Performance

Report

**1800 951 822**

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| Name: | Melaleuca Home For The Aged |
| Commission ID: | 8820 |
| Address: | 71-73 Mary Street, EAST DEVONPORT, Tasmania, 7310 |
| Activity type: | Review Audit |
| Activity date: | 27 February 2024 to 29 February 2024 |
| Performance report date: | 4 April 2024 |
| Service included in this assessment: | Provider: 11 Melaleuca Home for the Aged Inc  Service: 5092 Melaleuca Home For The Aged |

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 Melaleuca Home For The Aged (**the service**) has been prepared by Nicola Eastwood, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 27 March 2024.
* the following information given to the Commission, or to the assessment team for the Review Audit of the service:
* Compliance history related to:
  + Performance Report dated 27 July 2023 following an Assessment Contact between 21 June 2023 and 22 June 2023 – identifying continued non-compliance with Requirements 2(3)(a), 2(3)(b), 3(3)(a), 3(3)(b), 3(3)(f), 8(3)(d) and 8(3)(e),
  + Performance Report dated 11 July 2022 following a Site Audit between 24 May 2022 and 27 May 2022 – identifying Requirements 2(3)(a), 2(3)(b), 3(3)(a), 3(3)(b), 3(3)(f), 8(3)(d) and 8(3)(e) as non-compliant,
* Monitoring report following an Assessment Contact conducted on 13 December 2023,
* Monitoring report following attendance by Restrictive Practice Unit and Compliance 22 February 2024.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 2**

* Requirement 2(3)(a) update assessments and care planning to include consideration of risk and ensure communication of changed needs is contemporaneous and available in a centralised accessible system.
* Requirement 2(3)(d) ensure engagement and consultation with consumers and representatives in review of consumer assessment and planning.
* Requirement 2(3)(e) implement and sustain regular update and review of consumer assessment and care planning documentation.

**Standard 3**

* Requirement 3(3)(d) implement and evaluate use and compliance with Clinical Deterioration Policy and validated assessment tools.
* Requirement 3(3)(e) centralise sources of information to ensure point of care resources accurately reflect care needs.
* Requirement 3(3)(f) implement a formalised referral process for use both in situations of deterioration and where supportive care is required.

**Standard 8**

* Requirement 8(3)(e) maintain and evaluate adequate clinical oversight improvements and governance structure.

# Standard 1

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

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above, and as a result complies with this Standard.

Consumers confirmed they are treated with dignity and respect their identity, culture and diversity valued as individuals. Staff demonstrated an understanding of individual choices and preferences and care planning documentation included detail regarding individual preferences and the people important to them. There was evidence of training to support dignity, respect and cultural awareness of consumers.

The Charter of Aged Care rights is displayed in the services foyer and the service has policies and procedures to align with dignity and respect for the consumer. There is access to translator services where required and staff explained where English is a second language additional methods are used to support communication with consumers.

Staff demonstrated an understanding of consumer preferences and choices when it comes to their care and maintaining relationships. Care planning documentation demonstrated information regarding consumer preferences for maintaining relationships of their choice.

Management demonstrated processes to support consumer independence and choice. There was evidence of consideration to activities involving an element of risk to support maintaining independence and self-determination. Staff described how they maintain consumer privacy when providing care and how they protect personal information with password protected access to consumer files and keypad locked nurse’s stations containing sensitive information.

The service displays relevant information and emails consumers and representative’s material, including activity calendars, meeting minutes, visiting requirements, and newsletters.

# Standard 2

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

Findings

The service was previously found non-compliant with Requirements 2(3)(a) and 2(3)(b), following a Site Audit between 24 May 2022 and 27 May 2022 and subsequent Assessment Contact between 21 June 2023 and 22 June 2023. The Assessment Team noted actions to date which have been effective to address previous non-compliance with Requirement 2(3)(b). I note the ongoing non-compliance with Requirement 2(3)(a) and inability to sustain effective actions to address ongoing deficits. In addition to the existing non-compliance there is evidence of emerging areas of additional concern.

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 2(3)(a), 2(3)(d) and 2(3)(e) and as a result, does not comply with Standard 2.

