

**Performance Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Murray House |
| Commission ID: | 0312 |
| Address: | 31-37 Murray Street, WENTWORTH, New South Wales, 2648 |
| Activity type: | Site Audit |
| Activity date: | 29 October 2024 to 31 October 2024 |
| Performance report date: | 12 December 2024 |
| Service included in this assessment: | Provider: 40 Murray House Wentworth Aged Care Ltd  Service: 328 Murray House |

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 Murray House (**the service**) has been prepared by Gill Jones, 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 Site Audit report was informed by [a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others
* the provider’s response to the assessment team’s report received 28 November 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not 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 | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not 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.

Requirement 1(3)(a)

* Ensure staff are appropriately trained to provide care to each consumer that is respectful and dignified and values their identity, culture and diversity.

Requirement 2(3)(a)

* Ensure staff are appropriately trained to complete assessments and develop care plans using the electronic care management system.
* Ensure assessments undertaken consider risks to the consumer’s health and well-being and result in care plans that address the consumer’s needs

Requirement 3(3)(a)

* Ensure a quality system is in place with effective clinical oversight to provide safe quality care.
* Ensure staff have an understanding of best practice with regard to restrictive practices, person centred behaviour support, dementia care, time sensitive medication and wound care.

Requirement 3(3)(b)

* Ensure staff are appropriately trained to provide effective management of high impact or high prevalence risks, particularly in relation to medication management and choking.
* Ensure diabetic directives guide staff in how to manage consumer’s diabetes and insulin.
* Ensure Medicator staff work within their scope of practice for safe medication administration.
* Ensure appropriate equipment is in place to manage a medical emergency.

Requirement 3(3)(e)

* Ensure effective processes so consumer’s information is documented accurately and communicated with all personnel involved in consumer care.
* Ensure staff know how to use the electronic care management system and do so consistently so information can be located easily.

Requirement 3(3)(f)

* Ensure timely and appropriate referrals are made when required.

Requirement 5(3)(b)

* Ensure fire evacuation plans reflect the current building plan.
* Undertake an individual assessment of each consumer that considers risk of harm and their assessed need for a restrictive practice to enable all consumers to move freely both indoors and outdoors. This includes consumers living in the memory support unit (MSU) being able to access the garden/courtyard area as well as ensuring consumers can move freely through front door of the service

Requirement 6(3)(c)

* Ensure appropriate action and an open disclosure process is effectively used when things go wrong
* Ensure outcomes of complaints resolution are communicated to consumers and representatives and documented

Requirement 7(3)(c)

* Ensure the workforce is competent and have the knowledge to effectively perform their roles
* Ensure staff completing mandatory training and annual competencies as required
* Maintain effective oversight of training undertaken and that staff are working within their competency

Requirement 7(3)(d)

* Ensure onboarding processes to support new staff through their induction
* Ensure staff receive training such areas as restrictive practices, behaviour support and BSPs, medication management including the safe and effective management of high risk medications, incident reporting, person centred dementia care, time sensitive medication and the use of the electronic care management system

Requirement 7(3)(e)

* Ensure all staff have an annual performance appraisal/review and are appropriately supervised and their performance monitored

Requirement 8(3)(b)

* Ensure 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)

* Ensure effective organisation wide governance systems relating to the following: information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities and regulatory compliance; and feedback and complaints.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

Requirement 8(3)(e)

* Ensure where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship; minimising the use of restraint and open disclosure.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not 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 find Requirement 1(3)(a) is not compliant.

Most consumers and representatives interviewed indicated the service was treating consumers with dignity and respect and valuing their identity, culture and diversity. However, observations and interviews with staff did not support that consumers were always treated with dignity and respect. Staff were observed to speak about consumers in a disrespectful way, one consumer needing help was ignored and signage in consumer’s rooms was not dignified.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement. The provider intends to survey staff regarding their understanding/level of engagement with consumers living with dementia to determine workforce skill level. The results will inform staff training.

I find Requirement 1(3)(b), Requirement 1(3)(c), Requirement 1(3)(d), Requirement 1(3)(e), and Requirement 1(3)(f) compliant.

