Newstead Grand Care Community

Performance Report

Level 3 & 4, 50 Longland Street
NEWSTEAD QLD 4006
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**Commission ID:** 5758

**Provider name:** DPG Services Pty Ltd

**Site Audit date:** 19 April 2022 to 21 April 2022

**Date of Performance Report:** 7 June 2022

# Performance report prepared by

Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant  |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** |  **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* the Approved provider’s response to the Site Audit report received 25 May 2022.
* other information and intelligence held by the Commission in relation to the service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

Consumers and their representatives’ considered consumers were treated with dignity and respect, that staff were kind and caring when providing care and that consumers’ cultural needs and preferences were supported. Consumers and representatives described the ways that the service supported them to exercise choice and independence and to maintain relationships that were important to them. Staff spoke about consumers in a respectful manner and demonstrated familiarity and knowledge of individual consumers’ background and preferences. The Assessment team observed staff interacting respectfully with consumers.

Staff described how consumers' cultural backgrounds influenced how they supported consumers. Consumers from culturally diverse backgrounds provided examples of how staff provide culturally appropriate care and services. Consumers and representatives said they were supported to make decisions about consumers’ care and provided with sufficient information to make informed choices.

Consumers and representatives said consumers were supported to take risks and live the life they choose, with one named consumer describing to the Assessment Team how they were supported to maintain relationships and social connections inside and outside of the service, which included regularly leaving the service independently.

Consumers and representatives considered they received regular communication from the service. Consumers described receiving regular updates reading lifestyle activities and regular menu changes and staff described how information is provided in-line with consumers’ needs and preferences. The Assessment Team observed information such as calendars, menus and pamphlets displayed throughout the service along with individual residential handbooks.

Care planning documentation reflected the diversity of consumers and included information regarding what and who were important to them, their life journey, cultural background, spiritual preferences, family relationships and their individual personal preferences and the Assessment Team observed staff interacting with consumers in a friendly, warm, dignified, and respectful manner.

Consumers and representatives felt that staff respected their personal privacy when providing care and services, including through knocking on consumers’ doors before entering rooms. Staff described procedures and processes used to maintain consumer privacy and confidentiality such as asking before entering rooms and ensuring doors and blind were closed when providing care. The service had procedures and guidelines for staff regarding privacy and the Assessment Team observed information being shared appropriately during shift handovers.

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

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Care planning documentation detailed the consumer’s current needs, goals, and preferences. Consumers and representatives expressed satisfaction with the assessment and care planning process. Staff demonstrated an awareness of the commencing assessments, the four-monthly care evaluation process and monthly resident of the day checks. The Assessment Team noted policies and procedures available on the service’s intranet to guide staff practice regarding assessment and planning for consumers.

Consumers and representatives expressed positive feedback regarding the service’s ability to provide care in line with the consumer’s needs and preferences. Care planning documentation evidenced that consumers and representatives were consulted throughout assessment and care planning, including advanced care and end of life planning. Staff were able to describe how the assessment and care planning process identifies consumers’ goals, needs and preferences that inform the care plan development and delivery of care.

Care planning documentation evidenced an ongoing partnership with the consumer and others that the consumer wishes to be involved in their care. Consumers and representatives confirmed they were involved in the assessment and care planning process on an ongoing basis. The physiotherapist described the process for assessment, care planning and review of consumers cared for under the pain and falls management program.

Consumers and representatives confirmed outcomes of assessments are effectively communicated to them and they are kept inform of changes to the consumer’s care needs. Staff indicated the service communicates outcomes of all assessments and planning as well as plans through care plans conferences on a four-monthly basis or more often as necessary. Staff advised they have access to care plans for consumers they are providing care for through the electronic care management system.

Consumers and representatives indicated that consumer’s care and services are reviewed on a regular basis, or when the consumer’s circumstances have changed. Care planning documentation evidenced reviews occur every four months, or more often as required. Staff described the four-monthly care plan review process and outlined they review consumers’ care, pain and skin integrity needs as well as any other identified issues.

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

## Assessment of Standard 2 Requirements

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

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

Consumers considered they received personal care and clinical care that was safe and right for them, and representatives confirmed consumers get the care they need from various health professionals when they need it.

