McCauley Lodge

Performance Report

10-12 Tasman Parade   
THIRROUL NSW 2515  
Phone number: 02 4267 2135

**Commission ID:** 0168

**Provider name:** The Churches of Christ Property Trust

**Site Audit date:** 15 March 2022 to 17 March 2022

**Date of Performance Report:** 6 May 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** | **Non-compliant** |
| Requirement 2(3)(a) | Non-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** | **Non-compliant** |
| Requirement 3(3)(a) | Non-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** | **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) | 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** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Non-Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | 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 21 April 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 they were treated with dignity and respect, with their identity, culture and diversity valued. Staff spoke of consumers in a respectful manner and were understanding of their personal circumstances and life journeys and demonstrated a shared understanding of consumer’s identity, culture and diversity. The Assessment Team observed kind, respectful interactions between staff and consumers and among staff at the service.

Consumers expressed that they felt safe and staff respect them, consumers were able to provide examples as to how the service supports their cultural needs. Care planning documentation identified the cultural backgrounds of consumers. Staff described how the care and services provided to consumers was influenced by their cultural needs. The Assessment Team noted the service had policies in place which outline the provision of culturally safe care.

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 able to describe the various ways they support consumers to make informed choices about their care and services and maintain relationships with those people who are important to them. The Assessment Team reviewed the minutes of food focus meetings and identified that consumer have input into the menu design.

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 outlined the choice of some consumers to smoke within a designated area of the service and that the staff observe the consumers through the window to ensure their safety. A review of care planning documentation identified the involvement of medical officers and an acknowledgement of the risk by consumers associated with activities with elements of risk. Consumers outlined the ways they are supported to take risks which enable them to live their best lives.

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. Staff were able to describe how they communicate with and assist consumers, including those with cognitive impairments or difficulty communicating. The Assessment Team observed menu choices to be displayed on the notice board within the service’s lounge room. Daily menu choices are also discussed verbally with consumers.

Consumers and representatives confirmed their privacy and confidentiality is respected. Staff outlined the practical ways they respect the personal privacy of consumers, such as, knocking on consumers’ doors prior to entry and closing their doors during the provision of care, this feedback was consistent with observations made by the Assessment Team.

## 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.*

### 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 NON-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 Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

Care planning documentation evidenced that consumers and representatives were consulted throughout assessment and care planning, including advanced care and end of life planning. Although some consumers and representatives had chosen not to discuss their end of life wishes with the service, they felt comfortable to approach staff when they were ready. Staff demonstrated a shared understanding of the needs, goals and preferences of consumers and could describe the process to access information regarding the consumer’s documented end of life choices.

Consumers and representatives said they were consulted throughout assessment and care planning, and when required, input is sought from external health care professionals. Staff outlined the process for referrals to external allied health professionals and advised that any changes to the care needs of consumers identified by external parties is communicated internally during staff handover. The Assessment Team observed treatment directives from allied health specialists are uploaded in the service’s electronic clinical care system.

The Assessment Team observed staff accessing care plans and creating alerts on the electronic care system to advise of changes in the care needs of consumers. Staff indicated the service communicates outcomes of assessment and planning to representatives through meetings at the service, phone calls and electronic communications. Consumers and representatives confirmed that staff discuss their care and services with them and advise them of any changes.

The Assessment Team found the service did not meet Requirement 2(3)(a) regarding the consideration of risks to the consumer’s health and well-being during assessment and planning, and Requirement 2(3)(e) regarding the regular review of care and services. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint under Requirement 2(3)(a) and Compliant under Requirement 2(3)(e). I have provided reasons for the finding in the relevant requirement below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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.*

The Assessment Team identified that care planning documentation was not consistently completed and did not accurately reflect the clinical and health risks for consumers. Summarised relevant evidence relating to deficiencies in the assessment and care planning process included:

* A named consumer that periodically presented with behaviours of concern, the consumer’s care planning documentation did not outline any potential triggers for the consumer’s behaviours, nor the strategies in place to manage their behaviours.
* A named consumer with exit seeking behaviours, the consumer’s care plan does not include strategies to manage this behaviour. The Assessment Team was unable to locate any monitoring requirements in their care plan.
* A second named consumer with exit seeking behaviours. Staff indicated they routinely redirect the consumer away from the door when they are attempting to exit the service. Their care plan did not acknowledge any restrictive practices, nor any indication of the risks associated with the restrictive practices. The Assessment Team were unable to locate any monitoring requirements in his care plan.
* A review of care planning documentation identified that risks assessments are not individualised, and care plans do not consistently discuss individual strategies to minimise risk to the consumer.
* The service’s monitoring tools, which included the resident of the day process, care plan reviews and case conferences, did not identify the deficiencies in consumer assessment and planning.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged the issues raised and confirmed they had identified that their assessment and care planning processes required improvements.