Consumers and representatives interviewed indicated that staff delivering care and services understand their needs and preferences and know what to do to ensure they feel valued, and safe. Staff demonstrated knowledge of individual consumers’ cultural needs and preferences and provided information relevant to ensuring each consumer receives the care required that aligns with their cultural needs.

Consumers and representatives interviewed described how they are supported to exercise choice and independence and maintain relationships that are important to them. Staff were able to describe how consumers are supported to make informed choices about their care and services. It was observed however, that consumers in the Memory Support Unit (MSU) were not provided choice to enter the courtyard/garden unless staff accompany them. I will address this matter in Std 5.

The service was able to demonstrate that each consumer is supported to take risks to enable them to live the best life they can. The service has introduced dignity of risk (DOR) forms for consumers or their representative to sign acknowledging the risk the consumer wants to take. Care documentation indicated that the service completes risk assessments, discusses the risks associated with the activity with the consumer and the risk mitigation strategies implemented to support the activity.

Consumers and representatives indicated they get the right information, at the right time, in a way they can understand and are encouraged to ask questions. The service demonstrated and staff described, the multiple ways and channels information is communicated to consumers to ensure it is accessible to all consumers and easy to understand.

Consumers and representatives indicated they have confidence in the services ability to protect all personal information collected. Staff provided examples of individual consumer’s preference for privacy, including when they have visitors. Management explained the service has policies and procedures that guide the collection, use, sharing and storing of confidential information.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

I find Requirement 2(3)(a) is not compliant.

The service was not able to demonstrate assessment and planning considers risk to each consumer’s health and wellbeing and informs the delivery of safe and effective care and services. Assessments are not being undertaken or are incomplete, and not being reviewed 3 monthly or as the consumers care and services change.  Care plans do not adequately reflect risks to the consumer’s health and wellbeing to inform the delivery of safe and effective care and services. Some consumers with changed behaviours have not had a behaviour assessment and/or have a behaviour support plan (BSP) in place. For consumers who do have a BSP in place, assessments undertaken are not comprehensive, some plans are in complete and others do not demonstrate the risk posed by the changed behaviour to the consumer or others has been considered. Recommendations from Dementia Support Australia (DSA) were not included. Wound assessments are not completed. Diabetic directives are in place but diabetes assessments are generic and do not consider the risk of blood sugar levels being out of range for the consumer. Assessments were not carried out when required. Review of consumers lifestyle and wellbeing assessment and planning documentation indicated the consumer’s assessment did not consistently inform the delivery of effective care in relation to the consumer’s lifestyle as there is a lack of understanding by the lifestyle staff of how to holistically assess a consumer, and what information is required to have an effective care plan. Additionally, deficits in registered nurses’ knowledge of the consumer assessment process and the need to have clear BSPs, diabetic plans and behaviour assessments was also identified

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement.

The provider intends to upskilling the clinical team including the Registered Nurses to complete assessments and develop care plans using the electronic care management system. An audit program will be introduced to assess both the quality of the assessment and care planning. Care documentation is being improved and a review is being undertaken of the admission process. All consumers requiring a BSP will have a current plan in place and staff will receive education in completing same. Staff will receive further training in continence management. With regard to diabetes, care plans will be updated with the consumer’s diabetic directive as supplied by their medical officer and medication charts updated with the consumer’s blood sugar parameters. Wound assessments and care plans were completed late October 2024.

I find Requirement 2(3)(b), Requirement 2(3)(c), Requirement 2(3)(d) and Requirement 2(3)(e) compliant.

A review of consumer clinical files demonstrates assessment and planning takes into consideration consumers’ needs and preferences. Consumer goals are clinically based but care planning documentation reflects the consumer’s preferences and how they want to live. Advance care directives and/or end of life discussion outcomes are in place for most consumers. End of life and advance care planning is discussed with consumers and representatives at admission and/or care conferences/reviews and consumer’s wishes documented.