Requirement 2(3)(a):

The service did not demonstrate that assessment and planning was comprehensive or consistently considered risks to consumer health and wellbeing. Inconsistencies were observed among the multiple assessment and care planning documentation sources in use. Staff demonstrated an understanding of consumer care needs and associated risks. However, staff reported they do not routinely review progress notes despite being a more accurate data source. Despite this, consumers and representatives indicated they were satisfied with the care received.

The Assessment Team noted where restrictive practice had been implemented for a consumer, assessment and care planning documentation inconsistently reflected the restrictive practice and its associated risks. Feedback was provided to management during the Review Audit with the restrictive practice subsequently removed and destroyed. A Plan for Continuous Improvement (PCI) was reported to be in place including support for clinical staff related to the assessment and planning documentation policy and implementation of a task manager function within the electronic care system.

The Approved Provider submitted a response to the Assessment Team report (the response) indicating a quarterly review schedule has been developed and is underway. The response also described updates to handover processes to better facilitate communication of contemporaneous change to consumer condition. The response also included supporting evidence to address concerns raised relevant to named consumers. I acknowledge the service’s actions to date and proposed improvements including the quarterly review schedule. I note the response did not include further strategies to address the multiple sources of information currently relied upon and encourage the Approved Provider to consider how best to ensure accurate and centralised information is available, in addition to the handover improvements. As a result, I consider additional time to embed and evaluate proposed actions is required and find this requirement non-compliant.

Requirement 2(3)(d):

Consumers and representatives indicated assessment and planning outcomes are discussed when an incident or acute change occurs, however, they have not been involved in regular assessment and planning processes. Consumers and representatives also reported they were not aware that their care plans are readily available to them and advised they have not been offered a copy. The Assessment Team noted consumer documentation inconsistently reflected outcomes of assessment and planning with care plans reported not to be recent or accurately reflect consumer needs, goals, and preferences. The Assessment Team noted a consumer did not have assessment and planning documentation in place due to not being reviewed by a Medical Officer (MO) since their admission.

The response referred to the quarterly review schedule to address concerns related to assessments and the content of care plans as well as discussion of outcomes and access to copies for consumers and representatives. Education and communication of this new process is planned and missing assessments for named consumers has now been completed. I acknowledge the response and future actions planned to address the identified deficits at the time of the Review Audit. I consider more time is required to sustain this in practice and effectively evaluate expected outcomes. As a result, I find this requirement non-compliant.

Requirement 2(3)(e):

The service did not demonstrate regular review of consumer care and services. Consumers and representatives reported they are not involved in regular routine care plan reviews. Clinical staff and management confirmed consumer care and services are not reviewed in accordance with the service’s 3 monthly review process. Despite this, clinical staff and management discussed how they review and communicate consumer care needs. The Assessment Team noted that documentation inconsistently included alerts about consumer needs. Management and consultancy personnel acknowledged and agreed with the deficits identified by the Assessment Team. The consultancy personnel reported a care plan evaluation calendar has been developed with person centred care meetings to be established. A clinical deterioration policy is also currently being developed.

As indicated in Requirements 2(3)(a) and 2(3)(d) the response referred to the quarterly review schedule to address concerns related to assessments and the content of care plans as well as discussion of outcomes and access to copies for consumers and representatives. As previously noted, I consider more time is required to sustain this in practice and effectively evaluate expected outcomes. As a result, I find this requirement non-compliant.

Compliance with remaining requirements:

Consumers and representatives reported they were involved in discussions about their needs, goals and preferences including end of life care. Staff demonstrated knowledge of individual consumers including their needs, goals, and preferences. The Assessment Team observed staff responding to a consumer’s needs in accordance with their wishes. Care documentation demonstrated that the service consults with consumers and their representatives to discuss changes including advanced and end of life care needs.

