Mercy Place Colac

Performance Report

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**Commission ID:** 3011

**Provider name:** Mercy Aged and Community Care Ltd

**Site Audit date:** 22 March 2022 to 25 March 2022

**Date of Performance Report:** 1 July 2022

# Performance report prepared by

Meritt Nassif, delegate of the Aged Care Quality and Safety Commissioner.

**Publication of report**

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

**Overall assessment of this Service**

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **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** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-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) |  Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) |  Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

**Detailed assessment**

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

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 11 May 2022.

# STANDARD 1 COMPLIANTConsumer 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.

The Assessment Team recommended the service did not meet Requirement 1(3)(a). However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the findings are detailed in the relevant Requirement below.

Consumers confirmed they are receiving culturally safe care and services. Staff demonstrated understanding of consumer’s language and cultural preferences and confirmed equity and inclusion training is mandatory. Care plans reflected the diversity of consumers where the profile included consumer life stories, religion, and care preferences.

Consumers and representatives said consumers are supported to maintain important relationships and exercise choice in how their care is delivered. Staff described how they provide choice to consumers on a daily basis. Consumer meeting minutes demonstrated consumers have the opportunity to participate in decision making and are able to exercise choice and independence.

Dignity of risk assessments documented demonstrated the service encourages consumers to take risk and live the best life they can. This reflects feedback from consumers. The Assessment Team observed a consumer partaking in a risk activity and their care planning documentation reflected that a risk assessment was completed in relation to the activity.

Consumers expressed satisfaction with the information provided to assist them in making choices about their care and lifestyle. Staff demonstrated the way they communicate information to consumers who have difficulty communicating. This is consistent with the Assessment Team’s observation that information is delivered to the consumers in a way they can understand.

Consumers felt their privacy is respected by staff. Consumers reported that staff will knock on the door before entering the room and close the doors when assisting with showering. Staff reported that they gain consumer consent if they want the door closed or opened before delivering care. The Assessment team observed on three occasions staff not knocking on the door to a consumer’s room before entering. However, feedback from consumers raised no concerns with staff actions.

## 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.*

The Assessment Team found the service did not demonstrate that each consumer is treated with dignity and respect. Consumers were not being provided care and services in a timely manner, impacting the consumers’ dignity. Evidence relevant to the finding included:

* Four consumers and two representatives said that consumers have to wait long times for staff to provide personal care, such as toileting assistance, and this makes consumers feel frustrated.
* One consumer felt disrespected when addressed inconsiderately by staff and told to make their own bed.
* Two consumers said they receive food they did not order.
* The Assessment Team observed:
	+ One consumer left in the dining area and not being assisted with their meal.
	+ One staff telling a consumer not to ring their call bell.
	+ One consumer call for assistance with their meal and their call bell was on the floor and out of their reach.

Interview and observational evidence that consumers do not receive the personal care they need and want due to staff shortages is considered in Standard 7 Requirement (3)(a) where it is more relevant. Similarly, consumer feedback that they receive food they did not order is considered under Standard 4 Requirement (3)(f) where it is more relevant.

The Approved Provider’s responses provided additional evidence and information in support of this Requirement to be Compliant. The Approved Provider noted that the results of most recent consumer and family interviews show 100% of consumers interviewed confirmed staff always call them by their preferred name and 100% of family members interviewed said they feel their loved one is treated with respect. In relation to the consumer who said they were addressed inconsiderately, the Approved Provider noted the consumer could not identify the staff member, staff could not recall addressing the consumer in that manner and thought it unlikely any staff did address the consumer inconsiderately. The response also states staff were reminded of the need to always be respectful when addressing consumers.

The site audit report included positive feedback from three consumers and three representatives regarding staff treating consumers with dignity and respect. Further, staff demonstrated understanding of consumer’s life story, cultural backgrounds and personal preferences and these were reflected in care planning documents.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find the service Compliant with this Requirement.

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

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

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

# STANDARD 2 COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

Consumers and representatives expressed satisfaction with assessment and care planning at the service. Staff could outline the assessment and planning process that informs delivery of safe and effective care and includes consideration of risks to consumers. Care planning documents outline consumers’ goals, needs and preferences and identifies risks to consumers. There are policies and procedures to guide staff assessment and planning practice.