The service was able to demonstrate that it partners with consumers and others whom the consumer wishes to involve in the planning and assessment of care. The service has a monthly ‘resident of the day’ program where clinical supervisors contact the consumer or representative to provide information regarding the consumer. Representatives and some consumers interviewed indicated they are provided with a copy of the care plan prior to the care review. Most representatives interviewed indicated satisfaction with their involvement in their consumer’s care planning, however, not all consumers interviewed recalled staff talking to them about their care. The service demonstrates they include others who provide care and services to the consumer such as medical officers, physiotherapists, dietitians, speech pathologists and National Disability Insurance Scheme (NDIS) support workers.

The service was able to demonstrate the outcomes of assessment and planning are communicated to the consumer and representatives. Consumers are provided with a copy of a summary care plan prior to the 3 monthly review and a case conference is conducted with the consumer and or the representative. Consumers and most representatives interviewed indicated they feel the service generally maintains good communication with them, particularly around changes in care and medication. They also indicated that staff explain things to them and clarify clinical matters if needed. Clinical staff indicated representatives are contacted by phone and/or via email communications.

Overall, for consumers sampled, care planning documentation identified evidence of review when the consumer’s care change or a clinical incident. The clinical supervisors are responsible for reviewing the outcome of consumer incidents and to ensure the consumer care plans are reviewed. Most representatives interviewed indicated the clinical supervisors and registered nursing staff discuss changes in consumers care and care needs with them. Most consumers interviewed could not recall the clinical supervisors or the registered nursing staff discussing care changes however, indicated this did not concern them.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | 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

I find Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(e) Requirement 3(3)(f) are not compliant.

The service was unable to demonstrate that there were systems and processes to ensure safe and effective clinical care. The service does not have a quality system to identify clinical deficits and staff could not demonstrate who has overall clinical oversight at the service. Staff did not demonstrate an understanding of best practice with regard to restrictive practices, person centred behaviour support, dementia care, time sensitive medication and wound care. Deficits related to inappropriate use of restrictive practices and ineffective behaviour support practices. Psychotropic medications, used as a chemical restraint, were not being used as a last resort for all consumers sampled. BSP’s were not in place for consumers with a behaviour support need. Consumers receiving time sensitive Parkinson’s medications were not receiving these on time. The service did not demonstrate there were wound care treatment plans in place or effective clinical oversight of wounds at the service. Staff did not display a consistent understanding of wound management. Consumers and most representatives interviewed indicated overall satisfaction with care the consumer receives.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement.

Current improvements being implemented include behaviour support planning, monitoring of behaviour changes with increased behaviour charting. An audit schedule is being developed to monitor care provided where high risk clinical issues exist. Staff education on the best practice use of psychotropic medication has begun. An audit schedule is being developed to monitor practice regarding the administration of time sensitive medications and changes planned to the electronic medication system will flag when medication is overdue. Staff education is planned and improvements made to incident reporting to ensure late medications are reported on. With regard to wound management, improvements include staff training and ensuring Registered Nurses attend all wounds.

The service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Deficits in effective clinical oversight was evident when reviewing consumers with high impact or high prevalence risks, particularly in relation to medication management and choking. Some representatives interviewed raised concerns in relation to clinical oversight of the consumers’ care. Staff did not demonstrate a sound knowledge of the management of high impact, high prevalence risks to consumers. With regard to medication management there were no diabetic directives to guide staff in how to manage consumer’s diabetes and insulin. The insulin prescription for one consumer was unclear and may have been fatal if administered. Medicator staff were working in ways which was out of their scope of practice for safe medication administration and this had not been identified by management. A review of paper medication charts at the service indicated some medication charts were out of date and did not include updated consumer medication information which could be problematic in the event of a power outage. Deficits were identified in relation to management of choking for 2 consumers. Deficits related to lack of supervision of consumer’s when eating, a referral to a speech pathologist not being actioned when required, inconsistent/fragmented documentation, lacking staff skills and knowledge and emergency suctioning equipment not available when needed.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement.

With regard to medication management and diabetes, diabetes directives are to be obtained, further education provided to staff, audits implemented and greater clinical oversight provided. The diabetic management policy and procedure and medication management policy are to be reviewed and staff reminded of the correct procedure for administering insulin. To avoid care staff working outside their scope of practice with regard to medication management changes have been made to the rostering of Registered Nurses at night and changes made to ensure only Registered Nurses can access certain types of medications. Paper medication charts have been updated.