Clinical staff described how consumers are supported to direct their own care with referrals to organisations and external health providers completed if a change in consumer condition is identified. The Assessment Team confirmed assessment and planning of care is completed in consultation with clinical staff, medical and allied health professionals. Consumers and representatives confirmed they feel involved in the assessment and planning of their care and described how they are contacted to discuss changes to their assessed care needs.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | 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. | Not 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. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not 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

The service was previously found non-compliant with Requirements 3(3)(a), 3(3)(b), 3(3)(f), following a Site Audit between 24 May 2022 and 27 May 2022 and subsequent Assessment Contact between 21 June 2023 and 22 June 2023. The Assessment Team noted actions to date which have been effective to address previous non-compliance with Requirements 3(3)(a) and 3(3)(b). I note the ongoing non-compliance with Requirement 3(3)(f) and inability to sustain effective actions to address ongoing deficits. In addition to the existing non-compliance there is evidence of emerging areas of additional concern.

I am satisfied based on the Assessment Team’s report and the Approved Provider’s response that the service does not comply with Requirements 3(3)(d), 3(3)(e) and 3(3)(f), and as a result, does not comply with Standard 3.

Requirement 3(3)(d):

A review of consumer documentation demonstrated a delay in the service recognising and responding to consumer deterioration or changes including escalating concerns to medical and allied health professionals. Clinical staff described how deterioration or changes are identified, actioned, and communicated. Care staff described escalation processes including seeking immediate assistance from the nurse. Although staff described the service’s policy, they indicated it is not consistently followed. Despite this, consumers and representatives expressed satisfaction with the responsiveness of the service when there is a change in consumer health status. Consultancy personnel reported they have developed a clinical deterioration policy that is currently out for staff consultation, however, associated training is yet to be negotiated with the service.

The response included supporting evidence of a newly developed Clinical Deterioration Policy and flip chart, as well as introduction and of a pain flowchart and completion of validated assessments for named consumers. There is a plan in place for future staff education as well as a focus on ensuring timely referrals are completed and documented accordingly. I acknowledge the actions to date and the plan for further improvements. I note the introduction of this process is in its infancy with supporting education vital to ensure the success of improvements. Given the potential risks associated with this area of clinical care, further time to ensure the successful introduction of the Clinical Deterioration process and identification and response to deterioration is required. I find this requirement non-compliant.

Requirement 3(3)(e):

Clinical staff reported that multiple sources of information are used to understand consumer needs, goals, and preferences. Despite this, progress notes were reported to not be routinely reviewed by staff resulting in inconsistent information available to guide care. The Assessment Team noted multiple methods were used communicate with medical and allied health professionals. Allied health professionals and clinical staff described differing processes to communicate assessment and planning outcomes with these outcomes reported to be ad hoc and/or inconsistently documented. A review of consumer documentation noted inconsistencies in assessment, care planning and consideration of risks to inform consumer needs, preferences and current conditions. Despite this, consumers and representatives expressed satisfaction that consumer needs are communicated in a timely manner.

As indicated in Requirements 2(3)(a) and 2(3)(d) the response referred to the quarterly review schedule to address concerns related to assessments and the content of care plans. I note the response did not include further strategies to address the multiple sources of information currently relied upon and encourage the Approved Provider to consider how best to ensure accurate and centralised information is available, in addition to the handover improvements. As previously noted, I consider more time is required to sustain this in practice and effectively evaluate expected outcomes. As a result, I find this requirement non-compliant.

Requirement 3(3)(f):

The service did not demonstrate that referrals were timely or consistently completed to allied health professionals and external supports. Instead, the Assessment Team noted that referrals were completed in an ad hoc manner. Consumer documentation reviewed and interviews completed demonstrated that inconsistent processes were used to make referrals or referrals were not completed. While staff demonstrated knowledge of consumer care needs and described engaging allied health professional and external support services, they described various referral processes dependent on the type of referral.

The response submitted included reference to the actions related to Requirement 3(3)(d) and implementation of a Clinical Deterioration Policy with supporting flipchart. It is acknowledged that the service described external supports, medical and allied health professionals engaged for named consumers and has included the deterioration process for a number of acute scenarios. It is not clear from the response, how a consistent approach to general referrals has been implemented. It is also unclear what actions are proposed or have been implemented to ensure timely referrals are actioned and followed up. I consider further improvement is required to ensure there is a systematic process in place to support timely referrals and consistent collaboration with allied health professionals and external supports. I find this requirement non-compliant.

