Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | NewDirection Care at Bellmere |
| Service address: | 41 Lotus Avenue Bellmere QLD 4510 |
| Commission ID: | 5804 |
| Approved provider: | NewDirection Bellmere Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 5 September 2023 to 7 September 2023 |
| Performance report date: | 20 October 2023 |

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 NewDirection Care at Bellmere (**the service**) has been prepared by S Byers, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 29 September 2023
* other information and intelligence held by the Commission

# Assessment summary

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

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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. | 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

All consumers and representatives were satisfied that staff treat them with dignity and respect, and their care is personalised, inclusive and culturally safe. Consumer documents detailed the culture and diversity of each consumer and their individual choices and preferences. Staff were observed engaging with consumers in a respectful manner. Management confirmed staff have completed training in culturally safe care.

All consumers said they feel supported to exercise choice and independence, make connections and maintain relationships of choice. House companions described how they support consumers to make informed decisions and maintain relationships of choice, including intimate relationships. Consumer documents reflected individualised needs and preferences, including relationships of importance and links to community.

All consumers were satisfied they are supported to take risks to enable them to live life as best they can. Staff described the service’s risk assessment and dignity of risk processes. Care documentation reflected dignity of risk discussions with consumers, signed dignity of risk agreements and mitigation strategies to reduce risks. The service has policies and practices in place to guide staff to support consumers in pursuing activities that may have an element of risk.

Consumers and representatives were satisfied the service effectively communicates information. Consumers are informed of daily lifestyle activities and menus. Staff described how they communicate information to consumers with cognitive impairment or difficult communicating to ensure they understand and are supported to exercise choice. The Assessment Team observed lifestyle staff visiting each house and encouraging consumers to participate in the daily activities. A copy of the lifestyle activity calendar was displayed in consumer rooms, and menus and newsletter readily available.

All consumers and representatives were satisfied the consumer’s privacy is respected, and information is kept confidential. Staff demonstrated understanding about confidentiality of information and described how consumer information is protected. The electronic care planning system, computers and tablets were password protected. The service has privacy and protection of personal information policies and procedures in place to guide staff practice.

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

Findings

Consumers and representatives were satisfied the assessment and care planning process considers risks to the consumer’s health and well-being. Care documents reflected validated assessments that demonstrated risks are considered and individual interventions implemented to minimise risks. Staff demonstrated knowledge of individual consumers’ risks and described strategies to inform the delivery of safe and effective care. Management and staff described the admissions process that incorporates multidisciplinary approach to care planning, and timely completion of risk assessments and interim care plans. Care files reflected interim care plans were completed in accordance with admission processes. The service has policies and procedures in place to guide staff practice with assessment, risk identification and care planning.

Consumers and representatives were satisfied the service identifies what is important to them. Care planning documents reflected each consumer’s individual goals, current needs and preferences for care, including end of life wishes, which are considered during the assessment and care planning process. Advanced care plans are developed in consultation with consumers and representatives and reflected the consumers culture, identity and expressed wishes. Staff demonstrated that care planning documents are consistent with needs, goals and preferences, as supported by information provided by consumers. The service has policies and procedures in place to guide staff practice through all assessment and care planning stages, including end of life care.

Consumers and representatives expressed satisfaction with their involvement in the assessment, care planning and review of consumers care, confirming participation in formalised consultations and regular feedback. Staff and management described the involvement of other organisations and individuals the consumer wishes to involve in their care, including representatives, medical practitioners, allied health professionals, hospital in reach and health specialists. All care files sampled reflected ongoing partnership and a multidisciplinary team approach to assessment and planning, during the initial development of assessment and care plans and ongoing subsequent reviews.

Consumers and representatives said they had been informed about the outcomes of assessment and planning, and confirmed they are offered a copy of the care plan and can request a copy if they choose to. Staff said care plans are readily available through the electronic documentation system. Care planning documents reflected ongoing communication with consumers and representatives Outcomes of assessment and planning were documented and communicated to the consumer and representative in a timely manner.