Staff confirmed they discuss end of life planning and palliative care with consumers and representatives. Care planning documents showed that consumers’ needs, goals and preferences are captured during assessment and care planning includes strategies to address those needs and goals. Care plans also capture consumer’s end of life preferences and Advance Care Directives. The service has policies for end of life care planning to guide staff practice. Consumers and representatives confirmed staff have discussed end of life planning with them.

Care planning documents reflect ongoing partnership with the consumers, others that the consumer wishes to be involved, and other organisations involved in care. Allied health professionals were observed at the service and could describe assessment, care planning and review processes. Staff described the involvement of the physiotherapists for all mobility and transfer assessments and care planning, falls prevention and pain management. Feedback from consumers and representatives reflect their involvement in the assessment and planning process.

Staff said all care reviews involve discussion with consumers and representatives, which was confirmed by representatives and reflected in care planning documents. Consumers indicated they either have access to the care plan or are confident they would receive a copy if they ask for it.

Review of care planning documents showed evaluations occur every three months or as required, with all assessments current. Consumers and representatives confirmed they attend case conferences for the three-monthly care plan review. Staff interviewed were aware of the incident reporting process and how incidents could trigger a reassessment or review of care planning. Care planning documents show, and staff confirmed, that consumers are assessed and reviewed by health professionals for risk management strategies after an incident.

## Assessment of Standard 2 Requirements

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

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

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

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

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

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# STANDARD 3 NON-COMPLIANTPersonal 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 Assessment Team recommended that the service did not meet Requirements 3(3)(a) and 3(3)(b). However, my finding differs from the recommendation and I find Requirement 3(3)(b) Compliant. Reasons for the findings are detailed in the relevant Requirements below.

Staff described their role in recognising and addressing the needs of consumers nearing end of life. Care planning documents of a palliative care consumer evidenced the service had identified their needs, goals and preferences and implemented pain relief and comfort care strategies. Care planning documents indicated the consumer was assessed by a medical officer and their family involved in discussions about their deterioration. Staff are guided by service policies and procedures on end of life care, including for pain management and comfort care.

One representative reported they were satisfied with the delivery of care, including the service’s recognition of deterioration and change. Care planning documents reflected timely recognition of and response to deterioration and change in two consumers. Staff had shared understanding of assessments used to respond to behaviour changes and described how they recognised recent deterioration in one consumer.

Representatives were satisfied that consumer condition, needs and preferences are documented and communicated with relevant persons. Staff described how information is shared across the service and how changes are documented in handover notes. The Assessment Team observed a handover where staff communicated changes in consumer condition and the assessments and monitoring required on the next shift. The electronic care management system had alerts notifying staff of changes to consumers’ health, needs and preferences.

Representatives were satisfied consumers have access to medical officers and other health professionals when needed. Staff were able to describe the referral process and how input of health professionals directs care and services. Care planning documents demonstrated input is sought from allied health professionals and medical officers and their recommendations inform the delivery of safe and effective care for consumers. The Assessment Team observed allied health professionals on premises during the site audit.

The service has an antimicrobial stewardship policy and procedure to guide antibiotic prescribing practices. The service had taken infection and prevention measure, including staff training on hand hygiene, cleaning processes and the appropriate use of Personal Protective Equipment (PPE). However, the Assessment Team observed not all staff had completed infection control training.

### 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 found consumers do not get safe and effective personal care as consumers, representatives and staff raised concerns about not meeting personal hygiene preferences due to short staffing. Best practice guidelines were not followed in areas including wound management and restrictive practices. Evidence relevant to the finding included:

* Care planning documents for three consumers showed wound monitoring did not include regular measurement and photos.
* One consumer who had lost weight was commenced on a food chart however care planning documents showed the chart was not reviewed by a registered nurse.
* Feedback from three consumers reflected that they do not receive personal care in a timely manner due to staff shortages.
* Care staff said registered nurses are busy and not always accessible.
* Staff said they manage to attend to personal care needs but do not always have time to attend to needs as per care plans.
* Restrictive practices were not always managed in line with best practice. For example:
	+ Care planning documents for two consumers showed that ‘as needed’ psychotropic medication was administered without consent and with no evidence of non-pharmacological strategies trialled first.
	+ One consumer had a restraint authorisation form that was out of date.

In relation to feedback from consumers and staff that consumers do not receive timely personal care due to staff shortages, I have considered this under Standard 7 Requirement (3)(a) where it is more relevant.