The Approved Provider’s written response, received 21 April 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

* The named consumer that periodically presented with behaviours of concern; following the Site Audit, the consumer’s risk assessment and Behaviour Support Plan (BSP) have been updated to include additional information regarding their triggers. Furthermore, the consumer was referred to a dietician, and a medication review was conducted resulting in the cessation of certain medications.
* The named consumer with exit seeking behaviour; the risk assessment and care plan for this consumer has been updated.
* The second named consumer with exit seeking behaviour; the risk assessment and care plan for this consumer has been updated to include information regarding their exit seeking behaviour and environmental restraint, written consent has been also been obtained from their representative.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* A review and update of consumer risk assessments and care plans for those that were identified by the Assessment Team to contain inaccurate information.
* The dissemination of a quick reference guide regarding the risk assessment and care plan process.
* The review of all consumers’ risk assessment and care plans to ensure individualised and accurate information.
* The redistribution of the service’s resident of the day process to align staff practices and to ensure the accurate monitoring of consumers.

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 surrounding the accuracy of care planning documentation, at the time of the Site Audit, the service did not demonstrate that assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services. I therefore find this requirement Non-compliant.

### 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.*

The Assessment Team identified that some care plan reviews did not consistently demonstrate how risks to consumers are identified or reviewed for effectiveness, when circumstances change or when incidents impact on the needs, goals and preferences of consumers. Summarised relevant evidence relating to deficiencies in the review of care and services included:

* A named consumer’s care planning documentation did not include evidence of consultation between the service’s internal and external allied health therapists.
* A named consumer’s BSP had not been reviewed since creation on 30 September 2021. The Assessment Team noted the service conducts three-monthly reviews.
* A named consumer with exit seeking behaviours. The care planning documentation referred to the occurrence of a review by a medial officer, however the outcome of this review could not be located.
* The Assessment Team raised the above issues with management during the Site Audit, Management acknowledged that reviews of care and service plans were unable to demonstrate how risks to consumers are consistently identified or reviewed for effectiveness, when circumstances change or when incidents impact on the needs, goals and preferences of consumers.

The Approved Provider’s written response, received 21 April 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

* The named consumer with a purported outdated BSP; The Approved provider clarified the review date of care plans to be on a six-monthly basis or when required, as evidenced by the service’s Assessment and Planning Policy. As the elapsed duration between the creation of the BSP and the time of the Site Audit was less than six months, the BSP was not outdated. However, as previously described under Requirement 2(3)(a), the consumer had since been referred to a dietician, and a medication review conducted, resulting in the cessation of certain medications.
* The named consumer with exit seeking behaviours; the risk assessment and care plan for this consumer has been updated to include information regarding their exit seeking behaviour and environmental restraint, written consent has been also been obtained from their representative.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* A review and update of consumer risk assessments and care plans for those that were identified by the Assessment Team to contain inaccurate information.
* A review of the service’s Behaviour Support Policy and Procedures, to ensure a consistent approach to the documentation of BSPs.
* A review of the Psychotropic Self-Assessment to ensure all instances of chemical restraint have been identified.
* The redistribution of the service’s resident of the day process to align staff practices and to ensure the accurate monitoring of consumers.

Whilst I acknowledge the Assessment Team presented some discrepancies with the service’s process regarding the review of care and services for some consumers, the issues have been clarified by the Approved Provider’s response and further evidence brought forward that satisfies me that implemented and planned actions of the Approved Provider have addressed the deficiencies. Therefore, I find the service Compliant with this requirement.

# STANDARD 3 NON-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 Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

The service had processes in place to manage and monitor risks associated with the care of consumers. Care planning documentation outlined the key risks to consumers. Staff demonstrated a shared understanding of consumer’s high impact or high prevalence care risks, this information consistent with consumers’ care planning documentation and described strategies used to minimise risks for the consumers.