Consumers and representatives were satisfied the service regularly reviews the consumer’s care and services for effectiveness, when circumstances change and following incidents that impact the needs, goals and preferences of the consumer. Staff described the review process and demonstrated understanding of the different type of review required depending on the incident or change in circumstances. Care documents reflected timely and responsive review of care and services following incidents, deterioration in health, changes in clinical presentations and hospital admissions. Care plans were updated to reflect relevant changes.

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

Findings

The service was found non-compliant in Standard 3 in relation to Requirements 3(3)(a) and 3(3)(b), following an assessment contact in November 2022 where it did not demonstrate:

* each consumer receives personal and clinical care based on best practice, specifically behaviour management.
* effective management of high impact or high prevalence risks associated with behaviour management.

At the September 2023 site audit, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2022 assessment contact.

Requirement 3(3)(a)

The service has reviewed all consumers subject to environmental and chemical restrictive practices and consulted with medical practitioners to review ‘as required’ psychotropic medications. Staff have completed training in restrictive practices and behaviour management.

All consumers and representatives said they are satisfied the care delivered is tailored to their needs and optimises their health and well-being. Consumers and representatives provided positive feedback in relation to the management of changed behaviours. Staff demonstrated understanding of the consumer’s individualised personal and clinical care needs including effective strategies, monitoring and review for each consumer with changed behaviours. Consumers identified as subject to environmental restrictive practices were observed moving freely within the service and accessing outdoor areas, with staff supporting consumers with cognitive impairment to exit the service. Care documents for consumers identified as subject to chemical and environmental restrictive practices included current assessments, evidence of informed consent and documented authorisations in consultation with representatives and medical practitioners with regular medical review. Skin integrity, wounds and pain are managed through a multidisciplinary approach with the wound specialist nurse managing complex wounds. Care documents reflected skin integrity, wounds and pain are effectively managed in line with medical directives with evidence of assessment, monitoring and review. The service has a comprehensive suite of clinical care policies and work instructions to guide staff practice.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated systems are in place to ensure each consumer receives personal and clinical care that is best practice, tailored and optimises their health and well-being. I find Requirement 3(3)(a) is Compliant.

Requirement 3(3)(b)

The service has reviewed its high-impact and high-prevalence risk processes to ensure risks are effectively identified and managed. Staff have completed training in risk management and assessments.

Consumers and representatives were satisfied that risks are effectively managed, specifically in relation to changed behaviours, weight loss and falls. Consumer files reflected the identification, assessment, management and regular review for effectiveness of high-impact or high-prevalence risks and associated strategies in relation to changed behaviours, weight loss and falls management. Behaviour support plans were individualised with input and recommendations from a multidisciplinary team. Clinical documentation demonstrated appropriate referrals, and the identification of behaviour triggers and strategies to minimise and manage changed behaviours. Staff demonstrated understanding of the high-impact and high-prevalence risks associated with each consumer and the assessed strategies to manage and minimise risk to the consumer. The service demonstrated it has policies, protocols, and risk-related tools to guide staff practice in monitoring and assessing risks.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated systems are in place to ensure effective management of high-impact and high-prevalence risks associated with the care of each consumer including changed behaviours. I find Requirement 3(3)(b) is Compliant.

I am satisfied the remaining five requirements of Standard 3 Personal care and clinical care are Compliant:

Consumers and representatives expressed satisfaction with the palliative care approach provided by the service. Care documents reflected end of life needs, goals and preferences are met in accordance with the consumer wishes, dignity is preserved, and comfort is maximised. Staff described the palliative care pathway and available resources to support consumers nearing the end of life. The service has policies and procedures in place to guide the provision of palliative care.

Consumers and representatives were satisfied with the service’s response to a change or deterioration in consumer health status. Staff described how changes to a consumer’s circumstance or condition are identified, actioned, communicated and escalated, where necessary. Care planning documents and progress notes recorded the timely identification of, and response to, deterioration or changes in the consumer’s condition. Clinical management described the service’s escalation pathway relating to consumer deterioration and the available internal and external health resources and services.