The Approved Provider’s response acknowledged staff do not always measure wounds and said they were reminded of the need to do so. The response also said IT and internet issues prevent staff from being able to upload the photos of wounds they do take, however did not provide evidence of this in their response.

In relation to the consumer who lost weight and required food charting, the Approved Provider’s response states the service is waiting for a follow up from the dietician who initiated the charting.

In relation to management of restrictive practices, the Site Audit report states management is reviewing the service’s system to ensure all restraint authorisation forms are in place. The response expressed disappointment with the finding of the Site Audit report as the service has spent considerable time ensuring staff are aware of the various forms of restrictive practices and the actions required to be undertaken. The response also outlined other planned or implemented actions to address the deficits, including performance management of staff and more frequent audits of the service’s restrictive practice resident record.

While I acknowledge the service has taken appropriate actions to address some deficits identified by the Assessment Team, there has not been sufficient time to demonstrate the sustainability and effectiveness of the Approved Provider’s changes. I consider that at the time of site audit the service did not demonstrate each consumer gets safe and effective, best practice care. On the balance of the evidence provided, I find the service Non-compliant with this Requirement.

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

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

The Assessment Team found the service did not demonstrate it effectively manages high impact and high prevalence risks associated with two consumers. Evidence relevant to the finding included:

* One consumer was admitted to hospital following the discovery of severe bruising and pain. The reviewing doctor suggested that the incident should be reported via the Serious Incident Response Scheme (SIRS) however no SIRS report was lodged. Management said an investigation was conducted however the incident investigation form did not identify which staff members were interviewed or why the service decided not to lodge a SIRS report.
* One consumer experienced a choking incident which was documented in progress notes however no incident report was completed. Progress notes evidenced the service had taken appropriate action to manage the risk to the consumer including changing their diet and fluids and making a referral to a speech therapist.

The Approved Provider’s response provided additional evidence and information to demonstrate compliance. In relation to the consumer who was admitted to hospital after the discovery of bruising and pain, there is insufficient evidence to show the service did not appropriately manage the clinical risks to the consumer. In relation to the service not reporting the incident through SIRS, I have considered this under Standard 8 Requirement (3)(c) where I find it more relevant.

In relation to the consumer who experienced a choking incident, while the Approved Provider’s response acknowledged that no incident report was completed. As no further examples of incidents that were not reported were brought forward, I consider this example in isolation is insufficient to support a finding of non-compliance for this Requirement. Additionally, the Site Audit report demonstrates, through progress notes, that the service had taken appropriate action to effectively manage the choking risk to the consumer.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliance. On the balance of the evidence provided, I find the service Compliant with this Requirement.

**Requirement 3(3)(c) Compliant**

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

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANTServices and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Assessment Team recommended the service did not meet two of the seven specific Requirements. The Non-compliance was recommended in Requirements 4(3)(f) and 4(3)(g). However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the findings are detailed in the relevant Requirements below.

Consumers said staff support and encourage their lifestyle needs and assist them to engage in additional independent activities that interest them. The Assessment Team observed consumers engaged in a range of individual and group activities throughout the facility. Care planning documents identified the needs, goals and preferences of consumers and included information on their preferred activities. Lifestyle staff explained the service lifestyle program accommodates and modifies activities to cater for consumer’s needs, preferences, and varying levels of functional ability.

Consumers provided examples of supports the service offers that promote their well-being, such as supporting visits from friends and family and access to faith leaders. Care planning documents included information and strategies to support the emotional, spiritual and psychological wellbeing of consumers. Staff explained how they identify a consumer feeling low and the strategies they use to support them.

Consumers and representatives confirmed the service provides daily living supports that assist them to maintain social and personal relationships and participate in the community. Care planning documents detailed activities of interest, evidence of participation in group lifestyle activities and information about relationships consumers wish to maintain. Staff understood the services and supports sampled consumers need to participate in the community, maintain important relationships and do things of interest to them.

Consumers and representatives felt information about consumers’ daily living choices and preferences is effectively communicated between staff. Review of care planning documents showed, consistent with feedback from staff, that not all documents are up-to-date. Staff said this is because they might not have enough time and have to prioritise delivering care over updating care planning documents. The Site Audit Report did not identify any impacts to consumers as a result of care planning documents not being up-to-date and staff said they are verbally informed of any changes to a consumer’s needs during shift handover.