With regard to chocking incidents, Registered Nurse are to actively follow-up the recommendations of a Speech Therapist to ensure treatment changes are implemented in a timely manner. Relevant consumers will receive greater supervision when eating and staff reminded to ensure consumers are positioned safely. Staff training will be completed regarding dignity of risk and the management of choking episodes with emergency equipment sourced.

The service did not demonstrate effective processes to ensure consumer’s information is documented accurately and is reflective of the consumer’s current care needs. The service did not demonstrate they had effective oversight of information around consumers’ care, needs and preferences to ensure it is documented and communicated with all personnel involved in consumer care. There were deficiencies in relation to the communication of information regarding BSPs and DSA outcomes. There was missed communication with consumer representatives resulting in issues not being followed up and important information not conveyed. Care documentation was inaccurate, significant incidents were not being identified as incidents and the electronic medication system was not up to date resulting in a consumer receiving medication they were allergic to. Staff are not aware of how to effectively document consumer care in the electronic management system resulting in information being missed and difficult to find. Communication issues also arose from the fragmented distribution of clinical care responsibilities resulting in clinical supervisors not having oversight of all clinical care needs. Some consumer representatives indicated communication is an issue at the service.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement. The provider stated that the actions they intend to take to address the deficits identified have been addressed in a range of other requirements and include staff training.

The service was unable to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services. While there was some evidence of appropriate referrals to specialist services, deficiencies were identified in the timeliness of referrals for some consumers. Consumer representatives advised they were unsure why there were delays in referrals.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report. This was accompanied by a detailed plan for continuous improvement. The provider stated that the actions they intend to take to address the deficits identified will include improving admissions processes and better communication between professionals to avoid delays in referrals. The External Services and Resident Referral Policy will also be reviewed.

I find Requirement 3(3)(c), Requirement 3(3)(d) and Requirement 3(3)(g) compliant.

While the service did not have any actively palliating consumers, for the consumers sampled who are nearing the end of their lives, documentation indicates the consumers’ care needs and preferences have been identified and their wishes incorporated into the consumer’s care plan and associated documents. The service ensures a substitute decision-maker (where possible) is identified and documented. Consultation occurs with consumers and representatives when a referral to palliative care is required, when a consumer commences on a palliative pathway, and or is nearing end stage/end of life. The service has processes in place if a consumer requires urgent crisis medications and the medical officer is not available.

The service demonstrated consumers who have experienced a deterioration or change in their cognition, condition, function and/or mental health have had their needs recognised and responded to in a timely manner. Communication and consultation with the consumer and their representative occurs. For consumers sampled, their care planning documents and/or progress notes reflect the identification of, and response to deterioration or changes in function/capacity/condition.

The service demonstrated the minimisation of infection related risks through implementing precautions to prevent and control infection and practices are in place to promote appropriate antimicrobial usage. Staff demonstrated a general understanding of antimicrobial stewardship and the principles for outbreak management as well as standard precautions. The service has an outbreak preparedness/management plan (OMP) and associated documents in place to guide their practice in the event of an outbreak. There is an Infection, Prevention and Control Lead Nurse. The service has a surveillance system in place to record when infection incidents occur. All suspected infections are referred to the medical officer to order pathology prior to commencing antibiotics. Some deficiencies were identified: the OMP was last updated in 2021, staff were observed wearing their masks incorrectly, training for the ‘To Dip or Not To Dip’ program has not yet been implemented and there is overall a fragmented approach to infection prevention and control due to split responsibilities amongst the team.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 find Requirement 4(3)(a), Requirement 4(3)(b), Requirement 4(3)(c), Requirement 4(3)(d), Requirement 4(3)(e), Requirement 4(3)(f), and Requirement 4(3)(g) compliant.