The service has systems and processes in place for communicating information about consumers’ conditions, needs and preferences. All consumers and representatives were satisfied information about consumer needs and preferences are effectively communicated in a timely manner. Staff described how they refer to handover and care documentation to ensure the delivery of safe and effective care. Care documents reflected conditions, needs and preferences are communicated, and information exchange occurs with others who share responsibility for care. Where the electronic documentation system is not used directly by other health professionals, reference to their recommendations is entered into the electronic care system by clinical staff.

All consumers and representatives were satisfied with access and referral to medical practitioners, allied health professionals, the medical assessment team, and other external specialist services, when necessary. Consumer care files reflected timely referrals to individuals, other organisations and providers of other care and services. Clinical management described the service’s referral processes and provided practical examples of referrals completed.

All consumers and representatives expressed satisfaction with the precautions in place to prevent and minimise infection-related risks. Staff demonstrated knowledge and understanding of infection control practices and described how they promote antibiotic stewardship. The service appointed an infection prevention control lead who is enrolled in the relevant training. The organisation has policies in place to support the minimisation of infection-related risks through implementing infection prevention and control principles and promoting antimicrobial stewardship. The service maintains an outbreak management plan which provides guidance to prepare, respond and recover from outbreaks such as COVID-19. The service was observed to undertake entry screening in line with transmission-based precautions.

# 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

All consumers were satisfied they get effective services and supports of daily living to optimise their independence, health, well-being, and quality of life. Management demonstrated the activities scheduled are tailored to consumer interests and preferences and designed to suit the diverse cohort of consumers. Staff provided examples of how they support consumers to engage in activities and maintain their independence that aligned with consumer documentation. Consumer documents detailed individualised needs and goals, in consultation with a multidisciplinary team. Lifestyle staff develop an activities calendar based on the preferences of consumers. Consumers are encouraged to provide input at monthly resident and representative meetings. Consumers were observed actively engaging in group activities, offered in the wellness centre, craft room and café during the site audit.

All consumers were satisfied and provided examples of how the service supports their emotional, spiritual, and psychological well-being. For example, access to church services, spiritual groups, volunteers, and one-to-one time with staff. Lifestyle staff described the assessment and planning process where information relating to consumers’ emotional and spiritual needs are identified and documented upon admission, regularly reviewed and updated. Care planning documents detailed individualised consumer emotional support strategies and how these are delivered, and this aligned with information provided by staff. The service schedules services for different religious denominations and has multiple priests come to the service to provide religious support to consumers.

All consumers were satisfied they are supported to participate within and outside the service, maintain relationships of importance and do the things of interest to them. Consumers provided examples of their loved ones joining them in service-based activities and being supported to visit cultural support groups in the external community. Staff outlined activities provided at the service, and how consumers are supported with individual pursuits and personal relationships that are important to them. Care planning documents contained information about the consumer’s significant relationships, and activities of interest. The Assessment Team observed consumers engaging with visitors in the service café, communal areas, and houses during the site audit.

The service demonstrated it has systems and processes for communicating information about consumers’ conditions, needs and preferences within the organisation and with others where responsibility for care is shared. Consumers and representatives expressed satisfaction with the level of communication from the service and that staff are aware of their specific needs and preferences. Staff said they are informed about changes to consumer needs, and this is communicated through verbal and written handovers, progress notes and care plans. Care documents demonstrated that current information about the consumer is readily available in the service’s electronic management system.

The service has processes in place to ensure consumers can access and are referred to appropriate individuals, other organisations and providers in a timely manner. Staff described referral processes and provided examples of organisations regularly accessed to provide additional support to consumers. Consumer documents confirmed the involvement of a range of external providers to supplement the services organised within the service. The service maintains a wellness centre onsite, where consumers can visit internal and external providers of care and services within the comfort of their own community. The service has their own NDIS support team to support NDIS participants with daily personal activities managed onsite through the NDIS team.