Staff described the way care is provided to consumers that are palliating and practical ways staff ensure the comfort of consumers. Consumers and representatives expressed confidence that during end of life care, the service will support them to be with their friends and family members as well as having their pain effectively managed. Care planning documentation the needs, goals and preferences of consumers for end of life care. Clinical staff are available twenty-four hours per day to support and monitor care delivered to consumers nearing the end of life. Senior clinical staff are available on call and if required will attend the service to support staff in the care of consumers nearing the end of their life.

The service was able to demonstrate how 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. Consumers and representatives indicated their needs and preferences are effectively communicated between staff. Staff described how changes in consumers’ care and services are communicated in the handover process. Staff advised they are given information at handover which includes verbal discussion and access to the electronic care planning system.

Consumers and representatives confirmed they were satisfied that referrals to health professionals occurred in a timely manner and consumers have access to relevant external health professionals when required. The Assessment Team noted that information and recommendation arising from external referrals are consistently recorded within the consumer’s care planning documents. Staff explained that referrals are made in consultation with consumers, representatives, allied health professionals and medical officers.

The service had processes in place to promote antimicrobial stewardship and to prevent and control infection. Staff stated they had received training in infection control procedures, hand hygiene and the donning and doffing of Personal Protective Equipment (PPE). The Assessment Team observed several strategies in place in response to COVID-19, including the availability of hand sanitisers, the screening of visitors upon entry to the service and infection control information on display within the service.

The Assessment Team found the service did not meet Requirement 3(3)(a) regarding the delivery of safe and effective care for each consumer and Requirement 3(3)(d) regarding the recognition and response to deterioration or changes in consumer’s health. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint under Requirement 3(3)(a) and Compliant under Requirement 3(3)(d). I have provided reasons for the finding in the relevant requirement below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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.*

The Assessment Team identified that the service was unable to consistently demonstrate that each consumer received safe and effective clinical care that is best practice, tailored to their needs and optimised their health and well-being. Summarised relevant evidence relating to safe and effective personal and clinical care included:

* Two named consumers with exit seeking behaviours which is not listed within their BSPs. Management and clinical staff advised they regularly redirect these consumers from exiting the facility. The Assessment team noted these consumers are environmentally restrained, without the appropriate authorisation or consent documents in place.
* A named consumer that demonstrated an increase in behaviours of concern. Progress notes outlined a discussion between the service and the consumer’s family member which resulted in the family member providing consent to increase the dosage of the consumers psychotropic medication. However, the Assessment Team outlined there was no evidence of the restrictive practice from being re-signed following the dosage increase.
* A named consumer that periodically presented with behaviours of concern, the consumer’s care planning documentation did not outline any potential triggers for the consumer’s behaviours, nor the strategies in place to manage their behaviours.
* Wound care documentation was found to be incomplete, and photographs for multiple consumers showed what was presumably, a staff member’s hands in contact with the consumer’s surrounding skin. It was evident that protective gloves were not being utilised which was contrary to the service’s documented infection control measures.
* The Assessment Team raised the above issues with Management during the Site Audit, Management acknowledged the identified issues and indicated there were improvements to be made to their clinical care delivery.

The Approved Provider’s written response, received 21 April 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

* The two consumers with exit seeking behaviours; as previously discussed under Requirement 2(3)(a) and 2(3)(c), the risk assessment and care plans for both consumers have been reviewed and updated.
* The named consumer that periodically presented with behaviours of concern; as previously discussed under Requirement 2(3)(a) and 2(3)(c), the consumer’s risk assessment and BSP had been updated to include additional information regarding their triggers. Furthermore, the consumer was referred to a dietician, and a medication review was conducted resulting in the cessation of certain medications.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* A review of the service’s Behaviour Support Policy and Procedures, to ensure a consistent approach to the documentation of BSPs.
* A review of the Psychotropic Self-Assessment to ensure all instances of chemical restraint have been identified.
* The redistribution of the service’s resident of the day process to align staff practices and to ensure the accurate monitoring of consumers.
* A review of the Wound Management Policy and procedure, with the inclusion of wound photography instructions. In addition, wound care training has been organised for two nominated staff across all sites.
* Ongoing monitoring of staff practices in relation to wound care to be undertaken, with mentoring to be provided to individual staff as identified.
* A memorandum has been sent to all staff to remind them of the need for correct mask wearing.

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 surrounding the accuracy of care planning documentation, 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 therefore find this requirement Non-compliant.