The service demonstrated each consumer gets safe and effective care and 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. Consumers and representatives interviewed indicated they feel supported to participate in activities they like, and they are provided with appropriate support to optimise their independence and quality of life. Consumers provided a range of positive feedback around recreational activities, and the support they receive to do the things that interest them. Lifestyle and most care staff could explain how consumers’ preferences and needs are identified and communicated. Most staff could explain what sampled consumers like to do, however this did not always align with information in the consumer’s sampled care and service plans. The Assessment Team observed consumers of varying levels of ability engaged in daily living activities on several occasions during the Site Audit.

The service demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. Consumers and representatives interviewed indicated the emotional and spiritual needs of the consumers are met. They consistently expressed satisfaction with the caring and supportive attitude of the staff. The service has some processes to support consumers spiritual needs such as fortnightly church services and visits from a religious order. The service refers to appropriate services for psychological and other supports if needed. The spiritual and emotional support information in the consumer care and service plan was overall generic, not outlining specific needs or preferences consumers had for their spiritual/emotional wellbeing.

The service demonstrated services and supports for daily living assist each consumer to participate in their community, have social and personal relationships and do things of interest to them. Consumers and representatives interviewed indicated the consumers are supported to keep in touch with people who are important to them, and their visitors feel welcomed by staff and other consumers when visiting the service. Consumers indicated they are supported to do the things that interest them both at the service and in the community. Some consumers indicated they are supported to maintain social and personal relationships. The Assessment Team observed consumers with friends and relatives engaging and socialising at the café which was observed to be in a central meeting place.

The service demonstrated information about the consumer’s condition, needs and preferences is communicated within the organisation and with others where responsibility id shared. Consumers and most representatives interviewed indicated the consumer’s information regarding their daily living, choices and preferences is effectively communicated and staff, who provide daily support understand their needs and preferences. The lifestyle coordinator demonstrated a knowledge of consumers needs and preferences and demonstrated how the lifestyle department was meeting consumers’ needs and preferences. For the consumers sampled however, the care documentation, including assessments did not contain adequate information to support the effective and safe sharing of the consumer’s care needs.

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services. Consumers and representatives did not raise any concerns about daily living related referrals that are important for consumer well-being and to enable them to do the things they want to do. The lifestyle coordinator indicated that they would refer to external wellbeing/lifestyle support if required explaining they can refer to such services as Vision Australia, Hearing Australia, volunteer services, the NDIS, community library, DSA, pet therapy and spiritual leaders.

The service demonstrated they provide meals that are varied and of suitable quality and quantity. The service provides meals using a seasonal menu which is developed with input by the consumers, reviewed by a dietician and prepared at the service. Most consumers interviewed gave positive feedback saying the food was tasty, had variety and there was enough to eat. Consumers indicated they have opportunities to give feedback in relation to the meals provided through food forums and consumer meetings.

The service demonstrated where equipment is provided it is safe, suitable, clean and well maintained. Consumers interviewed together with staff interviews and observations indicated equipment to support consumer lifestyle is safe, suitable and clean.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

I find Requirement 5(3)(a) and Requirement 5(3)(c) compliant.

The service demonstrated the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence interaction and function. All consumers and representatives expressed satisfaction with the service environment. The Assessment Team observed the service is welcoming, well lit, and decorated with colourful artwork and has signage to assist the consumers with wayfinding. Consumers were also observed spending time in their rooms, outside in communal areas and interacting in shared spaces. Consumer rooms were observed to be personalised.

The service demonstrated furniture, fittings and equipment are safe, well maintained and suitable for the consumer. The maintenance staff have responsibilities for ensuring furniture, fittings and equipment is safe and well maintained. Contract cleaning staff have responsibilities for ensuring furniture is clean for consumers to use. Consumers interviewed indicated they felt the furniture and equipment was suitable for their needs.

I find Requirement 5(3)(b) not compliant.

The service was able to demonstrate the service environment is safe, clean and well maintained. Consumers and representatives interviewed confirmed the service is clean and well maintained. The cleaning staff indicated, and documentation demonstrated there are cleaning schedules for consumers rooms and all internal communal areas. The maintenance logs reviewed were up to date with no outstanding maintenance items, however the fire evacuation plans did not reflect the current building plan. The service and organisation are aware of this and have plans to address the deficit.