All consumers and representatives said the meals provided were varied and of suitable quality and quantity. The service has processes in place to support consumers to provide input into the menu and feedback about the meals. House companions were familiar with individual consumers’ needs, preferences and dietary requirements. Meals are prepared and cooked fresh onsite daily in each of the houses by the house companions. Management explained choices are available to consumers regarding the menu, and alternative meals can be accommodated upon request. Care documents and handover documents recorded consumer specific dietary requirements, preferences and allergies. Menus are developed for each house on a seasonal basis with dietitian review. Textured modified meals are sourced through an external provider and developed and reviewed with input by chefs and dietitians. Meals observed during the site audit were well presented and looked appealing. Staff were observed assisting consumers with their meals, offering them choice, and consumers were enjoying their meals.

All consumers and representatives said the equipment provided is safe, suitable, clean, and well-maintained. House companions confirmed they have access to sufficient equipment when they need it, described the cleaning process for shared equipment and reporting processes for maintenance and repairs. A maintenance schedule and electronic logbooks are in place to document maintenance requests. Equipment was observed to be clean, functional and well-maintained.

# 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service was found non-compliant in Standard 5 in relation to Requirement 5(3)(b), following an assessment contact in November 2022 where it did not demonstrate the service environment was clean, safe and that consumers were enabled to move freely.

At the September 2023 site audit, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2022 assessment contact.

The provider has commenced an ‘environmental improvement project’ to improve the cleanliness of the service environment. As part of the project, the service has reviewed its cleaning and documentation processes to ensure all houses are cleaned and tasks completed within timeframes, reviewed house companion roles and responsibilities including cleaning shifts and allocations, and implemented weekly environmental, catering and cleaning audits that incorporate consumer feedback and consultation. The service has installed a flame free lighter in the smoking area to reduce the risk of fire and improve the safety of consumers.

Most consumers and representatives were satisfied with the cleanliness of the service environment and confirmed being able to move freely throughout the service. Consumers who choose to smoke, said they felt safe smoking in the designated smoking area and provided positive feedback about the flame free lighter. Consumer documents reflected discussion with consumers about smoking risks and detailed smoking risk assessments and agreements. Management described improved cleaning regimes within the houses and timely follow-up of identified issues. Management explained cleaning is routinely scheduled and any special cleaning that is required is outsourced. House companions demonstrated understanding of their roles and cleaning schedules. Staff described maintenance reporting processes, and management confirmed that issues are prioritised daily and immediately addressed. Maintenance staff described the maintenance system that demonstrated both proactive and reactive maintenance was scheduled, completed, and monitored. Review of quality reports, Plan for Continuous Improvement and meeting minutes supported the progress and evaluation of the services implementation of the ‘environmental improvement project’.

To support the safety and monitoring of consumers and staff the service uses CCTV surveillance in communal areas, this allows the houses to be unlocked and consumers to move freely inside and outside at any time. Consumers said they do not notice the surveillance and felt it makes the service a safer place. The Assessment Team observed consumers freely accessing internal and external areas in the service, and the service environment to be safe, clean, and well-maintained.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and has systems in place to ensure the service environment is safe, clean and well-maintained. I find Requirement 5(3)(b) is Compliant.

I am satisfied the remaining two requirements of Standard 5 Organisation’s service environment are Compliant:

The service supports consumers with complex care needs and has adopted a ‘dementia village’ approach to design. The service is designed as a ‘microtown’ with several domestic style houses to optimise consumer independence, interaction and function. All consumers and representatives said the service environment felt welcoming and provided positive feedback about the layout and functionality of the service environment. Most consumers said the unique house model was the reason they chose to live at the service. Management described how the houses incorporate dementia design principles including lighting, tonal contrasts and noise control. Consumers were observed relaxing in the privacy of their room and interacting in the communal spaces.

All consumers and representatives said they were satisfied with the cleanliness and maintenance of furniture, fittings and equipment. Consumers were observed to have suitable equipment in their rooms. Staff described cleaning processes for shared equipment, and this was observed in practice. Management described the equipment maintenance and cleaning program and how they access external equipment services, if required. Furniture, fittings and equipment were observed to be clean and well maintained.

# 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-compliant in Standard 6 in relation to Requirement 6(3)(d), following an assessment contact in November 2022 where it did not demonstrate feedback and complaints were used to improve the quality of care and services, and actions to address complaints were ineffective in improving care and services.