### 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.*

The Assessment Team identified that 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 in some instances. Summarised relevant evidence relating to safe and effective personal and clinical care included:

* Two named consumers with care planning documentation that outlined rapid weight loss over recent months. The progress notes reflected regular monitoring of weight, however did not contain any record to indicate weights being checked for accuracy, nor evidence of any investigation or action taken for their weight loss.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged the deficits and reported there were improvements to be made to their clinical care delivery.

However, the Assessment Team also brought forward evidence in relation to two consumers that demonstrated the service did recognise and respond to changing conditions in a timely manner.

* The Assessment team brought forward evidence of one consumer who complained of abnormal pain. Care documents showed the service immediately sought medical advice and offsite medical care for this consumer, who’s condition was resolved. A further consumer who, after reported feeling unwell was identified as having low blood glucose levels and their condition was immediately managed by care staff.

The Approved Provider’s written response, received 21 April 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

* The two named consumers that experienced rapid weight loss; both consumers have been reviewed by a dietitian and their dietary care plans have been updated to include strategies to counteract the weight loss.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* The redistribution of the service’s resident of the day process to align staff practices and to ensure the accurate monitoring of consumers.
* The implementation of a draft care plan evaluation checklist.

Whilst I acknowledge the service has demonstrated discrepancies with their response to deterioration or changes, on the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate overall Non-compliance. Therefore, I find the service Compliant with this requirement.

### 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 COMPLIANT Services 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 Compliant as seven of the seven specific requirements have been assessed as Compliant.

Consumers and representatives felt that consumers received safe and effective services and supports for daily living that met their needs, goals and preferences and optimised their independence, health, well-being and quality of life. Care planning documentation outlined the goals of consumers’ and their preferences for daily living, leisure activities and meals. Staff demonstrated a shared understanding of the activities of importance to consumers and provided examples of how they support consumers, including those with physical impairments, to partake in these activities.

Consumers and representatives expressed that the service provides support for daily living to promote the emotional, spiritual and psychological well-being for each consumer. Care planning documentation included information about consumer’s spiritual beliefs, behaviours that indicate low-mood and strategies to support their emotional well-being. Staff demonstrated a shared understanding of the support preferences of consumers and how to support their health and well-being. The Assessment Team observed a religious service at the service and consumers were noted to be actively engaged.

Care planning documentation outlined the services and supports that assist each consumer to participate within and outside of the service environment, maintain social and personal relationships and do the things of interest to them. Consumers described the activities they enjoy and how the service assists to facilitate and organise these activities. The Assessment Team observed consumers interacting with each other including during meal times and consumers were observed engaging in a range of group and individual activities.

Information about consumers’ condition, needs and preferences was communicated within the organisation, and with other services where relevant. Staff described how the needs and preferences are documented, updated and communicated throughout the service to ensure consistency of care. The Assessment Team observed a shift handover and noted staff were communicating information about the consumers’ care needs and preferences. Consumers and representatives expressed that information about their needs are shared amongst the staff.

Care planning documentation demonstrated the occurrence of timely and appropriate referrals to individuals, other organisations and providers of other care and services. Staff demonstrated a shared understanding of the external supports utilised by consumers and could identify the supports and external organisations available to consumers if requested.

Consumers and representatives mostly expressed positive feedback regarding the quality and quantity of the meals provided by the service. Care planning documentation evidenced the identification of dietary requirements and meal preferences, this information aligns with consumer feedback. Staff demonstrated a shared understanding of consumer’s dietary requirements and outlined that consumers can provide feedback regarding their meals directly to staff or through the food focus meetings.

The Assessment Team observed that where equipment was provided, it was safe, suitable, clean and well maintained and that staff undertook ongoing monitoring to ensure equipment was fit for purpose. Staff indicated they have access to the required equipment and that equipment is cleaned and maintained by the maintenance staff. Consumers confirmed that equipment used to support lifestyle activities is clean and well maintained.

## 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) Compliant

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

### 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 and representatives said the service optimised their sense of belonging and independence and felt at home within the service. The Assessment Team observed the service environment to be welcoming and had shared areas for consumers to interact with each other, as well as spaces for quiet activity. The rooms of consumers were personalised with furniture, photographs, art works and bed covers. Staff noted that signage is utilised throughout the service to assist consumers to navigate the facility.

The Assessment Team observed the service to be safe, clean, well maintained and comfortable, consumers were able to move freely throughout the facility, both indoors and outdoors. Staff were able to describe the process for reporting maintenance issues and stated that they are promptly dealt with. Consumers were observed to traverse the facility and visit the outdoor garden areas. Consumers and representatives expressed that the service is safe, clean and well maintained.