The service was unable to demonstrate consumers can move freely both indoors and outdoors. Consumers were not able to move freely both indoors and outdoors into the garden area of the memory support unit (MSU). Consumers could also not move freely through front door of the service. The doors in the MSU that led into the courtyard and garden and the front door to the service were keypad locked requiring a code. Consumers wanting to leave the service through the front door needed to ask the receptionist or a staff member to open the door. The service did not demonstrate a consistent understanding of what practices or interventions may be considered environmental restraint and does not have systems to undertake an individual assessment for each consumer that considers risk of harm and their assessed need for a restrictive practice.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues which was accompanied by a detailed plan for continuous improvement. The provider stated that the actions they intend to take to address the issues will involve discussions with consumers and representatives about informed decision making around any managing risk to the consumer from being able to freely access the garden. Planning will be undertaken to enable consumers to come and go safely out through the front door of the service during the day. Staff will be trained in restrictive practices, behaviour support planning and the Quality of Care Principles.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

I find Requirement 6(3)(a), Requirement 6(3)(b) and Requirement 6(3)(d) complaint.

The service demonstrated consumers, and their representatives are mostly encouraged and supported to provide feedback and make complaints. There are processes for complaints to be made internally and externally. Most consumers and representatives indicated they are able to inform staff and management of any concerns they have, provide feedback and or make complaints. They indicated staff listened to them when they have a complaint. Most staff were able to describe complaints processes and how they can assist consumers to provide feedback.

The service demonstrated consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. Information is available on other methods for raising complaints and accessing services including advocates and language services. Management indicated staff can assist consumers to access advocacy services. There is information regarding the Aged Care Quality and Safety Commission available for consumers and representatives displayed around the service and in the consumer handbook. Staff interviewed indicated they would submit a complaint for any consumer who is unable to it themselves. Come consumers raised feedback around there not being enough information on the feedback and complaints process during admission.

The service demonstrated feedback, and complaints are mostly reviewed used to improve the quality of consumer care and services. The service has a process of tracking complaints and feedback received through its complaints register and feeding the information into relevant meetings for action as required.

I find Requirement 6(3)(c) not compliant.

The service was unable to demonstrate appropriate action and an open disclosure process is effectively used when things go wrong for all consumers. Not all representatives were satisfied with the service’s response to their complaints. Some representatives indicated the turnover of senior management over the past few years has led to communication breakdowns regarding consumer care and complaints.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report which was accompanied by a detailed plan for continuous improvement. The provider stated that communication had happened with family members but they could not evidence this as not documented. The actions they intend to take to address the deficits identified will include updating the feedback register with actions taken and open disclosure utilised, ensuring complaints staff consistently manage the complaints process, and longer period of tenure of senior staff including the CEO to bring stability.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

I find Requirement 7(3)(a) and Requirement 7(3)(b) compliant.

The service demonstrated 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. There are processes in place to identify the skill mix and number of staff required to meet consumer needs. Overall, consumers and representatives indicated staff generally take their time when delivering care and services and complete tasks safely. Staff interviewed indicated there is enough staff rostered, however when there is unexpected leave the service cannot always backfill the roster and this occurs mainly on the morning shift. Management indicated the service attempts to back fill vacant shifts however this is not always possible due to the remote location of the service.

The service was able to demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Consumers and representatives interviewed indicated workforce interactions with consumers are kind, caring and respectful. The Assessment Team mostly observed staff interactions with consumers to be kind, caring and respectful of consumer’s identity culture and diversity. Overall, staff interviewed had a knowledge of consumers’ cultural needs.

I find Requirement 7(3)(c), Requirement 7(3)(d) and Requirement 7(3)(e) not compliant.

