferences, the service undertakes lifestyle reviews every three months with consumers to understand what they want to do in their room, and what activities they want to include

Care planning documentation included information about consumers' spiritual beliefs, strategies to support their emotional well-being. Staff described how they monitored and supported changes in consumers’ well-being.

Consumers were supported to participate in the community and maintain personal relationships through social visits within and outside the service. Care plans identified consumers’ activity preferences and noted personal relationships that were important to them. Staff provided examples of how the service supported consumers to remain connected to their community, such as through zoom calls, family visits and activities.

Care planning documents provided adequate information about consumers’ conditions, needs and preferences and key information was shared within the organisation to ensure the provision of safe and effective care. Consumers and their representatives felt their needs and preferences were communicated effectively amongst staff. Staff were made aware of changes to consumers’ needs during verbal and documented handover processes and sharing dietary information.

Care documentation reflected the involvement of other providers of care and support services. The Assessment Team spoke with lifestyle staff about the process of engaging consumers with external organisations to supplement the lifestyle program. Brochures and other resources to support referals to external organisations were observed at the service.

However, not all consumers were satisfied with the variety and quality of food offered by the service. I have explored this further under the specific requirement.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team found the service did not demonstrate that meals were varied and of suitable quality and quantity. Relevant (summarised) evidence included:

* Consumers and representatives gave mixed feedback about the quality of food provided by the service, stating that at times their preferences weren’t met
* One named consumer stated that a recent meal was bland, without seasoning and the food options lacked fresh fruit
* One named consumer advised the meals were very repetitious with minimal variety
* One named consumer stated that the food offered does not always cater to individual dietary needs and the service offered very few pureed options
* One representative stated that they were unhappy with the food offerings and felt that the quality had declined, further that feedback obtained during meetings was not actioned

In its response dated 24 May 2022, the Approved Provider provided further evidence of the steps taken to ensure the quality of meals provided, these included:

* Monthly food focus groups in place, which were implemented prior to the Site Audit and offered to all residents on an ongoing basis with feedback used to improve the quality of meals
* Ongoing food and nutrition audits, undertaken by and external provider, with a focus on taste, dining experience and general nutrition
* A new Head Chef, engaged in early 2022, with a project commenced to focus on texture modified meals

While I acknowledge the actions taken by the Approved Provider in response to the Site Audit, I remain of the view that at the time of the Site Audit the service did not demonstrate that the meals provided, were varied and of suitable quality and quantity. I find this Requirement Non- Compliant.

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

Consumers considered the service environment welcoming, said they felt comfortable living there and they felt at home. The service environment supported consumer independence and consumers described how they access activities in different areas of the service, including outdoor.

The Assessment Team observed signage to direct consumers and visitors to the various areas of the service as well as clearly visible fire egress maps and emergency lighting. Indoor areas were observed to overall be safe and easy to navigate with wide corridors, hand railings and walkways equipped with signs. Staff described the processes in place to obtain feedback from consumers to improve the internal and external service environment. Staff explained the use and location of the maintenance request books located at both the east and west nurse stations. This book was observed by the Assessment Team to capture all maintenance requests lodged by staff including a severity/risk level and competition date observed to all be completed within the request severities timeframes. The service had a preventative maintenance program which was managed inhouse and outsourced where necessary.

The service had an Environmental Service Coordinator in place that oversaw cleaning and laundry operations and described the schedule in place that staff follow to ensure regular and detailed cleaning is undertaking across the service, which included both personal rooms and common areas. Staff described how shared equipment was cleaned, stored and maintained. Consumers considered that the service was clean and well maintained, and equipment, furniture and fittings in the service were clean, safe, well maintained and suitable to their needs and preferences.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as one of the four specific requirements have been assessed as Non-compliant.

Consumers advised they were made aware of advocacy and language services and other methods for making complaints through the consumer handbook, complaints management policies, the advocacy services policy, feedback forms, brochures and posters were displayed throughout the service.

Staff demonstrated a shared understanding of the internal and external complaints and feedback avenues, and advocacy and translation services, available for consumers and their representative and said consumers and their representatives are shown the location of the feedback forms and lodgement boxes on entry to the service.

The Assessment Team reviewed the service’s written materials, such as the Consumer Handbook, Complaints Management policy, Complaints policy for consumers, Advocacy Services policy, feedback forms, all of which provide information regarding internal feedback and complaints processes, and contact information for external assistance from the Aged Care Quality and Safety Commission (ACQSC), and advocacy and translation services.

