Performance

Report

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| Name of service: | North Eastern Community Nursing Home |
| Service address: | 580 Lower North East Road CAMPBELLTOWN SA 5074 |
| Commission ID: | 6921 |
| Approved provider: | North Eastern Community Hospital Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 November 2022 to 3 November 2022 |
| Performance report date: | 21 December 2022 |

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 North Eastern Community Nursing Home (**the service**) has been prepared by T Wilson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the 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 24 November 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Standard 8 Requirement 8(3)(e) – Ensure minimisation of restraint is assessed correctly and legislated procedures are followed in relation to minimisation of restraint.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(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 |

Findings

The service was found to be Non-compliant in a Site Audit conducted 7 to 10 March 2022 in Requirements 1(3)(a), 1(3)(b) and 1(3)(e).

Not all consumers were being treated with dignity and respect as one consumer’s room was used as continence aid storage room when they were not incontinent, and they felt degraded by this, with other consumers stating staff spoke in a derogatory manner and rushed their care. Care was not delivered in a culturally safe manner as communication was limited due to language barriers and activities were not culturally suitable. Information was not provided to consumers in a format they could understand as most consumers speak Italian and information was in English which many didn’t understand.

The provider undertook actions to address the identified issues which included:

* Staff education on dignity, respect and person-centred care as well as supporting people living with dementia and supporting culturally and linguistically diverse (CALD) consumers.
* Provision of additional signage around the service, including menus, activity planner, leaflets are displayed in Italian. Translation for the Resident handbook has commenced and is scheduled for completion in February 2023.
* The Assessment Team observed laminated menus for display were available in both English and Italian language as well as activity planners.
* The commencement of the Resident Liaison Officer for communication with consumers in Italian. The service seeks to employ staff who can converse in Italian where possible.
* Continence aid storage is situated in consumers' rooms where required, either on back of door or in wardrobe as per their individual preferences.
* The service has implemented an electronic communication application to communicate with families and representatives so social activity photographs and other direct communication can be uploaded for ease of access.
* Resident meetings have now resumed and are delivered in both English and Italian with communication being facilitated with the assistance of the Resident Liaison Officer.

The Assessment Team now recommends these Requirements are Compliant. Consumers and representatives confirmed they are treated with dignity and respect and staff are aware of who they are and what is important to them. Care plans were reflective of consumers’ individualised cultural and diversity preferences and personal interests. Staff were observed to be respectful, kind and engaging with consumers, speaking with them at eye level if they were seated and assisting them engage in activities and during mealtimes.

Consumers and representatives confirmed staff were respectful and supportive of their heritage, and preferences aligned to their cultural values and life experiences. Care documentation was tailored to individual consumers with consideration given to personal care choices, beliefs and traditions.

Most consumers and representatives confirmed they were satisfied with the communication. The service has a range of communication formats to support consumers and their ability to exercise choice such as the provision of the Resident Liaison Officer and other staff who can converse in Italian. The food menu, activity planner, advocacy leaflets and feedback forms are written in both English and Italian.

The service provided a response to the Assessment Team report on 24 November 2022 but did not provide any response specifically in relation to Standard 1.

I have considered the evidence provided and I consider the service has made sufficient improvements with the three Requirements. Consumers are satisfied their dignity and respect is being maintained and they are now receiving culturally safe care. Communications have improved and information is now being provided in Italian as well as English to assist consumers to make informed decisions.

Accordingly, I am satisfied Requirements 1(3)(a), 1(3)(b), and 1(3)(e) in Standard 1 Consumer choice and dignity are Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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

The service was found to be Non-compliant in a Site Audit conducted 7 to 10 March 2022 in Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e).

The service did not demonstrate that assessment and planning processes were consistently completed to enable risks to consumers’ health and well-being to be identified and appropriate management strategies implemented. Assessments, including in relation to falls risk and behaviour management strategies, had not been completed in line with the service’s processes. Consumers’ current needs and care plans were not being reviewed and/or developed to guide staff in the delivery of the consumers’ care during the end stage of life. Consumers were not supported and encouraged to make decisions about the care and services they were receiving and the way they were delivered. Consumers and/or representatives were not involved in discussions relating to consumers’ care or enabled them to have an understanding and ownership of the care plan. Care plans were not regularly reviewed including following incidents and changes in condition.