The service was unable to demonstrate the workforce is competent and have the knowledge to effectively perform their roles. Whilst members of the workforce have appropriate qualifications in place, deficiencies in relation to staff knowledge and skills was identified in relation to assessments, restrictive practices, behaviour support and BSPs, choking and wound assessments. There were deficits in staff completing mandatory training and annual competencies in subjects/topics such as medication management, hand hygiene, donning and doffing, cardiopulmonary resuscitation and food safety. The service did not demonstrate effective oversight in relation to education, training and staff competencies. Medicator staff were administering medication that they were not assessed to administer and were working outside their scope of practice. Staff interviewed who administered medication could not demonstrate they were aware of the importance of giving some medications within a strict timeframe to optimise consumer care. Staff were not adequately trained in the use of the electronic care management system resulting in information not being systematically entered into the same areas so that it was easily retrievable.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. The provider stated that work was already underway to improve their Human Resources (HR) function and establish HR procedures and sustainable systems. The provider stated registers are now in place which will enable them to identify gaps and priorities in staff competencies, staff appraisals, and staff education. The provider plans to develop an annual education plan, review their HR policies and procedures, ensure mandatory education has been completed and outstanding competencies are attended to, and implement an audit program to monitor compliance with police checks and staff compliance with training and competencies etc. There will be increased management oversight of the education being completed by staff. Medication competencies are to be introduced for Registered Nurses and education for staff on key clinical topics including using the electronic care management system will be introduced. Medicators are no longer working outside their scope of practice and RN’s administer all non-packed medications.

The service was unable to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Whilst there is a recruitment process the service was unable to provide evidence of overall staff orientation. The data base for staff education/training has been recently updated to indicate when staff completed training and education. Most care staff indicated they did not receive formal training in the electronic care management system or training in such areas as restrictive practices, behaviour support and BSPs, medication management including the safe and effective management of high risk medications, incident reporting, person centred dementia care, time sensitive medication and Huntington’s disease. Staff interviewed indicated they have not received or can recall receiving education and training since the previous educator left approximately a year ago and records of staff training attendance was not provided to the Assessment Team.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. Improvements included enhancing the buddy shift process to formalises learnings and follow-up new staff with a review of the induction and onboarding policies and procedures. Education of staff has begun on key topics and staff will be asked to complete an evaluation on the usefulness of training received including tool box training.

The service was unable to demonstrate that it has effective systems and processes to monitor and review the performance of each member of the workforce. The service’s protocol is that all staff have an annual performance appraisal/review however no staff interviewed indicated that they had a performance appraisal in the past 12 months. Review of the appraisal register that has recently been developed indicated approximately 60 percent of staff do not have an annual current performance appraisal/review and some staff are greater than 2 years overdue for their performance appraisal/review.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. The provider intends to develop a staff appraisal schedule to know due and completion dates to monitor staff appraisals are being done.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | Not 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. | Not 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. | Not 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**

I find Requirement 8(3)(a) compliant.

The service was able to demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. There is a Consumer Advisory Board (CAB) which the Board chairperson attends and CAB minutes support this is occurring. Feedback forms, surveys and care planning is also utilised to engage consumers in improving care and service delivery. Consumers and representatives overall felt the service is well run. A consumer on the CAB provided examples on how the service/organisation engaged with consumers in the evaluation of care and services.

I find Requirement 8(3)(b), Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) not compliant.

The organisation was not able to demonstrate how the organisation’s governing body promotes a culture of safe, and quality care and services. A review of Board minutes did not reflect continuous improvement as a standing item or that the Board was overseeing continuous improvement to monitor that the organisation is meeting the Aged Care Quality Standards. The minutes did indicate the service’s recent self-assessment was reported to the Board, however, did not reflect the reporting and review of the approximate 85 items that were placed on the services PCI in June 2024. The PCI indicated only one item has been completed and all other are pending with actions planned. The CEO (who resigned in recent months) provided reports to the Board that predominately reflected information relating to finance. A review of the reports provided to the Board indicated information regarding incidents is not provided hence the Board does not have detailed/accurate data on which to monitor performance. The Assessment Team was not provided evidence of how the governing body monitors that the service is compliant with the Aged Care Quality Standards or how the organisation monitors its performance against the Standards.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. The provider explained that continuous improvement was an area the Board considered but it was not a standing agenda item – now it will be. The Board had been monitoring the organisations compliance with the Standards following an audit done by a consultancy firm in April 2024. The Board will continue to do this to an enhanced capacity by updating their self assessment with items of the continuous improvement plan. This live document will be provided to the Board on a regular basis for oversight.