Care planning documents included information about individuals and external services who support consumers to maintain their interests and participate in the community outside the service. Staff were able to identify which external organisations or individuals assist to provide daily living supports to consumers. The Assessment Team observed activity programs displayed throughout the service which included external organisations and religious support personnel.

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

## 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.*

The Assessment Team found the service does not consistently provide meals that are varied and of suitable quality and quantity, based on mixed feedback from consumers. Evidence relevant to the finding included:

* One consumer indicated the food quality was excellent however has deteriorated recently. They did not provide this feedback to the service as the thought this was just a phase the service was going through.
* One consumer felt the meal sizes were small and raised a complaint about the quantity of salad served but feels this has not been resolved yet. Another consumer raised issues with serving size of their meal.
* Two consumers said lunch meal services were sometimes late and were informed that this is due to staffing shortage.
* Observations of dietary information for consumers located in the kitchen was not always current and reflective of the preferences and needs of sampled consumers

The Approved Provider’s response provided additional evidence and information to demonstrate Compliance. The Approved Provider’s response included evidence of positive consumer feedback regarding the meals and dining experience from February 2022 as results of their Food Satisfaction Survey which showed a satisfaction rating of 80%. The 2022 survey also showed a continued high satisfaction rating (over 90%) with the taste and flavour of the meal.

In relation to feedback from consumers on meal sizes, the response provided dietary plans for the consumers indicating the size of meals served to them listed as their preferred meal size. The response also provides that the service has increased the size of salad served and no complaints have been received.

In relation to feedback from consumers about receiving lunch meals late due to staff shortages, I have considered this under Standard 7 Requirement (3)(a) where I consider it more relevant.

The Approved Provider’s response states kitchen staff prefer to use a paper copy of consumer’s food preferences or requirements and every time there is a change clinical staff print off a paper copy of the most recent information to put into the kitchen. However, the Approved Provider’s response acknowledged that due to staff shortages this process is not always followed. The response provides that the electronic copy always contains the most current information which the Catering Manager routinely accesses to ascertain dietary requirements and inform the kitchen staff.

While I acknowledge the negative feedback provided by some consumers, the Site Audit report states that most consumers were satisfied with the quantity, quality and variety of food. The Site Audit report also provides that catering staff could explain specific dietary needs and preferences of consumers.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find the service Compliant with this Requirement.

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

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

The Assessment Team found equipment provided to consumers to support mobility including mobility aides, walking frames and wheelchairs was not clean and well maintained. Evidence relevant to the finding included:

* Observations of mobility aids showed equipment to be visibly dirty, it was reported that the ongoing shortage of cleaning staff has resulted in some cleaning tasks not being completed.
* Review of maintenance documentation identified poor adherence to scheduled preventative maintenance with a recent period where the monthly checks were not completed.

The Approved Provider’s response provided additional evidence and information to demonstrate Compliance with this Requirement.

The Approved Provider’s response indicated the Maintenance Officer position was vacant, and a replacement was not found for a long period despite best efforts. During this time, a care staff assisted with reactive maintenance. Once the position was filled, outstanding tasks were completed and was audited by an external company in March 2022 which found the service to be compliant.

While I acknowledge the observations made by the Assessment Team of some mobility equipment not being clean, the Site Audit report states that consumers reported equipment used for activities of daily living to be suitable and well-maintained. Ad-hoc maintenance requests are responded to in a timely fashion with a consumer being pleased with the timeframes for equipment to be attended to.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

# STANDARD 5 NON-COMPLIANTOrganisation’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 Non-compliant as one of the three specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended that the service did not meet two of the three specific Requirements. The Non-compliance was recommended in relation to Requirements 5(3)(b) and 5(3)(c). However, my finding differs from the recommendation and I find Requirement 5(3)(c) Compliant. Reasons for the findings are detailed in the relevant Requirements below.

Consumers said they felt that the service was welcoming, and they feel at home within the service environment. Management and staff described consumers are encouraged to personalise their rooms and decorate them according to their personal preferences. The Assessment Team observed the facility consists of many communal indoor areas where consumers congregate to participate in activities, socialise, and quietly reflect. The Assessment Team also observed consumer rooms to be personalised.