The Assessment Team observed the furniture, fittings and equipment at the service to be safe, clean, well maintained and suitable for consumers. A review of the preventative maintenance log indicated that the six-monthly mobility aid maintenance check had been completed and the call bell system was noted to be operating effectively. Staff expressed that shared equipment is regularly maintained and described the process they would follow to ensure the cleanliness of the equipment items.

## 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 COMPLIANT Feedback 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 Compliant as four of the four specific requirements have been assessed as Compliant.

Consumers felt they were encouraged and supported to provide feedback and make complaints and were familiar with the feedback and complaints processes. Staff indicated in the event they are approached by a consumer or representative with any concerns, they supported them to contact the registered nurse or manager to report those issues. The Assessment Team observed feedback forms and mailboxes available within the service as well as posters on display which outlined the feedback process.

Staff knew of the processes to access interpreter and advocacy services on behalf of a consumer and described how they support consumers and representatives to complete feedback forms. Consumers and representatives were aware they had access to advocates and other methods for raising complaints and knew where to locate additional information within the service. The Assessment Team observed information about advocacy groups, language services and external complaints processes on display throughout the service.

Consumers and representatives indicated that the service takes appropriate action in response to complaints and the practice of open disclosure is utilised. Staff demonstrated a shared understanding of the open disclosure process and provided examples how they have applied open disclosure in practice. The Assessment Team noted the service had a documented policy on open disclosure and complaints management. A review of the complaint and incident registers demonstrated that appropriate and timely actions were taken when a complaint is received, or an incident occurs.

The service demonstrated that feedback and complaints are used to improve the quality of care and services. Consumers and representatives provided examples of feedback they have previously raised and outlined the prompt and satisfactory outcomes the service had provided. Management advised that if consumers or representatives are not satisfied with the outcome of their feedback, they are able to contact the organisation’s advice line to escalate to the executive team. Management further advised that the service trends and analyses feedback and complaints made by consumers or representatives are used to inform continuous improvement activities across the service.

## 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.*

### 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.*

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 NON-COMPLIANT Human 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 and representatives were mostly satisfied that the workforce was planned to enable the delivery and management of safe and quality care and services. Staff expressed that although they can be busy at times, they were still able to promptly respond to consumers and complete their duties. Management described the process for rostering staff, including how the service manages planned and unplanned leave. The service had a pool of casual staff to ensure they do not have unfilled shifts.

The Assessment Team observed staff engaging with consumers and their family members in a respectful, kind and caring manner. Consumers and representatives expressed positive feedback regarding their interactions with staff and indicated that staff were respectful of consumer’s preferences and identity. Staff demonstrated a shared understanding of consumer’s needs and preferences, this information aligned with the Assessment Team’s review of care planning documentation.

Consumers and representatives expressed confidence in the workforce and stated that staff perform their roles effectively, and staff have the necessary knowledge, training and skills to meet their care needs. Position descriptions outlined the required qualifications, registration requirements, knowledge skills and abilities required for the relevant role. Management advised that all staff complete a general orientation program and then receive training that is specific to their role.

Staff were able to describe the training, support, professional development and supervision they receive during orientation and on an ongoing basis. Consumers and representatives confirmed that staff have the appropriate skills and knowledge to ensure the delivery of safe and quality care and services. A review of the service’s education register by the Assessment Team demonstrated staff have completed mandatory training modules, including COVID-19, manual handling, fire safety, elder abuse and infection control.

The Assessment Team found the service did not meet Requirement 7(3)(e) regarding the regular assessment, monitoring and review of the performance of each member of the workforce. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint. I have provided reasons for the finding in the relevant requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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.*

### 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.*

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

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

The Assessment Team identified that the service was unable to demonstrate how the performance of staff is regularly reviewed, or how the service monitors and controls when the performance reviews are due to be completed. Summarised relevant evidence relating to deficiencies in the monitoring and review of the workforce included:

* The Assessment Team noted that four staff, when asked about performance reviews were unable to recall when they had their last performance or probation review completed.
* A review of five staff files by the Assessment Team. All five files did not include a performance review conducted within the last twelve months.
* A review of documents regarding the service’s staff performance framework outlined that all employees must be assessed annually. In addition, probationary staff, the service must conduct a probation review within the first three months, followed by another review within six months. It was not evident that this process had been followed.
* The Assessment Team requested management to provide documentation regarding performance reviews. The Assessment Team received three incomplete performance assessments, written only by staff members and did not contain input from their managers.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged the lack of monitoring and review of the performance’s reviews and advised they will conduct a review of all staff files to check for overdue performance reviews.

