Performance

Report

1800 951 822

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| Name of service: | Performance report date: |
| Macquarie Lodge Aged Care Plus Centre | 4 August 2022 |
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| Approved provider: | Activity date: |
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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 Macquarie Lodge Aged Care Plus Centre (**the service**) has been considered by Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved Provider’s response to the Assessment Team’s report received 11 July 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 3(3)(a) – The service ensures that each consumer gets safe and effective care that is best practice, is tailored to their needs, and optimises their health and well-being.
* Requirement 3(3)(d) – The service ensures that 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 4(3)(f) – the service ensures meals to be of a suitable quality and variety, in line with consumers’ needs and preferences.
* Requirement 6(3)(b) – The service ensures consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints
* 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, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Requirement 7(3)(b) – The service ensures workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity
* Requirement 8(3)(e) – The service ensures the service’s clinical governance framework minimises the use of restraint.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

## Findings

Consumers and representatives expressed that consumers are treated with dignity and respect. Care planning documents incorporated consumers’ background information, personal preferences, identity, and cultural practices, which was consistent with consumer feedback.

Consumers and their representatives indicated the care and services provided to consumers is culturally safe. Care planning documentation evidenced the service had captured information regarding consumers’ religious, spiritual and cultural needs.

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 were observed offering consumers choices and providing information to inform those choices, such as menu options.

Care planning documentation evidenced the completion of risk assessments in consultation with allied health professionals and consumers. Staff demonstrated an awareness of activities that included an element of risk to consumers.

Consumers and representatives indicated they receive information that is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice and control. The Assessment Team observed menus, activity calendars and other correspondence on display throughout the service.

Staff described several ways to protect consumers' privacy, including knocking before entering a room and covering up consumers while attending to their hygiene needs, this information was consistent with observations made by the Assessment Team. Consumers confirmed their privacy is respected and staff will make their presence known and seek permission before performing tasks.

# Standard 2

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| Ongoing assessment and planning with consumers | | Compliant |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

## Findings

Consumers and representatives confirmed they were involved in their care assessment and planning. Care planning documentation evidenced the consideration of risks informing the delivery of safe and effective care and services.

Care planning documentation evidenced consultation throughout assessment and care planning, including advance health directives. Staff demonstrated an understanding of consumers’ needs and preferences and indicated they refer to registered staff if they require more information.

Care planning documentation demonstrated that consumers and representatives are consulted throughout assessment and care planning, and when required, input is sought from health professionals. Management described how they partner with consumers and representatives through care plan consultations to continually evaluate the care needs of consumers.

Management and nursing staff advised that the outcomes of assessments are documented in care plan consultation records. Care planning outcomes are communicated to the consumers and representatives through telephone calls and during care plan consultations. The Assessment Team observed a variety of documents, including handover sheets, progress note entries and activity alerts available through the Electronic Clinical Management System (ECMS).

Care planning documents showed that regular reviews occurred and following any change of circumstances or condition of the consumer and representatives confirmed they were informed of changes. The service monitors and trends clinical indicators including, but not limited to, skin integrity, behavioural incidents, medication incidents, falls and pressure injuries.

# Standard 3

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

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, tailored to their needs and optimises their health and well-being.
* 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.

The Assessment Team brought forward evidence of care planning documentation for a named consumer subject to restrictive practice that did not demonstrate best practice, nor was it tailored to their needs to guide staff practice. A further named consumer with pain management needs was not reviewed by their medical officer to ensure regular pain management that is tailored to their needs. Several consumers and representatives advised their personal and clinical care needs were not met, with a common theme being that staff are often unavailable to provide the assistance requested by consumers. In addition, a representative for a named consumer indicated that the consumer’s palliative care needs were not met.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider submitted additional evidence to demonstrate how they ensure the personal care needs of consumers are met. In relation to the representative that raised concerns regarding the palliative care needs of the consumer not being met, the service reviewed care planning documents and identified there were gaps in ongoing clinical monitoring. The service further acknowledged that matters concerning the consumer’s care were not escalated and as a result, a review by the medical officer did not occur. The Approved Provider outlined the service improvements and education provided to staff to ensure these issues do not occur in the future.