Compliance with remaining requirements:

Consumers and representatives expressed satisfaction with the personal and clinical care they receive. Staff described examples of how they tailor personal and clinical care to optimise consumer needs, goals, and preferences. Clinical staff demonstrated an understanding of organisation policies, procedures, and validated assessment tools to guide best clinical care including in relation to wound and pain management. Although most consumers with pressure injuries demonstrated wound healing with validated skin assessments and wound care plans evident, appropriate reviews and referrals were not consistently completed. Inconsistent use of validated pain assessments and documentation of pain were also noted by the Assessment Team across multiple information sources. Consultant personnel advised the organisation pain policy and flowchart have been reviewed. Consultant personnel advised a comprehensive review of restrictive practices has been undertaken. This review has resulted in restraint minimisation and an improvement in clinical staff understanding of restrictive practices, legislative and documentation requirements. During the Review Audit, the service identified the psychotropic register was inaccurate, this was updated the same day and the service has commenced processes towards enabling electronic psychotropic reporting. The Assessment Team observed a mechanical restraint which they had been advised was previously removed, it was established this had not occurred as expected and management subsequently removed and destroyed the restraint mechanism.

Management described and demonstrated how high impact high prevalent risks are managed through meetings, incident reporting, data analysis and trending. Clinical staff described nutrition and hydration, wound, falls and diabetes management in line with documentation including the organisation policy. The Assessment Team noted tailored diabetes and falls management plans; however, weight charting was not consistently completed in line with medical and allied health professional directives. In addition, the Assessment Team noted as indicated in Requirement2(3)(a) risk documentation and consideration of risks were inconsistently recorded.

There were organisational policies and procedures to guide the provision of palliative care, end of life care and advance care planning. Consumers and representatives reported advanced and end of life wishes are discussed when requested in consultation with a MO and clinical staff. A review of care documentation demonstrated consultation with consumers and representatives regarding changes, needs, goals and preferences. The Assessment Team noted that some advance care plans were not available, however, staff indicated these plans are in progress.

Consumers and representatives were satisfied with the management of consumer infections and the service’s outbreak management procedures. Clinical staff described precautions to prevent and control infection including actions implemented to minimise antibiotic use. Staff and management described how infection incident reporting, audits, trending, and data analysis is used. The service has a part time Infection Prevention and Control lead who works with management to monitor staff training and competencies around infection control practices and personal protective equipment. The service has a policy for antimicrobial stewardship and an outbreak management plan.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and, as a result, complies with this Standard.

Consumers and their representatives reported they are provided with support to optimise their independence, health, and wellbeing. Staff provided examples of how consumers are supported to engage in activities and maintain their independence and quality of life. Group activities are based on consumer preferences and are evaluated. The Assessment Team noted that consumer social and lifestyle plans are individualised with consumers supported to maintain their abilities where possible.

Staff described how support is provided in accordance with individual consumer emotional and spiritual needs including when changes in level of consumer engagement is identified. Consumers were noted to be supported by volunteers, external services, and organisations. Consumer documentation included information on emotional, spiritual, and psychological needs and preferences. The Assessment Team observed staff providing emotional support to consumers. This was consistent with reports by consumers and their representatives.

A review of consumer documentation demonstrated information regarding consumer relationships of significance, activities of interest and levels of involvement in activities. Staff described how they support consumer relationships, individual pursuits and participation in group and community activities. This was consistent with observations and consumer and representative reports.

Consumers expressed satisfaction that information regarding their needs and preferences is effectively communicated within the organisation. Documentation reviewed by the Assessment Team demonstrated safe and effective sharing of consumer information within the organisation. Staff demonstrated an understanding of all consumers needs and preferences including how information is shared with others providing care and where to locate this information.

The service demonstrated appropriate referrals to other organisations, individuals and providers of care and services. Consumers reported confidence that the service would make an appropriate referral if they could not provide the required support. The Assessment Team noted that consumer documentation inconsistently included information regarding external providers utilised to support consumer needs. Management acknowledged this feedback and indicated that consumer care plans would be updated.

The Assessment Team noted a variety of menu options catering for individual consumer preferences and requirements. Staff were observed to be respectfully assisting, encouraging, and offering choices of meals to consumers. Care planning documentation was noted to include consumer dietary requirements and preferences which was consistent with staff knowledge. Most consumers and representatives expressed satisfaction with the quality and quantity of meals. The Assessment Team noted the service reviews the consumer dining experience with consumers reporting that the service is responsive to feedback and suggestions.