The Assessment Team recommended Requirements 6(3)(a), 6(3)(c) and 6(3)(d) were not met. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit Report and the Approved Provider’s response and found the Service Compliant with Requirements 6(3)(a) and 6(3)(c) and Non-compliant with Requirement 6(3)(d). I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### The Assessment Team brought forward evidence that consumers and representatives were not supported to provide feedback and make complaints. Relevant (summarised) evidence included:

* The Assessment Team identified only 2 lodgement box and feedback form areas in the service and spoke with some consumers who did not know their location. The Assessment team observed feedback forms were only provided in English.
* One consumer who described a recent complaint lodged to Management of the service and reported not receiving an adequate response, however acknowledged the service had made attempts to speak with them
* Timeframes to acknowledge, respond and manage a complaint were not included in the service’s Complaints Management Policy.
* Actions arising from consumer and relative meetings were not included in the Plan for Continuous Improvement.

In its written response of 24 May 2022, the Approved Provider advised there were four lodgement boxes throughout the service plus a suggestions box, rather than the two identified by the Assessment Team. An additional suggestion box was installed following the Site Audit.

The Approved Provider outlined the ways consumers and residents were supported to provide feedback and make complaints, such as through the resident handbook and agreement, posters on display at the service, at resident and relative meetings and through lodgement and suggestions boxes. The Approved Provider undertook to include information on how consumers could provide feedback and make complaints in the service’s pre-admission checklist.

The Approved Provider described how complaint trends were identified, data was recorded, analysed, and reported to the Board in a timely manner. The service reviewed its complaint management procedure in response to the Assessment Team’s findings, and a new procedure was being finalised. The new procedure included a five-step process to manage complaints, required a documented response to the complainant within two working days, other timeframes for complaint resolution, a system to lodge complaints in the Continuous Improvement register, guidance on how to identify the level of risk of complaints and on where complaints and feedback are recorded from meetings.

While I acknowledge the evidence brought forward by the Assessment Team, I am not satisfied that the examples provided were demonstrative that consumers and other were not supported to make complaints. Therefore, I find the service Compliant with this requirement.

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### The service demonstrated that the open disclosure process was used when things go wrong, however, the Assessment Team brought forward evidence that appropriate and timely action was not always taken in response to complaints from consumers. Relevant (summarised) evidence included:

* A named consumer considered the service did not provide an adequate response to their complaint. The Assessment Team identified that management of the complaint was not in accordance with the service’s Complaints Management Policy which required complaint acknowledgement to be documented and logged through the Continuous Improvement process.
* A named consumer who advised the Assessment Team their care plan documentation had been falsified.
* Two consumers stated the service did not take appropriate action in response to feedback provided about the food served at the service.
* The service did not consistently update the complaints register or the Plan for Continuous Improvement with consumer feedback and complaints.

In its written response of 24 May 2022, the Approved provider gave additional context and evidence in relation to the issues raised by the Assessment Team

* In response to the concerns raised by the name consumer, the Approved Provider advised the complaint was addressed at the time the complaint was made through a visit to the consumer from the Care Manager. The Approved Provider met with the consumer following the Site Audit and noted the consumer confirmed management had responded at the time of the complaint
* In relation to the falsification of care documents, the Approved Provider found no evidence that documentation had been falsified
* In relation to feedback provided about food at the service, the Approved advised a number of new and existing actions were being taken to address concerns about food at the service. This included recruitment of a new head chef, a food action plan, dietician audits and increased food focus meetings to familiarise the head chef with residents’ preferences

While I acknowledge the evidence brought forward by the Assessment Team, on the balance of evidence, I am satisfied that the service did take appropriate action in response to complaints. Therefore, I find the service Compliant with this requirement.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team identified that feedback and complaints were not effectively reviewed and used to improve the quality of care and services. Summarised relevant evidence included:

* Complaints and feedback received through consumer meetings and surveys were not consistently recorded in line with the service’s policies and procedures. This included quality improvement actions not being recorded in the Plan for Continuous Improvement.
* Consumer feedback did not always lead to a demonstrated improvement in the care and services provided to consumers, including in response to feedback about food.
* The Assessment Team’s review of consumer meeting minutes and the service’s continuous improvement register demonstrated that complaints and feedback made by consumers were discussed at each meeting, but actionable items were not being recorded in the Plan for Continuous Improvement.

In its written response of 24 May 2022, the Approved Provider stated there had been a back log in consistently recording and documenting complaints due to challenges arising from COVID-19 and the timing of commencement of a new General Manager who started with the service the month prior to the Site Audit.

The Approved Provider evidenced several actions in the continuous improvement register arose from consumer feedback provided at consumer meetings and the annual survey. The Approved Provider undertook that a monthly meeting would take place between the General Manager and Care Manager to review feedback arising from all meetings, such as the Food Focus and Resident Relative meetings, to ensure all issues and complaints were logged and actioned in the Continuous Improvement register.