Whilst I acknowledge the immediate action taken by the Approved Provider to address the issues concerns raised, at the time of the Site Audit, the service did not demonstrate that each consumer received safe and effective clinical and personal care that is best practice, tailored to their needs and optimised their health and well-being. I find Requirement 3(3)(a) is non-compliant.

The Assessment Team identified the service was unable to consistently demonstrate that 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. A review of care planning documentation and progress notes identified a palliating consumer that was not appropriately reviewed. The representative for this consumer further informed the Assessment Team the service did not inform them of the consumer’s deterioration and requested the service to arrange a medical officer to review the consumer. In addition, another consumer’s care planning documentation evidenced their dietary and pain management issues were not responded to.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider advised the service uses an electronic consumer record system provides a real-time dashboard of high impact risks which metrics indicative of consumer deterioration, such as weight loss and incident profiles.

In relation to the palliating consumer, and as previously described within Requirement 3(3)(a), the service acknowledged there were gaps in their ongoing clinical monitoring and acknowledged that matters concerning the consumer’s care were not escalated and as a result, a review by the medical officer did not occur. In relation to the consumer with care planning documentation that did not evidence appropriate intervention for their dietary and pain management issues, the service provided evidence outlining the consumer’s behaviours and refusal for certain medications. Regarding this consumer’s pain management, the service advised the consumer has an ongoing pain chart to monitor their pain level and guide the Registered Nurses when to administer analgesia and noted the consumer has since been reviewed by a medical officer.

Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding deteriorations or changes in consumers’ health being responded to in a timely manner, at the time of the Site Audit, the service did not demonstrate compliance with this requirement. I therefore Requirement 3(3)(d) is non-compliant.

The Assessment Team recommended the following requirement was not met:

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

The Assessment Team brought forward evidence that the service was unable to demonstrate the effective management of high impact and high prevalence risks, such as weight loss and adequate nutrition and hydration for consumers. A review of care planning documentation identified two consumers that experienced significant weight loss and were not referred to a dietician. Feedback from consumers and representatives indicated that they did not like the quality of meals provided at the service, which resulted in weight loss.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider submitted additional evidence to demonstrate that the service effectively manages the high impact or high prevalence risks associated to the care of consumers. The Approved Provider outlined a real time Complex Care Register is maintained to monitor consumer high impact and high prevalence risk, including risks such as weight loss and nutrition and hydration impacts. Furthermore, the electronic resident record system provides a real-time dashboard of high impact risks which includes weight loss and other metrics indicative of nutrition and hydration deficits, such as bowel management and wound information.

In relation to the consumers that experienced weight loss and were not referred to a dietician, the Approved Provider provided additional evidence to demonstrate that while the consumers did not meet the criteria for a dietician referral, the weight loss was monitored and reviewed regularly by staff. In response to the feedback from the Site Audit the service advised that all future consumers with weight loss that do not meet a criteria of dietitian referral will be closely monitored using a food wastage chart and a weekly check of their weight.

Whilst I acknowledge the service has demonstrated discrepancies with management of high impact or high prevalence risks, on the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate systemic non-compliance. Therefore, I find the service is compliant with Requirement 3(3)(b).

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

Staff described how to provide care to consumers that are palliating or requiring end of life care. Care planning documentation evidenced the inclusion of advance care planning and the identification of the needs, goals and preferences of consumers for end of life care.

Consumers and representatives indicated the service provides regular communication between consumers, representatives and allied health professionals and are satisfied the consumer’s condition, needs and preferences are documented. Staff described how information is shared when changes occur and how changes are documented in handover documentation.

Care planning documentation evidenced timely referrals to medical officers, allied health therapists and other providers of care and services. Staff described how information is shared when referrals are made to individuals, other organisations and providers of other care and services.