## 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) Non-compliant

*The service environment:*

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

The Assessment Team found the service environment to be clean and comfortable however recommended the Requirement Non-compliant relying on the following evidence:

* Review of the routine inspection documentation for furniture and equipment and other regular maintenance tasks required was unavailable from October 2021 to February 2022 and completion of these tasks could not be substantiated.
* Observations including:
	+ Storage of items in some common areas and hallways effectively minimised the accessibility of these areas for consumers.
	+ Living areas were used for equipment storage for manual handling items such as wheelchairs and four-wheel walker frames.
	+ The courtyard chairs were dirty and covered in bird droppings.
	+ An unattended medication trolley in the hallway.
	+ A cat cage in the courtyard that was not secured to the ground and contained a cat litter with faeces that was accessible by consumers. There was also a broken path tile on top of the cat cage that presented a risk to consumers.
	+ Oxygen tanks stored with other chemicals, therefore compromising safe storage of these items.

In relation to routine inspection documentation being unavailable, this was due to vacancy in the maintenance position as previously outlined.

In relation to the storage of equipment in hallways and common areas, the Approved Provider’s response states the equipment is frequently used and staff are directed to ensure they are kept to one side to ensure clear passage at all times. The Approved Provider’s response also states that the service is undergoing refurbishment and has no other place to store the equipment during the refurbishment.

The Approved Provider’s response did not address the cleanliness of the courtyard however I note the Site Audit report provides positive feedback from consumers where they expressed great satisfaction with the cleanliness and maintenance of the service. Consumer feedback was also positive in relation to free movement across the facility, both indoors and outdoors.

In relation to the unattended medical trolley, the Approved Provider’s response states that trolleys may be left unattended if they are locked or within sight of staff managing the trolley.

In relation to the cat cage, the Approved Provider’s response states that the cat litter is cleaned at least once a day and the broken tile on top of the cage has been removed. The cage has also been moved to a more secure place.

In relation to the oxygen tanks stored with other chemicals, the Approved Provider’s response states that a review of this will be undertaken by the Work Health and Safety team.

I acknowledge all but one deficit listed by the Assessment Team have been adequately explained by the Approved Provider. The unresolved issue being the storage of Oxygen tanks with other unidentified potentially hazardous chemicals. The Approved Provider’s response indicates that a review into this will be undertaken, however, I consider that at the time of the site audit the service did not demonstrate the service environment was safe.

On the balance of the evidence provided, I find the service Non-compliant with this Requirement.

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

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

The Assessment Team observed the service was unable to demonstrate that furniture, fittings, and equipment is safe, clean, well-maintained, and meets the needs of the consumer cohort. Evidence relevant to the finding included:

* Not all equipment was routinely inspected as per maintenance schedules due to the maintenance position being vacant for a period of time.
* Observations that many wheel chairs had dirty seats and footrests.

The Approved Provider’s response provided additional evidence and information in demonstrate Compliance. The Approved Provider’s response explained the attempts made to fill the maintenance position and said care staff assisted with reactive maintenance, as previously outlined.

While I acknowledge the observations made by the Assessment Team of some mobility equipment not being clean, the Site Audit report states consumers reported that furniture, fittings, and equipment are safe, clean, well maintained, and suitable for them to use. Ad-hoc maintenance requests are responded to in a timely fashion with a consumer being pleased with the timeframes for equipment to be attended to. Additionally, the Assessment Team observed the furniture and fittings in the service to be relatively clean.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

# STANDARD 6 COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

The Assessment Team recommended the service did not meet three specific Requirements. The Non-compliance was recommended in relation to Requirements 6(3)(a), 6(3)(b) and 6(3)(d). However, my finding differs from the recommendation of the Assessment Team and I find these Requirements Compliant. Reasons for the findings are detailed in the relevant Requirement below.

Consumers and representatives expressed satisfaction that their concerns have been addressed and the service acknowledged their complaints. The complaints register reviewed by the Assessment Team includes documentation to support that an open disclosure has been consistently and effectively applied. Although staff were not able to demonstrate an understanding of open disclosure, they were able to demonstrate how to address complaints.

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found the service was not able to demonstrate that consumers, family, friends, and others are encouraged and supported to provide feedback and make complaints. Evidence relevant to the finding included:

* One consumer stated that they did not know how to make a complaint and was hesitant to do so as they believed the long wait times for care are due to staff shortages.
* Another consumer said they feel uncomfortable to raise concerns as staff are always in a hurry.
* One consumer said they are comfortable to raise complaints to staff, but feels they are never listened to.