Consumers and representatives confirmed they were satisfied that referrals to health professionals occurred in a timely manner and consumers have access to relevant external health professionals when required. Staff advised that referrals are made in consultation with the consumer and representative and consent is obtained prior to referrals being made. The Assessment Team observed referrals to allied health professionals such as the physiotherapist, podiatrist and other health professionals.

Staff were able to describe to the Assessment Team high impact or high prevalence risks and how they related to individual consumers including falls risk, pressure injuries and skin tears. Strategies to manage these risks were also described such as the use of hip protectors for falls risk, regular repositioning for pressure injuries and skin tears, as well as use of limb protectors. Progress notes showed that administration of heat pack have been in line with the care plan.

Care planning documentation demonstrated that most consumers had advanced care directives in place and staff were guided by policies and procedures for guiding the management of palliative care.

Care planning documents reflected the identification of, and timely response to, changes in the consumers condition and/or health status. Staff were able to describe their roles and responsibilities in identifying and reporting changes or deteriorations in consumer’s health. Consumers and representatives indicated that the service responds appropriately to deteriorations in consumer’s health and refers consumers to external providers as required. A review of clinical records by the Assessment Team demonstrated consumers are regularly monitored by staff and if deterioration or change of a consumer’s mental, cognitive, or physical function, capacity or condition occurs, this is recognised and responded to in a timely manner and representatives notified. ‎

Consumers and representatives stated that their condition, needs, and preferences are well communicated throughout the service and external health care professionals. Staff described the various ways information about the consumer’s condition is communicated and advised they access to consumer files to ensure appropriate care needs are attended to. The Assessment Team observed shift handover and staff communicating any changes to consumer’s care needs and preferences.

Consumers and representatives confirmed they were satisfied that referrals to health professionals occurred in a timely manner and consumers have access to relevant external health professionals when required. Staff advised that referrals are made in consultation with the consumer and representative and consent is obtained prior to referrals being made. The Assessment Team observed referrals to allied health professionals such as the physiotherapist, podiatrist and other health professionals.

The service had documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. Staff advised they have received education and training in relation to infection control and COVID-19. Consumers and representatives advised the service’s communication and infection control practices regarding the management of COVID-19 were well coordinated and managed.

The Assessment Team found the service did not meet Requirement (3)(a) regarding the delivery of safe and effective care for each consumer. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Non-compliant. I have provided reasons for the finding in the relevant requirement below.

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

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team brought forward evidence that consumers did not consistently receive safe and effective personal and clinical care that was best practice, tailored to meet the individual consumer’s needs and optimised their health and well-being.

The Site Audit report found that the service demonstrated effective understanding and application of restraint management and appropriately and effectively identified issues in relation to the management of pain. However, the Assessment Team spoke with consumers who reported that peronsal care was not consisitenlty delivered in accordance with their preferences. Relevant summarised evidence included:

* One named consumer who advised the Assessment Team that their preference was for a daily shower, however care documents showed this had not occurred in the last week, with no documented explanation as to why.
* One named consumer who advised they preferred second daily showers who had only received two in the week preceding the Site Audit.
* One named consumer who stated to the Assessment Team they were advised they were only able to receive showers when staff have time, and a sponge is provided at other times.

In its written response of 25 May 2022, the Approved Provider provided some further context to the evidence brought forward by the Assessment Team and provided the following summarised evidence:

* The Approved Provider contended that each consumer is asked each day their preference to shower prior to assistance being given by staff, which is sometimes declined, and alternatives offered, including sponges.
* The service has undertaken a review of individual preferences and care needs for each consumer, including time of day and frequency of shower
* Education led by the Care Manager around process changes and the undertaking that exceptions to care plans will be documented.

While I acknowledge the actions undertaken and planned by the Approved Provider, I remain of the view that at the time of the Site Audit the service did not demonstrate that each consumer was receiving safe and effective personal care and/or clinical care, tailored to their needs. I therefore find the service Non-compliant with this Requirement.

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

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

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 NON-COMPLIANTServices and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers expressed confidence in the way the service shared and communicated their needs and preferences both internally and to external health professionals. Consumers provided various examples to the Assessment Team of how the service ensured they maintained relationships that were important to them.

Staff explained how they were updated on the changing condition, needs and preferences of consumers through documentation and verbal communication which included shift handovers, communication diaries and care documentation.