The service was able to demonstrate minimisation of infection-related risks through standard and transmission-based precautions to prevent and control infection and through antimicrobial stewardship.

# Standard 4

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| Services and supports for daily living | | Non-compliant |
| 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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

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

The Assessment Team identified the service was unable to demonstrate the meals provided were of suitable variety, quality and quantity. Feedback from consumers and representatives indicated the meals provided were bland, unappetising, with meats being tough and dry. The Assessment Team observed consumers being served meals that were inconsistent with the dietary needs and preferences and staff members being unfamiliar with consumers’ preferences.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The service outlined that a Chef manager has since been recruited and will be trained prior to taking over the full capacity of the kitchen. In addition, a food focus meeting has been organised, inviting consumers and representatives to attend to provide their feedback. The service will implement a meal-time monitoring spreadsheet to document meal related feedback from consumer, and an audit will be undertaken to the menu choice form against the consumer’s nutrition and dietary profile.

The Approved Provider responded to the feedback provided by consumers and representatives and clarified their dietary preferences, acknowledged errors and outlined additional service improvements, such as, including additional cultural cuisines to the menu and further staff education.

Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding the quality of the meals provided, at the time of the Site Audit, based on consumer feedback, the service did not demonstrate the provision of meals that were suitably varied and of high quality. I therefore find Requirement 4(3)(f) is non-compliant.

The Assessment Team recommended the following requirement was not met:

* Services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do the things of interest to them.

The Assessment Team identified there were limited activities of interest within the service for consumers. A consumer informed the Assessment Team they did not have much contact with anyone in the service and disliked the activities offered by the service. A representative for consumers indicated that the service does not engage and encourage consumers to participate in activities and has found the consumers to be unwilling to participate in activities they previously enjoyed prior to joining the service. The Assessment Team observed care planning documentation to contain generic statements and goals for consumers as well as the displayed activity calendar to be unclear regarding what the activity on offer is, and where it is located.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. In relation to the consumer that indicated they disliked the activities offered, the service acknowledged there had not been many activities of choice for this consumer. The Approved Provider indicated this consumer enjoys having lunches outside of the service, however due to COVID-19 restrictions, this was not possible from March – May 2022, these activities have now resumed. A case conference has since been held with this consumer and the service to better understand their lifestyle activities of choice. The service has reviewed the activity calendar and changes were made to improve the clarity of the activity description and location.

I have considered the information provided by the Assessment Team and the Approved Provider and find that at the time of the Site Audit, the service did demonstrate it has appropriate daily living services and supports for each consumer to do the things of interest to them. Therefore, I find the service compliant with Requirement 4(3)(c).

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

Consumers and representatives indicated that information about their condition, needs, and preferences is communicated within the service to staff who provide daily care. Staff indicated that information about the consumer’s condition is communicated verbally as well as through handover sheets.

Care planning documentation identified the involvement of other organisations and providers of care and services. The service had policies and procedures in place to guide staff when referring consumers to other service providers who provide support and care.

The Assessment Team observed that where equipment was provided, it was safe, suitable, clean and well maintained. Staff advised that equipment is sanitised and wiped down prior to use.

# Standard 5

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| Organisation’s service environment | | Compliant |
| 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

The service environment was observed to be welcoming and optimises the consumer’s sense of belonging. Consumers and representatives expressed satisfaction with the service environment and felt at home within the service.

The service was observed to be safe, clean, well maintained and comfortable, consumers were able to move freely throughout the facility, both indoors and outdoors. Staff described the process for reporting maintenance issues.

The service has a system to ensure that furniture, fittings, and equipment are safe, clean, well maintained and suitable for consumers. The Assessment Team reviewed the maintenance logs and feedback forms, the call-bell system was observed to be working and operating effectively.