At the September 2023 site audit, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2023 assessment contact.

The service has reviewed their feedback and complaints management processes to improve reporting, trending and analysis of improvement actions, established a bi-monthly resident and participating advisory committee consisting of consumers and families to discuss opportunities of improvement within the service, and implemented quality surveys to seek consumer feedback.

All consumers and representatives were satisfied feedback and complaints are reviewed and used to improve the quality of care and services. Consumers and representatives spoke positively about improvements resulting from concerns raised at resident and representative meetings. Meeting minutes supported the review of feedback to inform continuous improvement. Management demonstrated that feedback and complaints are reviewed and analysed for trends and reported to organisation management monthly in accordance with updated processes. Monthly reporting detailed trends on feedback and complaints. The continuous improvement register detailed the improvement actions implemented in response to consumer feedback and complaints, including actions to address complaints about cleanliness. The Assessment Team observed complaints relating to cleanliness have reduced and actions implemented to improve quality of care and services.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated it has effective systems in place to review feedback and complaints to improve quality care and services. I find Requirement 6(3)(d) is Compliant.

I am satisfied the remaining three requirements of Standard 6 Feedback and Complaints are Compliant:

All consumers, representatives and house companions interviewed stated they felt comfortable to provide feedback and make complaints. Consumers and representatives said they are encouraged to participate in meetings. Meeting minutes demonstrated feedback and complaints are welcomed and discussed during ‘resident and representatives’, and ‘resident and participation advisory committee’ meetings. Staff and house companions demonstrated understanding of the mechanisms available to provide feedback or complaints, including electronically, verbally or written. The service has a feedback and complaints policy and procedure in place to guide staff practice in the timely and effective management of feedback and complaints. Feedback forms, consumer experience and complaints brochures on display and available throughout the service.

All consumers and representatives said they are informed about how to access advocacy, language services, and external complaint organisations, however all also said they feel comfortable raising concerns directly with management. Staff demonstrated understanding of how they would access language or advocacy services. Staff induction includes information about internal and external complaints, and available translation support services. Written resources about advocacy and language services were observed on display and readily available throughout the service.

All consumers and representatives were satisfied the service responds to their complaints appropriately and in a timely manner. Management and clinical staff described the complaint management and open disclosure process. Complaints documents including registers and meeting minutes, demonstrated open disclosure principles implemented in practice and complaints have been appropriately recorded, actioned and resolved.

# 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was found non-compliant in Standard 6 in relation to Requirements 7(3)(a) and 7(3)(d), following an assessment contact in November 2022 where it did not demonstrate:

* sufficient staff to ensure the delivery and management of timely care and cleaning services
* the workforce is adequately trained to meet the outcomes required by these Quality Standards.

At the September 2023 site audit, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2022 assessment contact.

Requirement 7(3)(a)

The service has reviewed its rostering processes with consideration of the consumers’ needs and acuity as part of workforce planning. A people coordinator has been employed to plan and manage rosters, and management review the roster weekly. Incidents, quality surveys and feedback from staff and consumers are now monitored and trended to inform rosters. The service has implemented recruitment initiatives including partnering with registered training organisations and participating in a graduate registered nurse program to engage staff.

All consumers and representatives expressed satisfaction with the improved staffing levels at the service and provided positive feedback about continuity of care and their care needs being met in a timely manner. House companions were satisfied with the support from additional cleaning staff that enables them to focus on care delivery, and clinical staff were satisfied with the rostering of additional clinical team leaders. Lifestyle staff were satisfied there is sufficient staff to support lifestyle and well-being activities. Rostering personnel described the strategies in place to manage planned and unplanned leave, and that shifts are filled by permanent and casual staff to ensure consistency. Management described the workforce is planned based on the consumers’ care mix and acuity in each house to ensure staff skill mix and consistency of care. Roster and allocation documents reflected sufficient staffing numbers and mix across the service and shifts being filled including planned and unplanned leave. Staff skill levels and mix are reviewed and maintained through the daily operational roster meeting and weekly senior management review of the roster. The night shift structure includes clinical staff, house companions and security to monitor the CCTV boundaries, provide support where needed and respond to CCTV and calls from consumers. Calls from consumers and bed sensor movements are monitored and responded to as needed. Staff and consumers were satisfied with the night staffing structure implemented by the service. Call bells are monitored through call bell reports and consumer feedback.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated systems are in place to ensure the workforce is planned and deployed, with appropriate number and mix to deliver safe and quality care and services. I find Requirement 7(3)(a) is Compliant.