Staff also described how they work with other individuals, external organisations, and volunteers to supplement the lifestyle activities within the service which included citizen’s clubs, entertainers, and personal care services.

The Assessment Team observed a variety of brochures and resources available to support referrals to external organisations as required.

However, not all consumers were satisfied they received safe and effective services and supports for daily living. Consumers reported issues with the laundry services and some consumers were also dissatisfied with the variety and quality of food offered by the service. The Assessment Team recommended Requirements 4(3)(a), and 4(3)(f) were not met, regarding the provision of services and quality of meals.

I have considered the Assessment Team’s findings, the evidence documented in the Site Audit Report and the Approved Provider’s response. I have found the service Non-compliant with Requirements 4(3)(a), and 4(3)(f). I have provided reasons for my findings in the specific Requirements below.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The Assessment Team found the service did not ensure each consumer received safe and effective services and supports for daily living that met the consumer’s needs goals and preferences and optimise their independence, health, well-being, and quality of life. Relevant (summarised) evidence included:

* One named consumer who stated to the Assessment Team, items of their clothing had gone missing after sending them to be laundered.
* A representative of a consumer who stated that the consumer had received multiple pairs of pants that were not theirs and had an unlabelled shirt go missing during laundering.
* A further representative who stated multiple items of the consumers had gone missing, some potentially after being sent to the laundry.
* Laundry staff who advised that numerous items had been reported missing by consumers and identified it as a problem.
* Staff who advised there is an inconsistent process for collecting laundry items from consumers rooms and no process for labelling clothing.

In its written response dated 25 May 2022 the Approved Provider gave explanation of steps taken prior and since the Site Audit to resolve the issues raised by the Assessment Team, noting that some of the issues raised were historical issues that have since been resolved.

The Approved Provider advised; consumer’s clothing and belongings are now labelled to ensure no further items go missing, with this process communicated to consumers and representatives upon entry to the service and through posters throughout the service. The Approved Provider further advised that the Service is currently transitioning from a partially outsourced, to a fully onsite laundry service that it anticipates will reduce the instances of lost items.

While I acknowledge the actions taken by the Approved Provider to address the deficiencies identified under this requirement, I remain of the view that at the time of the Site Audit the service did not ensure each consumer received safe effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimised their independence, health, well-being and quality of life. I find the service Non-Compliant with this Requirement.

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

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

### Requirement 4(3)(e) Compliant

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

### Requirement 4(3)(f) Non-compliant

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

The Assessment Team found the service did not demonstrate that meals were varied and of suitable quality and quantity. Relevant (summarised) evidence included:

* Consumers and representatives gave generally negative feedback about the quality of food provided by the service, meaning that at times their preferences aren’t met.
* One consumer stated that the quality of food was low, not always served hot not enough potatoes were offered and the process of food service, generally disorganised.
* One consumer advised that the food is not served warm enough and the tea served too cold. This consumer further advised that the final meal service is served at 5:30 pm, leaving consumers with nothing to eat until the following morning.
* One consumer stated that the food is often served soggy, and they found the salads boring.
* One representative advised that they had made a written complaint to management about the quality of the food, without a response to date.

In its written response dated 25 May 2022, the Approved Provider provided further evidence of the steps taken to ensure the quality of meals provided, these included:

* Monthly food focus groups in place prior to the Site Audit and offered to all residents on an ongoing basis with feedback used to improve the quality of meals.
* Additional portions of potatoes and greater variety of salads offered at each meal.
* Processes put in place to provide food specifically to the liking of individual consumers, with the chef working with individuals to cook meals to their liking.
* A larger range of desserts, more variety at morning and afternoon teas and greater variety of vegetables at meals.

While I acknowledge the actions taken by the Approved Provider in response to the Site Audit, I remain of the view that at the time of the Site Audit the service did not demonstrate that the meals provided, were varied and of suitable quality and quantity. I find the service Non-Compliant with this Requirement.

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team observed the service was welcoming and easy to navigate, and optimised each consumer’s sense of belonging, independence, interaction, and function. Consumers and representatives expressed positive feedback regarding the service environment and indicated that the service was an enjoyable place to live. Staff described how the layout complimented the service, with courtyards and common areas for consumers to socialise and relax throughout the day.