**Standard 6**

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| Feedback and complaints | | Non-compliant |
| 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. | Non-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. | Non-compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.
* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team identified that consumers were not made aware of, nor had access to advocates, language services and other methods for raising and resolving complaints. Consumers were not all aware of external complaint mechanisms, however expressed they would be comfortable to raise feedback directly with staff. Staff were able describe the internal complaint process but did not demonstrate a shared understanding of the external complaint processes and advised they would ask representatives or other staff that spoke the consumer’s language to assist with translation. The Assessment Team observed that the service had posters and brochures on how to raise concerns externally, however noted that the brochures were in Serbian and Arabic and not in English. Feedback forms were only available on the ground floor.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The service has included additional brochures and documents regarding the external complaints process, available in multiple languages throughout the service. In addition, staff education on advocates and external complaint processes has been added to the service’s mandatory training day. In relation to the consumers that expressed they were unaware of external complaints processes, the service has provided these consumers with written information in their preferred language and organised staff to go through this information with them.

Whilst I acknowledge the actions taken by the Approved Provider in response to feedback from the Assessment Team, these resources and systems were not in place at the time of the Site Audit. Therefore, I find the service non- compliant with Requirement 6(3)(b).

The Assessment Team identified that feedback and complaints were not reviewed and used to improve the quality of care and services. Consumers and representatives indicated that feedback that was previously raised with staff and management have not effectively been actioned. Complaints regarding staff behaviour, meal quality, clinical care and staffing levels were the most common complaints that consumers had raised and believed were ineffectively actioned.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The service has acknowledged deficits in this requirement and as an improvement, ongoing reviews adhering to the Complaint Management Flowchart will be utilised. All complaints will be evaluated within three months after the closure date of the complaint. The service will provide a copy of the Complaints Feedback Survey to seek information on the management of the complaint, review any continuous improvement identified as part of the complaint to determine its effectiveness, and keep notes of investigations, discussions and finding. All complaints, as with other feedback will be reviewed for trends at the monthly Clinical Governance meeting to ensure trends are acted on and informs continuous improvement. In relation to the complaints received regarding the meals provided, and as previously discussed under Required 4(3)(f), the service has commenced to gain feedback from consumers on meal services. Feedback obtained is shared with the catering team for immediate action and follow up.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues with the way feedback and complaints are reviewed. At the time of the Site Audit, the service did not demonstrate that complaints were used to improve the quality of care and services. I therefore find Requirement 6(3)(d) is non-compliant.

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

Consumers stated they felt comfortable to raise a complaint or concern with staff and management. Staff were aware of the avenues available to consumers and representatives to provide feedback and could describe the ways they support would support a consumer to lodge a complaint.

Consumers indicated management responded in a timely manner, and their concerns were addressed to some extent but required additional work. Management described actions taken to resolve complaints and demonstrated an understanding of open disclosure.

**Standard 7**

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

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are 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.
* Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

Consumers and representatives expressed to the Assessment Team they felt the service did not have enough staff to assist consumers with their personal care needs and do not have the time to engage with consumers, consumers described the negative impacts to their care and needs as a result. Staff further expressed that there were not enough staff during shifts, resulting from the service’s change in its model of care, and indicated that consumers are not monitored and supervised as required. A review of care planning documentation indicated that some consumer’s personal care needs with toileting and showering were not consistently met.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. In response to the feedback provided by staff, the service outlined the results of their September 2021 staff engagement survey which showed high levels of staff engagement. Regarding the service’s model of care, the Approved Provider, the model of care rosters is developed in collaboration with the Centre Management team, Area Manager and General Manager Residential Services. The process considers consumer’s acuity and needs, the size of the centre, the building floor plan and occupancy. It also reviews the master roster with industry benchmark information to ensure the roster is consistent with industry standards. The care roster is flexible and is continuously being reviewed and monitored. A detailed clinical review of the roster was undertaken in May 2022 after the commencement date which reviewed key areas including call bell reports and resident acuity. As a result of the clinical review and in line with an increase in occupancy, staffing levels increased with a total of 56 care hours per fortnight were added to the master roster.