Requirement 7(3)(d)

The service has employed a quality and education manager to identify staff training needs, plan and implement the training and education program and provide one-one-one education to staff. Clinical team leaders have been appointed to support clinical training and provide mentorship to individual staff through a leadership program. Education sessions have been delivered in behaviour management, restrictive practices, complaints and open disclosure, high-impact and high-prevalence risks and SIRS.

The service has implemented an orientation and induction program to prepare new staff. Staff expressed satisfaction with the induction program, training, ongoing support, and mentorship provided to effectively perform their roles. Staff confirmed receiving relevant training and have access to additional training, where required. Management described how the organisation’s education and training program identifies staff training needs and is developed in line with consumers’ new or changing needs. Training records demonstrated the implementation of a comprehensive training program to support staff including completion of regulatory and mandatory training which includes training on Aged Care Quality Standards. Consumers were satisfied staff are trained and supported to provide quality consumer care.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated systems are in place to recruit, train and support the workforce to meet outcomes required by these Quality Standards. I find Requirement 7(3)(d) is Compliant.

I am satisfied the remaining three requirements of Standard 7 Human Resources are Compliant:

All consumers and representatives were satisfied staff are kind, caring and respectful. House companions demonstrated they are familiar with each consumers’ identity, diversity and individual cultural needs. Staff demonstrated understanding of the organisation’s values and described how the values guide their behaviour and practice. Management described how they lead a culture of respect for diversity, and staff interactions are monitored to ensure the culture of respect is reflected in day-to day interactions and care of consumers. Organisational policies and procedures including the staff handbook and code of conduct guide staff practice. Staff interactions with consumers and representatives were observed to be positive, kind and respectful.

All consumers and representatives expressed confidence in the workforce and were satisfied that staff are trained, knowledgeable, and qualified to meet the consumer’s needs. Management described recruitment processes including the verification of staff credentials and competency relevant for their roles. Staff are monitored to ensure they are working within the scope of their practice, responsibilities, and skills. Staff were satisfied with the support they receive to learn new skills or upgrade their skills, knowledge, and qualifications. Position descriptions detailed specific staff duties, responsibilities, and professional accountabilities, and staff records reflected relevant professional registrations and qualifications.

The organisation demonstrated it has effective processes in place to regularly assess, monitor and review the performance of the workforce. Clinical staff and house companions confirmed participating in performance reviews with the opportunity to provide and receive feedback. Performance review records demonstrated processes to monitor and evaluate employee performance. Management described how informal and formal performance review methods are used to identify, plan, and support the needs for staff training and development.

# 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. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found non-compliant in Standard 8 in relation to Requirement 8(3)(b), 8(3)(c), and 8(3)(d) following an assessment contact in November 2022 where it was unable to demonstrate:

* the governing body’s accountability in managing risks to the health and safety of consumers
* effective organisation wide governance systems relating to workforce governance and feedback and complaints
* the organisations risk management system effectively managed high-impact or high-prevalence risks or managed and prevented incidents in relation to changed behaviours.

At the September 2023 site audit, the Assessment Team found the service had implemented improvements to address the deficits identified at the November 2022 assessment contact.

Requirement 8(3)(b)

Consumers and representatives said they feel safe and live in an inclusive environment and have observed the positive behaviour management strategies to support consumers with changed behaviours. The service has implemented a buddy program to support new consumers to adapt to the service community. New consumers to the service described feeling safe, included and supported. The organisation has a quality assurance framework in place that has oversight of risk assessment and mitigation from the point of care to executive governance to ensure safe care and services. The organisation has a suite of policies and procedures that support and guide management and staff to provide a safe and inclusive culture for consumers and stakeholders. The governing body is informed of clinical indicators, quality of life outcomes, feedback and complaints through monthly reporting and is supported by established committees to ensure accountability in the delivery of quality care and services.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated systems are in place to ensure the governing body promotes and is accountable for the delivery of a culture of safe, inclusive and quality care and services. I find Requirement 8(3)(b) is Compliant.