The Approved Provider’s response provided additional evidence and information to demonstrate Compliance. The Approved Provider noted that all consumers receive regular information about how to lodge a complaint and this information is also contained in the Resident Handbook provided to every consumer as well as discussed at Resident & Relative Meetings. The Complaints Register includes complaints from the consumer who said they did not know how to make a complaint.

The Site Audit report includes positive feedback from five consumers who reported that they feel comfortable to raise any concerns. The Assessment Team reviewed the service’s complaints register that demonstrated consumers/representatives are encouraged and supported to provide feedback generally and raise any issues or concerns through various ways including face to face, phone, emails, letter, feedback forms and residents’ meetings. The Site Audit report also notes that staff demonstrated their understanding of the process and how they support the consumers to make a complaint.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

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

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

The Assessment Team found that the service did not demonstrate that consumers are made aware of and have access to advocates, language services and other methods for raising complaints. Evidence relevant to the finding included:

* Feedback from three consumers who said they were not aware of external methods for raising a complaint.
* Care staff where not aware of advocacy or language services available to consumers however clinical staff were aware of language services.

The Approved Provider’s response provided additional evidence and information to demonstrate Compliance. The Approved Provider’s response stated that all consumers are provided with a Handbook and Local Information Guide on admission and these include information on external complaints methods. Additionally, the service displays the Commission’s feedback poster on the general noticeboard located in each area of the home. The response also said brochures on external complaint processes are available in three languages, as stated in the Site Audit report.

In relation to care staff not being aware of advocacy or language services, the Approved Provider’s response states there are only three consumers from non-English speaking background but that two of then still speak and understand English. The third consumer has a cognitive impairment and cannot communicate. The Approved Provider reported that they involve family members and representatives for translation as it is the common practice in the sector if required. The Approved Provider noted that cue cards are printed and placed in the resident’s room when the service has residents with non- English-Speaking background and staff are made aware at handover and via the care plan when this occurs. The Approved Provider’s response also provided evidence of several consumers who attended a session on advocacy services.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

### 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.*

The Assessment Team found the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Evidence relevant to the finding included:

* One consumer said no changes have occurred after raising issues in relation to food. Another consumer said nothing often happens but did not refer to a specific example.
* Staff identified the main area of complaints being related to the shortage of staff which has resulted in meals being late, care being late and staff not having time to speak to consumers.
* Staff reported that the annual resident survey hasn’t been undertaken for two years.
* Management stated that there is no appropriate continuous improvement plan in place for food and call bell issues.
* The Assessment Team reviewed the service’s ‘compliments and complaints register’ which identifies 15 ongoing complaints relating to food, four complaints relating to call bell response times and two complaints about dining room noise levels.

The Approved Provider’s response disagreed with the Assessment Team’s recommendation and provided evidence of the organisation’s feedback review processes to improve quality of care and services, supporting this Requirement to be Compliant. The response included a Compliance Action Plan Register which demonstrated a number of improvement activities undertaken in response to issues identified by consumers and staff, including food.

The Approved Provider’s response indicated call bell response times are a direct result of the staffing shortages which is not included in continuous improvement process as it is an operational business issue to action. Relevant evidence which stems out of staff shortages issue has been considered under Standard 7 Requirement 7(3)(a) where I consider it more relevant.

In relation to noise issues raised and consumer meetings, the Approved Provider’s response states that action was taken to resolve this issue and this was reported back at the subsequent consumer meeting however the minute taker failed to record this in the minutes.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliant. On the balance of the evidence provided, I find that the service is Compliant with this Requirement.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Assessment Team recommended that the service did not meet two specific requirements. The Non-compliance was recommended in relation to Requirements 7(3)(a) and 7(3)(d). However, my finding differs from the recommendation. I find the Requirement 7(3)(d) compliant. Reasons for the findings are detailed in the relevant Requirement below.

Consumers indicated that staff are kind, caring and gentle when providing care. The Assessment Team observed workforce interactions consistent with feedback from consumers.

Consumers reported that staff are skilled enough to meet their care needs. Management reported that staff are screened in the recruitment process to ensure that staff have the relevant qualifications for their role. Position descriptions are maintained for different role types, which contain information regarding required qualifications and experience, competencies, position summary and required duties.