The Assessment Team observed the service to be safe, clean, well maintained, and comfortable, consumers were able to move freely throughout the facility, both indoors and outdoors. Consumers described how they are supported to move around the service, including access to the courtyards and gardens and exiting the service. The Assessment Team reviewed maintenance requests that showed maintenance issues were addressed in a timely manner.

The Assessment Team observed the furniture, fittings and equipment at the service to be safe, clean, well maintained and suitable for consumers. Consumers confirmed they felt safe when staff were providing care using mobility or transfer equipment. Maintenance staff described the maintenance paper-based system where all maintenance updates are recorded, actioned and managed. These were kept in folders in the maintenance office and were observed to be current and up to date.

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

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers felt they were encouraged and supported to provide feedback and make complaints and were familiar with the feedback and complaints processes. Staff advised that when they receive feedback from consumers, they initially attempt to address the issue at the time feedback was provided, otherwise they escalate the issue to management. Management described various ways that consumers are encouraged and supported to provide feedback and raise complaints.

The Assessment Team found the service did not meet Requirement 6(3)(b), Requirement 6(3)(c) and Requirement 6(3)(d). I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service Compliant under Requirement 6(3)(b) and Non-Compliant under Requirement 6(3)(c) and Requirement 6(3)(d). I have provided reasons for my findings in the relevant requirements below.

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

## Assessment of Standard 6 Requirements

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

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

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

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

The Assessment Team identified that consumers were not made aware of, nor had access to advocates, language services and other methods for raising and resolving complaints. Summarised relevant evidence included:

* A named representative expressed they did not understand the external complaints process as no one had explained it to them.
* A further named representative expressed they were unaware of alternative feedback avenues available to escalate their concerns when they were dissatisfied with the response received to their complaints on several occasions.
* A named consumer who expressed they did not know how to make a formal complaint, however stated they would inform the staff of any concerns.
* Out of the staff interviewed, none were able to discuss how they would access advocacy or translation services and outlined they had not witnessed the occurrence of translation services at the service.
* Out of the staff interviewed, none were aware of the information displayed in the library regarding complaint escalation and advocacy services.

The Approved Provider’s written response, received 25 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider outlined that:

* Information about accessing advocacy services, including Older Person’s Advocacy Network (OPAN) and Disability Advocacy Network Australia (DANA) is detailed across multiple resources. These resources are widely available and have been distributed to Newstead families in situations where appropriate.
* The service had an extensive welcome and information pack which is provided to prospective consumers and representatives to support them in their decision making and when moving into the service. The information pack includes contact details for providing feedback and complaints, both internally and externally of the service. The residential agreement has a supplemental guide detailing information of importance to consumers and representatives to view prior to entering into a contract. Specifically, the guide includes links to the Charter of Aged Care Rights and information on how to make a complaint.
* The service also has various posters on display for consumers, representatives and staff to access. These provide contact details of the service’s General Manager (GM) should they wish to make contact, as well as information for advocacy groups and the Aged Care Quality and Safety Commission (ACQSC).
* The service also utilises a visitor log in system which allows visitors to put in comments about their visit which are directed to the GM, and a summary is provided daily to the Regional GM.
* The service noted a key support is their Overcoming Language Barriers in your Home resource, which translates the feedback handling practices into numerous languages. The resource details how to access translation services and how to engage with staff to provide the necessary support. These resources outline how to access advocacy services and provides contact details for OPAN, DANA and the ACQSC.
* The service indicated that staff may not have been aware of specific instances involving translation support as these cases are not widespread and are generally addressed by the Administration team as part of the pathway into care and ‘getting to know you’ stages. To support increased awareness of accessing translation services, the service has discussed this in their daily huddles and have issued a memo to widely circulate this information.
* The service noted that they are an overwhelmingly English-speaking cohort, the translated guidelines resource is not on general display. The service believes their obligation to ensure consumers and their families are aware of all support available to them in the home, notwithstanding that some of the families had not accessed this information.

Whilst I acknowledge that the Assessment Team identified that staff and management were unable to demonstrate how consumers and representatives were informed of advocates, language services and other methods of resolving complaints. On the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate overall Non-compliance. In addition, the service has provided a satisfactory explanation as to the issues identified by the Assessment Team. Therefore, I find the service Compliant with this requirement.