Requirement 8(3)(c)

The service has reviewed and developed improved reporting and documentation processes to ensure the governing body is provided relevant information to make informed decisions. As demonstrated by the decision of compliance in Standards 6 and 7 the service has implemented improvement actions to address and remediate the deficits in relation to workforce planning and feedback and complaints to demonstrate effective governance systems are now in place.

The service demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. The governing body monitors, and reviews routine reporting and analysis of data related to the consumer experience and satisfies itself that systems and processes are in place to ensure the right care is being provided in accordance with the Quality Standards. Staff demonstrated understanding of the policies and processes that supported each of the governance systems, and how they applied to their roles and responsibilities. Workforce roster processes have been improved with regular review, planning and consultation by senior management. The governing body engages in the review and restructuring of the services workforce profile to meet requirements. Workforce education has been improved with the engagement of a quality and education manager to over see mandatory and supplementary training. Feedback and complaints are analysed and trended monthly with the governing body providing oversight of continuous improvement actions. Feedback and complaints reporting reflects a reduction in complaints relating to cleanliness and meals, and no further complaints about staffing since the improved workforce structure has been implemented.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated effective organisation wide governance systems are in place. I find Requirement 8(3)(c) is Compliant.

Requirement 8(3)(d)

The service has reviewed, updated and implemented its incident management policy and evaluated it in practice. The service has developed and implemented improved reporting and documentation processes for incident investigation, with weekly meetings to discuss effectiveness of strategies and actions. Staff have completed incident management training, as supported by training records and staff feedback.

The organisation demonstrated it has effective risk management systems in place supported by policies and procedures documented to manage risk, incidents, abuse and neglect of consumers and to support consumers to live the best life they can. High-impact or high-prevalence risks are identified through clinical data and incidents in the service’s electronic incident management system. High-impact and high-prevalence risks are discussed at the service and organisation level, as reflected in the weekly clinical governance meeting minutes and reports. Incident reports for incidents involving changed behaviours detailed investigation, escalation, analysis of reportable incidents, including root cause analysis and individualised strategies to manage and prevent reoccurrence. Staff described how consumer risks and incidents are reported, escalated, and managed in accordance with policies and procedures. Dignity of risk documentation and feedback from consumers demonstrated how the service supports consumers to live the best life they can. Training records and staff feedback demonstrated training has been delivered in relation to incident risk and incident management, SIRS and behaviour support management.

Based on the findings in the site audit report, I am satisfied the provider has addressed the non-compliance and demonstrated effective risk and incident management systems are in place. I find Requirement 8(3)(d) is Compliant.

I am satisfied the remaining two requirements of Standard 8 Organisational Governance are Compliant:

All consumers and representatives were satisfied they participate in how the service is run and broader service improvement, providing examples of engagement through advocacy meetings, feedback mechanisms, and individual care plan consultations. Meeting minutes and the services current Plan for Continuous Improvement reflected that consumers are supported and engaged in the development, delivery, and evaluation of care and services. For example, the environmental improvement project, commenced following consultation with consumers and representatives and endorsement by the Board, has been implemented and has resulted in ongoing improvements and positive feedback from consumers about the cleanliness of the service environment.

The organisation demonstrated it has a clinical governance framework in place that provides an overarching monitoring system for clinical care. The framework, supported by a suite of updated policies and procedures, addresses key clinical governance areas such as antimicrobial stewardship, minimising the use of restrictive practices, and open disclosure. Management described the oversight of clinical care at the point of care by clinical staff and at an organisation level through the clinical governance committee. Clinical reports reflected the organisation’s systematic approach to quality audit and data comparisons that support improvements in clinical care. Staff demonstrated understanding of the policies and procedures and provided examples of the relevance to roles and responsibilities.

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-2)