Management said that there is an annual performance appraisal process whereby staff can identify their training needs and any additional supports they need. Management reported assessing staff performance based on the staff members self-assessment and feedback from other senior staff, consumers and representatives.

## Assessment of Standard 7 Requirements

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team found the number of members of the workforce deployed does not enable the delivery of safe and quality care and services. Evidence relevant to the finding includes:

* One consumer, who needs mobility assistance, is not provided the assistance to move from the bathroom to bedroom safely.
* Three consumers and one representative stated they have to wait for long periods for staff to assist them with personal care, including toileting.
* Staff reported they don’t have time to attend to consumer’s personal care needs in a timely manner or provide support for daily living.
* Staff indicated that they always feel rushed and do not have time to complete the care documentation.
* Review of staff rosters showed that the service was unable to cover 54 shifts in the previous fortnight for clinical, care, kitchen, cleaning and lifestyle staff.
* The complaints register demonstrated trends regarding long call bell response time including considerable delay in attending to the toileting needs for consumers.

The call bell response time data showed that there were a number of calls with a wait time over 15 minutes, with one call being responded to in three hours. The Approved Provider’s response acknowledges the deficits identified in the Assessment Team’s report, however states that despite efforts to recruit staff, roster agency staff and request current staff to work double shifts, the service still find that there is not enough staff to fill every shift.

While I acknowledge the service has, and continues, to take appropriate actions to address the deficits in staffing, I consider at the time of the site audit the service did not demonstrate that the workforce enables the delivery of timely and appropriate support and services to consumer’s satisfaction.

On the balance of the evidence provided, I find the service Non-compliant with this Requirement.

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

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

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

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

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

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

The Assessment Team found the service has processes to train staff, however have not all staff had received adequate training to meet consumer care needs. Evidence relevant to the finding included:

* Staff were unable to recall receiving training on the SIRS and described being too busy to complete training while at work.
* Review of online training records indicated that only 67% of staff had completed mandatory training, which includes SIRS.

The Approved Provider’s response provided additional evidence and information in support of this Requirement to be Compliant. The response corrects that, in relation to not all staff completing mandatory training, at the time of the site audit 88.1% of staff had completed mandatory training and the Approved Provider provided evidence of this. The remaining staff were on leave and the responses states a follow up would be undertaken when staff return from leave.

The evidence presented under this Requirement is insufficient alone to support that the workforce is not trained to deliver the outcomes required by the Quality Standards. On the balance of the evidence provided I find that the service is Compliant with this Requirement.

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

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team recommended the service did not meet three specific requirements. The Non-compliance was recommended in relation to Requirements 8(3)(c), 8(3)(d) and 8(3)(e). However, my finding differs from the recommendation and I find Requirements 8(3)(d) and 8(3)(e) Compliant. Reasons for the findings are detailed in the relevant Requirements below.

The service is supported and governed by the wider organisation and has a governing body, which is accountable for delivery of care and services and promotes a culture of inclusivity. Management provided information and examples which included different mechanism’s the governing body uses to provide oversight of the service, including risk management reports, regular engagement with staff and consumers and review of daily operations. The service has a food focus group to seek feedback from consumers regarding the quality of food.

## Assessment of Standard 8 Requirements

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

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

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

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

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The service was able to demonstrate organisation wide governance systems are in place for information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. However, the Assessment Team found the governance systems pertaining to workforce management, feedback, complaints and the reporting of SIRS incidents was not effective. Evidence relevant to the finding included:

* Consumers, representatives, and staff provided feedback that there is a shortage of staff.
* Feedback from consumers that their complaints have not been appropriately addressed or responded to.
* Management and staff not adhering to SIRS policy which went undetected in the review of SIRS reporting by the Quality Team.

The Approved Provider’s response disagreed with the recommendation of the Assessment Team. The response included:

* Acknowledgment of the deficits identified in relation to staff sufficiency, however stated the management is devoting all available resources to solve this issue.
* Evidence of actions taken in relation to complaints received. For example, the Compliance Action Plan Register previously outlined. In relation to non- reporting of an incident via SIRS, the Approved Provider’s response states that an investigation found the incident did not require reporting through SIRS.
* In relation to not reporting through SIRS the administration of ‘as needed’ psychotropic medication without prior consent, the response stated that review of progress notes is supposed to occur to ensure consent has been undertaken. However, the clinical manager has not been able to conduct such reviews over recent months due to staffing pressures.