The Approved Provider also observed that outcomes from the consumer experience survey should have been included in the Plan for Continuous Improvement. The Approved Provider advised the Service would monitor and review records and follow up all items required to be registered in the Plan for Continuous Improvement.

I have considered the information presented by the Assessment Team and the Approved Provider. While I acknowledge the actions taken by the Approved Provider to address the issues with the way feedback and complaints are reviewed and used to improve the quality-of-care services, at the time of the Site Audit, the service did not demonstrate that complaints were consistently documented and used to improve the quality of care and services. I therefore find this requirement Non-compliant.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

Consumers received quality care and services from staff who were knowledgeable, kind, capable and caring. Consumers and representatives were confident staff were competent and adequately trained.

The organisation had documented policies and procedures relating to human resource management which outlined processes to be implemented by the service to ensure staff were equipped, trained and supported to meet the needs and preferences of consumers across all areas of service delivery. There were defined position descriptions for all positions at the service, mandatory training and core competency requirements, processes to ensure vacant shifts are filled, and processes to monitor staff performance and rectify any training or knowledge deficiencies as required.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful manner. Staff were observed treating consumers with dignity and respect and greeting and interacting with them in a familiar and friendly manner, calling them by their first name. Consumers and representatives confirmed staff are kind and respectful when providing care services.

The Assessment Team recommended Requirements 7(3)(a) and 7(3)(d) were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit Report and the Approved Provider’s response. I found the service Non-compliant 7(3)(a) and Compliant with 7(3)(d). I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

Consumers and representatives reported staff shortages that impacted the timing and delivery of care and services. Consumers considered their care preferences were not consistently being delivered in line with their expectations. Relevant (summarised) evidence included:

* Reduced kitchen staff from early 2022, affecting the ability of the service to provide consistent meals
* One consumer stated to the Assessment Team they felt there were not enough staff at the service, especially impacting the delivery of care to those requiring higher levels of care
* One consumer felt there were not enough care staff, impacting them receiving showers in line with their preferences
* One consumer stated feeling as though there were not enough staff during the day and stated they sometimes must wait for staff to become available
* Staff advised that there were at times some staff shortages, particularly in care staff numbers. Staff considered that the met consumer care needs in line with expectations but advised they did feel rushed to ensure all tasks were completed at times.
* The Assessment Team noted that the call bell response times for April 2022 fell below the service expectation of 8 minutes.

In its written response of 23 May 2022, the Approved Provider addressed some of the issues raised by the Assessment Team by stating.

* In relation to the evidence in the Site Audit report that stated there were no permanent kitchen staff, the Approved Provider disagreed with this information and advised that while the chef resigned in February, there had been no change to kitchen staff who were employed consistently with the assistance of agency staff. The Approved Provided noted that a permanent chef commenced in May 2022.
* In relation to the consumer who stated that they do not always receive showers in accordance with their preferences, the Approved Provider advised that they have investigated this matter further and ensured that the consumer is offered a shower as per their preferences
* The Approved Provider further stated that to address staffing more generally it has implemented the following processes:
	+ Daily calls to staff to fill empty shifts
	+ Engagement of local agency networks
	+ Staff engagement and rewards programs

The Approved Provider undertook to continue monitoring staffing levels and maintain resourcing initiatives to ensure staffing meets demand.

While I acknowledge the actions taken by the Approved Provider, I remain of the view the number and mix of members of the workforce was not sufficient to meet demand and delivery of safe and quality care and services at the time of the Site Audit. I therefore find this Requirement Non-compliant.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team spoke to staff and management during the Site Audit who described ways in which training can be accessed both when at the service and remotely from home. The Assessment Team spoke with staff who described with accessing and completing mandatory online training to equip them to deliver care to consumers. Management further described to the Assessment Team the recruitment, onboarding and training process undertaken by the service to ensure staff are suitable trained and equipped and further advised that staff training needs are identified through various means such as through complaints data, annual performance reviews, annual training needs analysis report that provides management with feedback given by staff about training preferences, observations by senior staff whilst staff are performing their duties or staff may request additional training.

The Assessment Team further described the orientation and induction process in place within the service, which included, mandatory education requirements prior to commencement, a suite of training modules and topics completed as part of the onboarding process and buddy program and checklist.

The Assessment Team identified a training register that recorded mandatory training modules for each member of staff and found that at the time of the Site Audit a large number of staff had not completed these training modules. The Site Audit report further identified that toolbox training sessions had been completed, but not recorded within the centralised training register.

In its written response of 24 May 2022, the Approved Provider provided additional evidence in relation to this requirement, specifically.