In its written response, the Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* A reminder to all of the organisation’s sites to ensure performance appraisals are conducted in accordance with policy and to identify any issues with completing appraisals.
* Individual performance review meetings with all staff at the service.
* A spot audit of compliance with current performance appraisal processes within the last 12 months will be conducted across all sites.
* Implementation of an updated performance review process involving regular “quick check-in” performance and capability development conversations.
* Implementation of a Human Capital Management System – Performance Module, providing automated reminders of appraisal due dates and a repository for performance conversations.

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 surrounding performance reviews, at the time of the Site Audit, the service did not demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. I therefore find this requirement Non-compliant.

# STANDARD 8 COMPLIANT Organisational 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 Compliant as five of the five specific requirements have been assessed as Compliant.

Consumers and representatives confirmed they are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. A review of consumer meeting minutes by the Assessment Team identified consumers engaging with the service and providing their feedback regarding a variety of matters. The service noted they monitor the satisfaction of consumers/representatives through collection of feedback and audits.

The organisation’s governing body promoted a culture of safe, inclusive and quality care and services and took accountability for their delivery through meetings, monitoring, audits and reporting. The organisation’s governance structure includes the direct dissemination of information to the organisational management operations and clinical team from front line managers of each service.

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 been educated on these policies and could provide practical examples of their relevance to their work and responsibilities. However, the Assessment Team identified a named consumer that was involved in an incident and no subsequent incident report or investigation were recorded. Management advised that as the consumer had been reviewed by a doctor, they did not identify the need to investigate or record the incident, although management further advised they would open an incident report and investigate the incident.

The service was able to demonstrate a clinical governance framework and supporting polices that addressed antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff demonstrated a shared understanding of the open disclosure principles and provided examples of how they kept consumers and representatives informed of any changes relating to an adverse event. Management were able to describe changes that have been made to care and services arising from the implementation of the aforementioned policies.

The Assessment Team found the service did not meet Requirement 8(3)(c), regarding the effective organisation wide governance systems relating to regulatory compliance. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service complaint. I have provided reasons for the finding in the 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) 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 found the service had effective systems in place relating to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. The Site Audit report did identify some deficiencies in relation to regulatory compliance in that the service did not consistently identify consumers who were subject to restrictive practices. Summarised relevant evidence relating to this issue included:

* Two named consumers with exit seeking behaviours. Management and clinical staff advised they regularly redirect these consumers from exiting the facility. The Assessment team noted these consumers are environmentally restrained, without the appropriate authorisation or consent documents in place.
* A named consumer was prescribed psychotropic medication, and their BSP did not mention the administration of this medication.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged the deficits and reported there were improvements to be made to their clinical documentation process.

The Approved Provider’s written response, received 21 April 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider has outlined that in relation to:

* The named consumers with exit seeking behaviours; as previously discussed under Requirements 2(3)(a) and 3(3)(a), the risk assessment and care plans have been reviewed and updated. For one of these consumers, a report has been made under the Serious Incident Response Scheme regarding the inappropriate use of restrictive practice due to the absence of documented consent.
* The named consumer being prescribed psychotropic medication; as previously discussed under Requirements 2(3)(a) and 3(3)(a), a further review of the consumer’s care planning documents revealed a signed consent form for chemical restraint was present, dated 21 October 2021. This consumer’s BSP has been updated and a review of their medication by a doctor has occurred, resulting in the cessation of certain medications.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* A review of the service’s Behaviour Support Policy and Procedures, to ensure a consistent approach to the documentation of BSPs.
* A review of the Psychotropic Self-Assessment to ensure all instances of chemical restraint have been identified.
* A review of psychotropic medication consent documentation.
* The redistribution of the service’s resident of the day process to align staff practices and to ensure the accurate monitoring of consumers.

Whilst I acknowledge the service has demonstrated discrepancies with their regulatory compliance, these examples alone were insufficient to indicate significant deficits in the overall efficacy of the service’s governance systems. Therefore, I find the service Compliant with this requirement.

### 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 2(3)(a) – The service ensures that assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* Requirement 3(3)(a) – 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 7(3)(e) – The service ensures the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.