Consumers and representatives expressed satisfaction that equipment used to provide care is appropriate for consumer needs, clean and well maintained. This was consistent with observations by the Assessment Team. Staff explained cleaning protocols, infection control practices and maintenance of mobility equipment.

# Standard 5

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

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above, and as a result complies with this Standard.

Consumers and their representatives confirmed the service environment is welcoming and homely. There was free access to the service with consumers able to utilise communal areas as they choose. Staff described how consumer and representative feedback regarding environmental improvements is discussed during ‘Resident-Representative’ meetings.

Maintenance programs include essential services, preventative maintenance schedules, reactive maintenance processes and the use of external contractors when required. Preventative and essential services maintenance is scheduled with documents viewed confirming regular preventative maintenance occurs with oversight of the organisation. Reactive maintenance is documented on logs, and maintenance signs off when issues are resolved.

The Assessment Team observed a range of equipment available to meet consumer care and clinical needs. Staff effectively demonstrated the maintenance process for equipment requiring repair and the cleaning process for shared equipment before and after use. Consumers were observed utilising various equipment, including wheelchairs and comfortable chairs.

# Standard 6

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

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above, and as a result complies with this Standard.

Consumers and representatives said they are aware of the feedback process including how to complete the complaint and compliment forms and are encouraged to provide feedback. The Assessment Team noted positive feedback from staff in relation to being encouraged and supported by management to provide and record feedback and complaints. Management said feedback gathered during consumer and representative meetings is included in the meeting minutes and further recorded within the electronic management system.

Consumers, representatives, and staff were aware of the information displayed across the service’s information boards, reception, and other methods of raising complaints. Management described online feedback forms, and hard copy forms are available for consumers and representatives to access and can be printed in a variety of languages, should that be required. The Assessment Team noted publicly available information with contact information and phone numbers for both Advocacy Tasmania and the Department of Health and Aged Care related to complaint and advocacy assistance.

Staff demonstrated an understanding of the open disclosure process and explained how they apologise to a consumer when incidents happen, or when something goes wrong. Management explained how staff are guided by policies on open disclosure and complaints management. The service has an electronic complaints and suggestions database reflecting consumer and workforce feedback. The electronic management system is reviewed weekly and used to guide internal audit processes and trending. The service’s complaints register demonstrated that staff responses aligned consistently with the service’s open disclosure policies and procedures, ensuring that appropriate actions are taken in response to complaints.

Staff and management confirmed they participate in team meetings to review feedback and improve consumer care. Management said they have undertaken consumer feedback surveys and internal audits resulting in improvements based on the information obtained.

# Standard 7

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

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above, and as a result complies with this Standard.

Consumers and representatives were satisfied with the quantity of staff and the promptness of attendance to call bells. The service has been actively recruiting for the clinical care director role to ensure adequate clinical governance oversight. Management described their efforts to ensure effective staffing to provide safe and quality care. The services electronic rostering system highlights ‘vacant shifts’ to ensure that consumer care needs are reviewed in line with rostering requirements. The Assessment Team noted all clinical and care staff said staff levels and rostering practices were appropriate and well managed.

Staff were observed engaging with consumers in a warm, gentle and respectful manner. Care planning documentation was individualised to accommodate the personal preferences, needs, and interests of each consumer at the service. Staff were also trained in the services ‘person first approach’ and an organisational framework where experiences, wellbeing, needs, and feelings are prioritised.

Management explained they check worker qualifications, referees and all other required information prior to working for the service. All qualifications are reviewed and saved within an electronic application system. Position descriptions and duty lists for clinical and care roles are reviewed regularly by management to ensure they align with the required competencies.

Staff confirmed attendance at a range of educational topics in relation to legislative and regulatory changes such as manual handling, fire training and open disclosure. Management explained they identify training opportunities through ongoing staff discussions, staff meetings and annual competency assessments. Training records and courses for the previous 12-month period reflected a range of mandatory and elective educational opportunities.

Annual performance reviews are completed using an electronic register to ensure compliance. The reviews allow staff to identify learning opportunities for both develop their personal and professional development. Feedback, complaints, and compliance data are evaluated by management at the time of annual performance reviews.