* Evidence that the training register identified by the Assessment Team as showing many staff as not having completed mandatory training is an annual register that recommences each March. The Approved Provider submitted further evidence to demonstrate that 99% of staff, excepting for those on long term leave had completed the training as of the previous year.
* The Approved Provider further undertook to recorded toolbox training session in the centralised register, noting that they had not done so previously due to the ad hoc nature of the training.

I have considered the evidence brought forward by the Assessment Team in the Site Audit report and the response provided by the Approved Provider. On the balance of evidence in the Site Audit report I am satisfied that the Approved Provider has a workforce that is trained, equipped and supported to deliver the outcomes required by these standards. I find the service Compliant with this Requirement.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

Most consumers considered the organisation was well run and they could partner in improving the delivery of care and services. Management provided examples of how consumers engaged and were supported in the development, delivery and evaluation of care and services, including through feedback forms, discussions, consumer and relative meetings, food focus meetings, consumer experience surveys and annual relative and representative surveys.

The organisation’s governing body promoted and was accountable for the delivery of safe, inclusive and quality care and services. The Board met regularly with management and considered information such as risk and quality, industry body updates, corporate risk register, clinical governance, clinical care reporting, complaint trends, continuous improvement, training compliance and infection control. Management advised the Board used information such as the results of consumer experience surveys, discussions with management and reports to programs such as the National Aged Care Quality Indicator Program to oversee the performance of the service. The frequency of communication between the Board and management increased when needed, in response to the management of issues such as COVID-19.

The service had a documented risk management framework, which included policies on high-impact or high-prevalence risks, identifying and responding to the abuse and neglect of consumers and supporting consumers to live their best life. Staff had been trained on the policies, demonstrated an understanding of them and provided examples relevant to their work.

The organisation had a clinical governance framework that supported clinical care practice, which included policies relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. Management provided examples of changes to how care and services were planned, delivered and evaluated as a result of the implementation of these policies.

The Assessment Team recommended Requirements 8(3)(c) was not met, regarding organisation wide governance systems for continuous improvement, workforce governance and feedback and complaints. I have considered the Assessment Team’s findings; the evidence documented in the Site Audit Report and the Approved Provider’s response and found the service Non-compliant with Requirement 8(3)(c). have provided reasons for my findings in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

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

### Requirement 8(3)(c) Non-compliant

*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.*

### The Assessment Team considered the service had effective organisation wide governance systems relating to information management, financial governance and regulatory compliance. However, it found deficiencies relating to systems for continuous improvement, workforce governance and feedback and complaints. Relevant (summarised) evidence included:

* Consumer feedback and complaints were not consistently documented, actioned and used to improve the quality of care and services. The Complaints Management policy did not specify a response timeframe to acknowledge or respond to complaints.
* Loss of staff, which impacted the service, however noted these roles had been recently filled
* A training register monitored staff compliance with mandatory training, but the service could not demonstrate how it followed up outstanding training or staff performance management.
* The Plan for Continuous Improvement did not consistently reflect consumer and representative feedback and complaints, and actions for improvement.

### The Approved Provider responded in writing on 24 May 2022, and stated it had an effective organisation wide governance system relating to feedback and complaints and had identified opportunities for improvement. This included reviewing the complaints procedure to specify response timeframes. The Approved Provider noted its continuous improvement register included 37 complaints over the past 12 months, arising from feedback forms, interviews and meetings.

### In relation to workforce governance, the Approved Provider stated it had a thorough and comprehensive training records system which monitored mandatory training records, performance appraisals and general training attendance. The system enabled the Approved Provider to immediately identify staff training compliance. The Approved Provider required staff to complete mandatory training prior to commencing employment with the service and noted it also used an electronic training platform which recorded details of staff attendance and completion of modules. Training attendance was reported to management and the Board on a monthly basis.

### The Approved Provider considered it had a robust and comprehensive organisation wide continuous improvement program, and provided examples of actions included in the continuous improvement register and advised that continuous improvement activity and the status of the register was reported across the organisation and included in the report to the Board.

I have considered the information presented by the Assessment Team and the Approved Provider. While I acknowledge the actions taken by the Approved Provider to address the issues with organisation wide governance systems, at the time of the Site Audit, the service did not demonstrate effective organisation wide governance systems relating to continuous improvement, workforce governance and feedback and complaints. I therefore find this requirement Non-compliant.

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

# 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 4(3)(f) - The service ensures where meals are provided, they are varied and of suitable quality and quantity.

### Requirement 6(3)(d) -The service ensures feedback and complaints are reviewed and used to improve the quality of care and services.

### Requirement 7(3)(a) - The service ensures the workforce is planned to enable the delivery and management of safe and quality care and services.

### Requirement 8(3)(c) - The service ensures effective organisation wide governance systems relating to continuous improvement, workforce governance, and feedback and complaints.