### Requirement 6(3)(c) Non-compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team identified that appropriate action is not taken in response to complaints. Summarised relevant evidence included:

* A named consumer indicated they had made numerous reports regarding the disappearance or misplacement of personal belongings, however did not feel they had received satisfactory follow up and the complaints had not been resolved. These complaints were not found to be documented on the service’s complaint register. The Assessment Team raised these issues with management during the Site Audit, management advised that some of the missing items were originally reported to the service prior to the change in ownership and had been discussed with the consumer’s representative.
* A named consumer’s representative indicated they had raised several concerns including:
	+ Safety concerns following an incident between the consumer and another consumer of the service.
	+ Concerns relating to staff sufficiency and staff attending rostered shifts.
	+ The Assessment Team raised the above issues with management during the Site Audit, management advised that a Serious Incident Reporting Scheme (SIRS) report had been lodged following the incident resulting in safety concerns. However, management did not provide addition information relating to the other areas of feedback provided by the representative.
* A named consumer had raised concerns at the consumer forums over several months regarding the cleanliness of the carpets. The consumer indicated they had to raise the issue on a number of occasions over a period of three months carpets, however the carpets were now being cleaned on the day of the Site Audit.
* A named consumer raised their concerns regarding clothing items that have gone missing during the laundry process. The consumer reported the missing items to staff, however had not received any response to the concerns raised and the items are still missing. This feedback is not documented within the service’s complaint register.
* The Assessment Team made contact with a representative to follow up a complaint identified in the complaint register. The complaint was regarding the consumer was seen to be wearing clothing items that did not belong to them, as well as several items of clothing found in their room which also did not belong to them. The representative indicated they had received contact from management, however had not had the opportunity to return the phone call.
* Staff did not demonstrate a shared understanding of open disclosure principles and how it impacts their practice.
* A review of staff training records indicated that 33.3% of staff had completed training on open disclosure, however management identified that records are inaccurate.

The Approved Provider’s written response, received 25 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that:

* The service has a strong culture of resolving complaints immediately at the time concerns are raised. This means that the team will often deal with informal complaints without logging the complaints in the system, in the belief that resolving complaints of these nature are part of the general good practice of the service. It has since been communicated to the team, that all complaints are to document within the complaints management system, so that evidence of actions taken in the future can be viewed, and to support the identification of trends and opportunities for improvement.
* The Approved Provider acknowledged the service had not utilised their complaints management system to its capacity and acknowledged the importance of responding to and documenting concerns. This is evidenced by multiple entries into progress notes relating to complaints received as well through SIRS reporting. These documentation efforts were considered by the service to be swift, comprehensive and appropriate.
* The service indicated that their supportive and open approach to soliciting feedback is also evidenced by the large number of consumers and families that participate in resident-relative meetings, food focus groups and the Resident Food Planning Group. The service noted they have responded to feedback received at meetings with a variety of changes being made to the menu choices and variety provided at the service.
* The Approved Provider also responded to the individual consumers and representatives that provided feedback during the Site Audit and detailed the steps taken in response to the Site Audit report to resolve the individual issues raised, which included apologies where appropriate.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the deficiencies identified by the Assessment Team. At the time of the Site Audit, the service did not demonstrate that appropriate action is taken in response to complaints. I therefore find this requirement Non-compliant.

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team identified that feedback and complaints were not reviewed and used to improve the quality of care and services. Summarised relevant evidence included:

* A named consumer provided feedback on several occasions regarding the temperatures of their meals. The consumer does not feel that any action has been taken in response to the feedback provided. In addition, the consumer had raised feedback requesting a change in cuisine as well as feedback in relation to missing laundry items and reported that the feedback have not been actioned.
* A representative for a named consumer indicated that although consumers and representatives are encouraged to provide feedback, they are not confident that feedback and complaints result in any changes within the service. The representative reported they had previously made a written complaint regarding the food, although an email response was provided, the representative expressed there has not been any notable improvements to the quality of food services.
* Discussions with staff about feedback regarding missing clothing items, or consumers being dressed in other people’s items indicated that:
	+ Feedback and complaints regarding these issues is frequently provided.
	+ Due to the frequency of items being misplaced, consumers have lost confidence in the laundry process.
	+ There is often little communication regarding the admission of a new consumer, although sometimes the registered nurse will inform staff on the day.
	+ There is no clear process in place to address the issue of consumer clothing not being labelled.
* The Assessment Team reviewed a complaint report at random. The complaint reviewed was regarding the quality of the food provided at the service, the outcome of the complaint indicated that management were working with the chef to transition to the service’s new menu as soon as possible. This item was noted to be moved to the service’s Plan for Continuous Improvement (PCI), however a review of the service’s PCI and this item was not found to be listed, there was no further evidence of the actions implemented or review of stated actions.