The service provided a range of data and statistics concerning the service’s use of agency staff, casual staff, unplanned leave, vacant shifts and overtime usage. The data, in most cases, shows spikes in the months in April – May 2022, the service has indicated this was due to COVID-19 outbreaks within the service.

I acknowledge the additional information provided by the Approved Provider, however, have also given weight to the feedback from consumers that indicates impacts to their care due to staffing. Based on the feedback provided by consumers, representatives and staff, the service did not demonstrate 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. I therefore find requirement 7(3)(a) is non-compliant.

The Assessment Team identified that consumers provided mixed feedback regarding their interactions with staff. Consumers expressed that staff are sometimes rude and argumentative towards them, however they attributed these experiences to staff often being rushed and not having time to engage with consumers. Observations made by the Assessment Team during meal times included consumers declining the meals offered and staff not providing an alternative.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined behaviours of concern that displayed by the consumers that expressed their feedback which may have influenced the way interactions are interpreted. A memorandum has been sent to staff regarding the dignity and respect, and posters have been displayed at the nurses’ stations outlining the service’s values.

Whilst I acknowledge the actions taken by the service in response to the Site Audit based on the observations of the Assessment Team and feedback received by consumers, the service did not demonstrate positive interactions, respectful of each consumer’s identity, culture, and diversity during the Site Audit. I find Requirement 7(3)(b) is non-compliant.

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

Staff are trained and equipped to undertake their roles and supported to deliver consumer outcomes. Consumers expressed that staff are competent to perform they roles and mostly know them well.

Staff confirmed adequate training programs are undertaken yearly as part of their mandatory training and they felt comfortable discussing further training needs with management. Consumers confirmed that staff have the appropriate skills and knowledge to ensure the delivery of safe and quality care and services

Management advised all staff complete an annual performance appraisal undertaken by the staff and their direct supervisor and reviewed by the residential manager. The service has policies and procedures to monitor and guide staff on performance management and appraisals built into the performance system.

**Standard 8**

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| Organisational governance | | Non-compliant |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* Where clinical care is provided - a clinical governance framework, including but not limited to the following, antimicrobial stewardship, minimising the use of restraint, open disclosure.

The Assessment Team reviewed care planning documentation and identified the service was unable to evidence the trial non-pharmaceutical interventions prior to the administration of psychotropic medications. In addition, A review of the restraint guidance and information sheet noted that the service does not distinguish between the five forms of restrictive practices, i.e. mechanical, environmental, physical, chemical and seclusion, to help guide staff on what is to be considered a restraint.

The Approved Provider’s written response, received 11 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved provider has organised training for RNs regarding chemical restraint usage. The Behaviour Support Plans of consumers’ have been updated to remind staff that non-pharmacological interventions should be utilised prior to administering psychotropic medications. In relation to the restraint guidance and information sheet, these documents have been updated and reviewed to reflect current practices. Ongoing education will be provided for staff to ensure the appropriate forms are being utilised for each type of restraint.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the identified issues, at the time of the Site Audit, the service did not demonstrate that the service’s clinical governance framework minimised the use of restraint. I therefore find Requirement 8(3)(e) is non-compliant.

I am satisfied that the remaining four requirements of Quality Standard 8 are compliant.

Consumers and representatives confirmed they are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Management described promoting open and transparent approaches in all interactions and encouraging consumer engagement through verbal and written feedback, surveys, and an “open-door policy,” describing themselves and other staff as part of the consumers’ community.

The service demonstrated that the governing body is accountable for the delivery of care and services and promotes a culture of safe, inclusive and quality-driven culture. The board utilises monthly audits, feedback reports and trend data to ensure their services align with the Quality Standards.

There were organisation wide governance systems to support effective information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaint management.

The organisation provided a documented risk management framework, including policies describing how to manage high impact or high prevalence risks, identifying and responding to consumer abuse and neglect, supporting consumers to live the best life they can and how to manage and prevent incidents. Staff confirmed they had access to these policies and further advised they had been educated on these policies and could provide practical examples of their relevance to their work and responsibilities.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)