The organisation did not demonstrate it has effective organisational governance relating to information management, continuous improvement, workforce governance and regulatory compliance. The organisation could not demonstrate how systems and/or processes implemented are monitored to ensure they remain effective. In terms of information management limited information is provided to the Board about the organisation’s performance. The electronic management system is ineffective as staff have not been trained in using it and there is no consistency in where staff place information making it difficult to retrieve.

The organisation did not demonstrate an effective continuous improvement system. The continuous improvement system consists of scheduled audits, national quality indicator data surveys and complaints and feedback but only the required national quality indicator information and reporting the 24/7 registered nurses’ hours are being reported on. The current PCI for organisation contains 85 items with only one complete.

In terms of workforce governance, there was no evidence of workforce governance in ensuring staff are adequately trained to do their job and care staff were working outside their scope of practice in relation to medication management. Staff performance is not monitored through appraisal systems. Not all staff had the required police checks. Deficits in compliance/oversight of 24/7 service level registered nurse coverage was evident on 2 recent occasions, which lead to a potential risk for consumers.

In relation to regulatory compliance, the organisation did not demonstrate monitoring and governance of restrictive practices, in particular environmental restrictive practice and chemical restraint. The organisation did not demonstrate a consistent and correct understanding of the Quality of Care Principles definitions and types of restrictive practices.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. In addition to improvements previously referred to improvements include enhancing Board reports to provide more risk based, accurate data to enable the Board to oversight incidents and monitor trends. Also a review of the organisation’s policies around information management and risk. To address workforce governance the organisation plans to implement a Workforce Governance Statement which includes key roles and responsibilities and expectations around workforce performance, development and training. Increased governance and oversight is planned to ensure criminal history checks are undertaken and 24/7 RN coverage is monitored by the Board. With regard to regulatory compliance, in addition to plans to address staff knowledge of restrictive practices the organisation plans to review and update various risk assessments including the Consumer Care and Services risk assessment and the Clinical Governance risk assessment.

The organisation was unable to demonstrate effective risk management systems and practices managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers: supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system. The system for managing risk for high impact or high prevalence risks associated with consumer care and/or managing and preventing incidents using the incident management system was ineffective. Risk mitigation strategies were not implemented when risks identified as the root cause analysis undertaken did not identify the root cause. An investigation undertaken failed to identify that care staff had been provided with keys to the Dangerous Drugs cupboard and had administered a Schedule 8 drug which should only be administered by a Registered Nurse. Risk was not managed in terms of consumers smoking in their rooms and common areas not allocated for smoking which posed a threat to others. Risks associated with medication addiction were not being managed proactively to safeguard the consumer from possible overdose or death.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included actions taken to address issues for individual consumers named in the report which was accompanied by a detailed plan for continuous improvement. Plans included risk assessments for consumers who smoke, a BSP developed for those consumers who will not smoke in the designated area and incident reporting to capture non-compliance. Full implementation of a new smoking area and education for staff on procedure around risk assessment and incident reporting non-compliance and greater Board oversight is planned. In addition to planned improvements already referred to changes planned regarding how medication changes are managed aims to ensure better communication and planning amongst the team to prevent staff working outside their scope of practice. A review of the high impact, high prevalence and risk management policies and procedures is planned.

The organisation has clinical governance frameworks however, the organisation/service did not demonstrate that their clinical governance systems and processes are effective in ensuring consistent positive consumer outcomes in relation to safe and appropriate use and oversight of restrictive practices, best practice care and the management of clinical high impact high prevalence risks. The Quality Care Advisory Body minutes do not clearly indicate the reporting and evaluation of all the clinical data. In relation to restrictive practices there is a lack of understanding of what is considered a restrictive practice, particularly environmental and chemical restraint. The clinical risk matrix that commenced development in April 2024 is still under development.

In their response to the Assessment Team’s report the provider supplied a detailed response to the Assessment Team’s report which included a detailed plan for continuous improvement. In addition to improvements already referred to plans include Board education about restrictive practices and the implementation of clinical analysis and evaluation reports to monitor consumer outcomes provided to the Board to increase oversight.

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