The Approved Provider’s written response, received 25 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that:

* The service noted that in addition to addressing individual feedback from residents, dedicated systems are in place to leverage feedback to drive improvements at a service and organisational level. These systems are integral to the service’s management, governance and compliance processes and policies, which is anchored in analysing feedback to identify trends and opportunities within the service.
* The service’s complaint management system provides an opportunity to link feedback with PCI. This mechanism is in place to leverage customer feedback to drive improvement within the service. The service acknowledges that these systems were not utilised to the maximum, the culture of focusing the team’s energy and resources on what matters most to the resident cohort is evident at the service.
* The service has a resident preference sheet that is referred to by staff during meal service to ensure the consumer is offered the meal that was requested. Staff check with consumers prior to serving their meals and consumers can change their preference with other options offered.
* The sequence of the in-room dining service has altered to ensure consumers in the dining room are served first followed by assisted in-room dining. This change in process has improved meal experiences for consumers and ensures meals are received at appropriate temperatures.
* A further example outlining how the service acts on feedback is through their recruitment. Prior to the current management’s acquisition of the service, feedback from consumers and representatives indicated that consistent staffing and an absence of agency staff was requested, resulting from this feedback, the service have recruited extensively.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the deficiencies identified by the Assessment Team. At the time of the Site Audit, the service did not demonstrate that complaints were consistently documented and used to improve the quality of care and services. I therefore find this requirement Non-compliant.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Consumers and their representatives said although staff were busy and under pressure, they treated consumers in a caring way and respectful way. Staff were observed interacting with consumers in a kind and respectful manner when providing care and services, including through addressing consumers using their preferred names.

The service had systems in place to monitor and report staff compliance with professional registrations, police clearances and vaccinations. The training calendar was reviewed, which included training options on a range of subjects. Staff were observed delivering care in a safe manner that was within their scope of practice. Clinical staff felt supported and able to access training and education, while care staff provided mixed feedback regarding the training, support and information they received.

The Assessment Team recommended Requirements 7(3)(a), 7(3)(d) and 7(3)(e) were not met, regarding workforce planning, training and monitoring. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit Report and the Approved Provider’s response. I have found the service Non-compliant with Requirements 7(3)(a), 7(3)(d) and 7(3)(e). I have provided reasons for my findings in the specific Requirements below.

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

## Assessment of Standard 7 Requirements

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

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

Several consumers expressed concern about the timeliness of care provided and felt they compromised on their preferred care options to accommodate workforce levels. The Assessment Team brought forward several examples where consumers experienced delays in support being provided, delays in call bell responses, staff providing care in a hurried manner and care preferences being compromised due to staff availability. Relevant (summarised) evidence included:

* Five named consumers and representatives told the Assessment Team their shower preferences were not able to be met due to staff levels and staff having insufficient time.
* Four named consumers described how delays in requests for assistance delayed the provision of personal care and toileting support.
* Eight care staff confirmed to the Assessment team that they worked short staffed once or twice a week.
* Care staff advised consumer care was compromised when there were insufficient staff and that work stress resulted in rushed care delivery.
* The Assessment Team reviewed the care plans of 3 named consumers and identified that none of the consumers received personal care in accordance with their preferences.
* The Assessment Team reviewed call bell response times for the period 11 to 17 April 2022 and calculated that over 12% of consumers waited more than 20 minutes for staff to respond to their request for assistance.
* Management advised the Assessment Team that call bell reports were reviewed every morning, 28 new staff had recently started and the organisation would soon roster an additional two care staff and one clinical staff daily to backfill planned and unplanned leave.

Management described how registered and care staff were rostered to enable the delivery of safe and quality care. This included rostering an additional two care staff for a four-hour shift from 6am. Management also told the Assessment Team of a reluctance to use agency staff and instead described how extra shifts were offered to existing staff, to ensure consistency in service provision. There were three unfilled shifts in the week prior to the audit.