# Standard 8

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

Findings

The service was previously found non-compliant with Requirement 8(3)(e) following a Site Audit between 24 May 2022 and 27 May 2022 and subsequent Assessment Contact between 21 June 2023 and 22 June 2023. The Assessment Team noted actions to date have not been effective to address previous non-compliance with this Requirement. As a result, I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service does not comply with Requirement 8(3)(e) and as a result does not comply with Standard 8.

Requirement 8(3)(e):

The service has a clinical governance framework in place providing an overarching monitoring system for clinical care. However, in the absence of a long-term clinical care director, the service was not effectively considering risk as a component of care delivery.

The service was not able to demonstrate that assessment and planning are consistently comprehensive and inclusive of consideration of risk for consumer health and wellbeing. The service was further unable to demonstrate that regular reviews of consumer care and services are taking place and that timely referrals are consistently occurring.

As reflected in Standards 2 and 3, the absence of adequate clinical oversight and governance has directly contributed to ongoing access to an extreme form of mechanical restraint without indication and contrary to best practice. The impact associated with a lack of consideration to risk assessment, inconsistent communication and document review is both significant and evident. This is further highlighted through evidence of delayed response to deterioration and change in consumer physical function and where consumers are not afforded the opportunity of oversight or collaboration with other specialty services.

The response indicated recent recruitment of a Clinical Care Director to ensure adequate clinical oversight. The response also included information pertaining to the use of mechanical restraint in Standard 3, asserting that a review of restrictive practices had taken place as well as staff education to increase understanding and knowledge. The response also confirmed that all extreme methods of restraints had been removed from the service. I acknowledge the actions completed at the time of, and after the Review Audit. Given the potential risks associated with a lack of adequate clinical oversight as was demonstrated in this instance, further time is required to ensure that improvements are effectively implemented. I find this requirement non-compliant.

Compliance with remaining Requirements:

Consumers and representatives said they are supported to provide feedback including telephone contact with the service, feedback forms, and face to face with care staff. Staff described how they support consumers to be involved in service planning, development, and evaluation of their own care to the extent they wish. Feedback and complaints are reviewed and discussed by the Board. The meeting minutes are stored electronically and available for all staff and Board to review. A member of the Board regularly attends the ‘Resident and Representative’ meetings to ensure greater transparency and to provide a direct point of contact for residents and representatives.

The organisation has a range of policies, and procedures that support and guide management and staff to provide a safe and inclusive culture. Management and staff described how the organisation’s governing body promotes a culture of well-being, choice, and empowerment for consumers. Organisational supports are provided through the Board, committee, and sub-committee structures. These supports facilitate adherence to accountability at an organisational and service level. The organisation monitors care and services through the review of key performance indicators, incidents, audits, and consumer feedback and complaints.

Staff confirmed information provided at shift handover and ‘huddles’ is easily accessible, accurate and assists in providing personalised care to the consumers. They also confirmed they can access the incident reporting system and policies and procedures on a web-based system.

The service maintains two continuous improvement plans that reflect a range of local and organisational improvements identified and implemented in response to feedback and complaints from consumers and staff. One continuous improvement plan relates directly to matters of non-compliance and includes a remedial action plan. Management demonstrated the hierarchical process for financial approval of expenditures with recent financial approvals included capital expenditure for recruitment to address ongoing workforce shortages.

Management and clinical staff demonstrated knowledge of their legislative obligations related to reportable and non-reportable incidents. Clinical staff effectively demonstrated their knowledge of the Serious Incident Response Scheme (SIRS) and correctly outlined their respective responsibilities based on their position. The service has an effective feedback and complaints process that defines and describes open disclosure.

The service has a risk management system implemented to monitor and assess high-impact or high-prevalence risks associated with the care of consumers. Risks as a result of incidents are reported, escalated, and reviewed by management at the service level and organisation level. Management and staff discussed how to identify and respond to allegations of abuse or neglect of consumers and how to document and report incidents. SIRS training has been provided and management discussed recent SIRS reports demonstrating appropriate actions had occurred.

1. The preparation of the performance report is in accordance with section 76A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)