In relation to feedback from consumers and staff regarding consumers not receiving personal care in a timely manner due to staff shortage, I have considered this under Standard 7 Requirement (3)(a) where I consider it more relevant.

In relation to feedback from consumers that their complaints have not been appropriately addressed or responded to, I have considered this under Standard 6 Requirement (3)(c) where I consider it more relevant.

In relation to the incident that the service investigated and concluded did not need to be reported through SIRS, as there was insufficient information available to the Assessment Team regarding incident investigation and the Approved Provider’s response lacked evidence to support their assertion that the incident was not a SIRS incident, I find that there is insufficient evidence to demonstrate the regulatory compliance of the service. Further, the Approved Provider’s response acknowledged deficits in staffing which has resulted in a lack of review to obtain consent prior to administration of PRN psychotropic medication. The Site Audit report provides that management said a full investigation into SIRS reporting would be conducted.

While I acknowledge the service will undertake a full investigation to appropriately report SIRS incidents, I consider at the time of the site audit the service did not demonstrate effective governance systems to ensure regulatory compliance.

On balance of the evidence presented, I find the service Non-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.*

The Assessment Team found the organisation has risk management systems to direct and guide staff. However, it was identified that a number of PRN psychotropic medication was administered without consent obtained from consumer’s representatives and these incidents were not reported through SIRS. I have considered the evidence presented by the Assessment Team and the Approved Provider’s response in relation to the administration of PRN psychotropic medication without consent under Standard 3 Requirement (3)(a) where I consider it more relevant and find Non-compliant.

I have considered the evidence presented by the Assessment Team and the Approved Provider’s response in relation not reporting SIRS incidents under Standard 8 Requirement (3)(c) where I consider it more relevant and find Non-compliant.

### The Site Audit report demonstrates that the service has a documented risk management system and practices and management was able to describe how these systems and practices were effective. Staff also demonstrated education in the relevant policies and procedures in relation to risk management and these policies and procedures had to their work.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliance. On the balance of the evidence provided, I find the service, Compliant with this Requirement.

### 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.*

The Assessment Team found the organisation has a clinical governance framework that included policies in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. However, the Assessment Team found this Requirement was not met. Evidence relevant to the finding included:

* Staff noted that consent for PRN psychotropic medication that as administered was not always obtained in a timely manner.
* Management was not able to demonstrate how they were minimising consumers on chemical restraint.
* Staff were unable to describe how they used open disclosure and were unfamiliar with the terminology.
* Not all staff had completed infection control training.

The Approved Provider’s response provided additional evidence and information in support of this Requirement to be Compliant. The response provided that the need for chemical restraints is reviewed by a medical officer every three months. The response also provides that although staff may not be familiar with the term ‘open disclosure’ they have received training and are able to describe how to manage complaints, including offering an apology. This is consistent with the finding of the Assessment Team under Standard 6 Requirement (3)(c) which I find Compliant.

I have considered the evidence presented by the Assessment Team and the Approved Provider’s response in relation to the administration of PRN psychotropic medication without consent under Standard 3 Requirement (3)(a) where I consider it more relevant and find Non-compliant.

The Site Audit report demonstrates that the service has a clinical governance framework that staff have been educated on and demonstrated how it is relevant to their work. It is acknowledged that not all staff had completed infection control training, however, staff demonstrated understanding of antimicrobial stewardship and could explain the importance of discouraging unnecessary use of antibiotics, obtaining pathology results and utilising preventative strategies.

The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliance. On the balance of the evidence provided, I find the service Compliant with this Requirement**.**

# 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 3 Personal care and clinical care

* Requirement (3)(a) Ensure practice in relation to restrictive practices, wound care, skin care and pain are in line with best practice and the service’s procedures to optimise the wellbeing of the consumer.

Standard 5 Organisation’s service environment

* Requirement (3)(b) Ensure the service environment is safe, including the safe storage of equipment and other items.

Standard 7 Human resources

* Requirement (3)(a) Ensure sufficient staff are deployed to support care and service delivery in line with consumers.

Standard 8 Organisational governance

* Requirement (3)(c) Ensure the service has effective governance systems relating to regulatory compliance to ensure all reportable incidents are reporting through SIRS.