In its written response of 25 May 2022, the Approved Provider stated the Assessment Team’s report did not represent most consumers. It advised that an additional 33 team members had recently been recruited and there was almost no reliance on agency staff, which aligned with consumers’ expressed preferences. The Approved Provider stated it reviewed rosters on a monthly basis, and its rostering approach ensured there was an appropriate mix of staff relevant to the number and needs of consumers. The Approved Provider advised that team preference, skill mix and experience informed its rosters.

In it written response, the Approved Provider noted the senior clinical team had been restructured and a Care Manager had been recruited, to support Registered Nurses and Assistants in Nursing. The Approved Provider advised the results of regular surveys did not align with the evidence brought forward by the Assessment Team.

While I acknowledge the action taken by the Approved Provider, I note that consumer and staff experience does not align with the organisation’s view that staffing mix and levels are appropriate. I agree with the Assessment Team that the number and mix of members of the workforce deployed does not enable the delivery and management of safe and quality care and services. I find this Requirement Non-compliant.

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

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

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

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

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

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

The service demonstrated effective systems to recruit and orient new staff, however, it could not evidence that staff had undertaken mandatory training.

The Assessment Team brought forward evidence that staff training needs, including mandatory training, were intended to be captured in a new training management platform. Management further advised training records would be generated from this platform, however, due to a recent transfer of ownership training records from the previous organisation had not been consolidated and were therefore not up to date. Management noted it was awaiting practical competencies to be uploaded into the new system, noting this had not been completed due to a change of staff.

During the Site Audit, the service developed an item in its Plan for Continuous Improvement to consolidate all training records, which is intended to track staff compliance with education.

The Approved Provider provided a written response on 25 May 2022, stating it developed 4 weeks of mandatory training for all team members when planning its transition in ownership. The Approved Provider noted that as new staff join the service, they also undertake mandatory training. In its response, the Approved Provider supplied data for training completed since 1 December 2021, identifying between 33% and 81% of staff had completed each of the mandatory training topics listed.

While I acknowledge the service is transitioning to a new training platform, the service has not consolidated available records and is therefore unable to evidence staff compliance with mandatory training. At the time of the Site Audit, the service could not demonstrate that all staff were trained, equipped and supported to deliver the outcomes required by this standard. I find this Requirement Non-compliant.

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

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

The Assessment Team brought forward evidence that staff had not participated in formal performance appraisal over the past six months. Staff reported varying levels of informal support, with clinical staff stating they felt well supported and confident performing their roles. Care staff reported they were reliant on receiving feedback from clinical staff and each other for support and direction.

Management advised the Assessment Team that new staff received regular informal monitoring upon commencement and that all staff completed annual appraisals after six months at the service. Management explained it used an escalation approach in dealing with performance management issues.

The Approved Provider responded on 25 May 2022, noting that while staff training and support had been prioritised during the transition in ownership of the service, general oversight of all team members had occurred. The Approved Provider advised it was developing a schedule of performance conversations, and nine performance meetings had been held over the previous six months in response to poor performance or not following policy and procedure.

The management team elected not to conduct any performance appraisals for six months after the service changed ownership. This was intended to provide staff the time to acclimate to the new organisation before assessing their performance. However, the service was unable to demonstrate that the performance of the workforce was regularly assessed, monitored or reviewed.

While I acknowledge the Approved Provider maintained general oversight of its staff, it has not demonstrated that regular performance assessment takes place. I find the service Non-compliant with this Requirement.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The majority of consumers considered the organisation well run and confirmed they were able to provide feedback to the service through monthly meetings. Staff outlined how consumers and representatives informed the design, delivery and evaluation of services through case conferences, consumer and relative meetings, food focus groups, feedback forms and monthly consumer experience surveys. Management identified the need to increase their presence and described to the Assessment Team the actions taken to introduce the new management team to consumers.

The organisation’s governing body promoted and was accountable for the delivery of safe, inclusive and quality care and services. Management advised the Board meets weekly with the executive leadership team and is in regular communication with services. The Board was supported by sub-committees such as the clinical governance committee, which reported on consumer quality indicators to inform the delivery of care and services. The Board provided examples of changes it implemented in response to consumer feedback. The customer insights manager is present at each Board meeting to identify trends and key focus areas resulting from consumer feedback.

The service had a documented risk management framework, which included policies on high-impact or high-prevalence risks, identifying and responding to the abuse and neglect of consumers and supporting consumers to live their best life. Most staff demonstrated an understanding of these policies and provided examples relevant to their work. Care staff were not aware of the Serious Incident Response Scheme and how it related to their role.

The organisation had a clinical governance framework that included policies relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. Clinical staff received training on these policies and provided examples of how they were applied.

The Assessment Team recommended Requirement 8(3)(c) was not met, regarding information management governance systems. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit Report and the Approved Provider’s response. I find the service Non-compliant with Requirement 8(3)(c). I have provided reasons for my findings in the specific Requirement below.

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

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team brought forward several examples where staff had difficulty accessing consumer information and experienced inconsistent handover processes. The was a deficit in the reporting and monitoring of staff training as discussed in Requirement 7(3)(d) and capturing and addressing complaints as discussed in Requirement 6(3)(c). Relevant (summarised) evidence included:

* Consumer information was accessible electronically, however, the majority of care staff reported they had limited access to computers, which were prioritised for use by nursing staff. The Assessment Team observed examples of this.
* Clinical staff completed a handover between shifts, documented handover notes and attended a huddle meeting twice a day with the care manager to share key information. Care staff relied on verbal handovers with other care staff, did not have access to handover notes and were sometimes updated by a Registered Nurse. The Assessment Team observed handovers were not inclusive of all staff.
* Management reported Registered Nurses had a huddle with care staff to disseminate information, with care staff reporting this takes place time permitting, on occasion.
* Clinical staff stated monthly meetings and education sessions were held to disseminate information. Care staff noted emails were occasionally distributed regarding service updates and observed they had not had a meeting since the change of ownership. Management confirmed there had not been any meetings held with care staff at the time of the Site Audit, and an all-staff meeting was scheduled to be held soon.
* The service was unable to describe how staff would be trained on new restraint and Serious Incident Response Scheme (SIRS)/Incident Management System (IMS) requirements.
* The service was unable to evidence how it monitored and reported staff training.

In its written response of 25 May 2022, the Approved Provider stated workforce, regulatory and legislative compliance and feedback and complaints were embedded within the care community. The Approved Provider advised individual staff logins to the care system, and access to computers supported efficient sharing of information. The Approved provider considered verbal handover were best practice and an efficient way to share information and noted other information about consumers was available in consumers’ rooms.

The Approved Provider advised the handover process for Registered Nurses and Assistants in Nursing had been reviewed, which resulted in changing the location of where handovers were held to maintain social distancing. The Approved Provider noted the service developed a new handover document that had received positive feedback from Registered Nurses, as it supported improved communication between the teams. The Approved Provider also listed the use of the ‘message of the day’, notice boards and a meeting calendar as options for the timely sharing of information.

While I acknowledge the Approved Provider had information management systems in place, it was unable to demonstrate how these systems enabled all staff to access the information required to complete their roles, in a timely manner. I note the Approved Provider’s response did not address the concerns identified by care staff, nor how the issues would be addressed.

I agree with the Assessment Team that the service has not demonstrated that its information management is embedded at the service level. I find the service Non-complaint with this Requirement.

### Requirement 8(3)(d) Compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

### Requirement 8(3)(e) Compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

# Areas for improvement

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

* Requirement 3(3)(a) – The service will ensure each consumer receives effective personal care that is best practice and tailored to individual needs.
* Requirement 4(3)(a) – The service ensures each consumer receives safe and effective services and supports for daily living that meet individual needs, goals and preferences.
* Requirement 4(3)(f) – The service ensures that meals provided are of suitable quality and quantity.
* Requirement 6(3)(c) – The service ensures appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d) – The service ensures feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(a) – The service ensures that the workforce is planned and appropriately recruited to enable the delivery of safe and effective care and services.
* Requirement 7(3)(d) – The service ensures that the workforce is appropriately trained and equipped to perform their roles.
* Requirement 7(3)(e) – The service ensures regular assessment and monitoring occurs for each member of the workforce.
* Requirement 8(3)(c) – The service ensures effective, organisation wide information management systems are in place.