The provider undertook actions to address the identified issues which included:

* Review of care plan checklist and protocols with implementation of processes to ensure assessments are undertaken in alignment with these.
* Full review of all consumer assessments and care plans with those consumers identified as being at high risk identified through summary care plan, verbal, and written handovers and on whiteboards.
* Monitoring processes for daily charting to ensure completeness and identify follow up actions, undertaken by Registered Nurses.
* Ensuring consumers identified as receiving palliative care have end of life care plans.
* Monitoring staff compliance with care plans and medication chart instructions and undertaking spot check audits to verify improvements.
* Establishing processes to ensure communication with consumers or their representatives about changes in assessments, and evaluation of these changes with a follow up contact 1 or 2 weeks after implementation.
* Establishing improved open disclosure protocols, with education for staff to ensure effective communication with families following incidents.
* Review of care plan checklist and protocols with implementation of processes to ensure assessments are undertaken in alignment with these.
* Develop a schedule of review for all consumer assessments and care plans, prioritised by those with high risk.
* Undertaking spot check audits to verify all improvements are sustained.

The Assessment Team now recommends Requirement 2(3)(a) is Non-compliant and 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) as Compliant.

Requirement 2(3)(a) was recommended as Non-compliant as the service did not demonstrate it was effectively using monitoring through pain and behaviour charts to assess and inform consumer needs for care delivery, and wound assessment for one consumer did not identify, capture, and record each injury or measurement.

For one consumer the Assessment Team found the service did not complete pain charting in full. The clinical nurse manager stated it should be completed twice each shift but also stated that charting is done by exception only, if there is pain it would be charted. The five day pain chart showed that charting was only completed over four days, not five and it was not completed each shift. Another consumer’s wound charting did not identify how many wounds the consumer had, and photographs were taken from inconsistent angles.

The service provided a response to the Assessment Team’s report on the 24 November 2022 providing a plan for continuous improvement in relation to the areas outlined by the Assessment Team. The service have implemented a number of actions including spot audits for incident management, pain management and behaviour management to ensure compliance and provided coaching to staff as required. Education for staff on the electronic care management system and electronic prompts in the system to complete tasks such as charting, diaries to evaluate charting and documentation checks at the conclusions of shifts. The service also addressed the consumer with the wounds stating all Stage 1 wounds are now resolved. Education has been completed on wounds with additional education planned and spot check audits to ensure compliance of wound procedures.

I have considered the information provided by the Assessment Team and the provider, and I have come to a different view than the Assessment Team. While I acknowledge the Assessment Team has found areas for improvement for the service, the information provided did not outline clearly what part of the care planning was missed to inform staff of how to deliver safe and effective care to the consumers.

Whilst it was unclear exactly what the pain charting procedure was, I was not provided any information and evidence that shows whether incomplete pain charting resulted in the consumer not receiving safe and effective clinical care specifically in relation to pain management. It is the same for the consumer with wounds, again the Assessment Team’s report does not provide any evidence to show whether wound charting did not identify how many wounds the consumer had, and that the photographs were taken from inconsistent angles resulted in the consumer not receiving safe and effective wound care. The summary of the Assessment Teams report also provided additional information which stated consumers are assessed on entry and had care plans developed, including individualised strategies to manage and reduce identified risks.

The Assessment Team and the provider also provided information in relation to chemical restrictive practice under this Requirement, however, I have considered this inform under Standard 8 Requirement 8(3)(e) where it is expected for services to follow the minimisation of restraint legislation.

I acknowledge the provider has continued to make improvements with the assessment and planning for consumers which can only lead to better outcomes for them.

Accordingly, I find 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.

Consumer and staff interviews confirmed the service is addressing consumers wishes for advanced care planning and end of life care. Care planning documentation demonstrated assessment and planning identifies and addresses consumer needs, goals and preferences and includes advance care and end of life planning in alignment with consumer wishes.

Representatives confirmed they are aware of the care planning process and could describe their involvement and consultation of changes to care following incidents. Clinical staff confirmed that care reviews are completed in consultation with representatives and there is ongoing communication with families and documentation showed involvement of other organisations with consumer care.

Staff confirmed they have access to consumer care plans. Whilst representatives are not provided with a printed copy of consumer care plans due to privacy, they did confirm they have access to care plans if they wish and they are kept well informed of consumers care including following incidents or changes to care. Documentation confirmed that consumers care is reviewed regularly.

Accordingly, I am satisfied that Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) in Standard 2, Ongoing assessment and planning with consumers are Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(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 |

Findings

The service was found to be Non-compliant in a Site Audit conducted 7 to 10 March 2022 in Requirements 3(3)(a),3(3)(b), 3(3)(d) and 3(3)(e).

The service was unable to demonstrate that each consumer received safe and effective clinical care specifically in relation to administration of time sensitive medications and management of wounds, restraint, weight loss and pain. The high impact or high prevalence risks associated with each consumer were not reviewed or monitored, specifically in relation to behaviour management, including reporting of behavioural incidents. The service could not demonstrate consumers were assessed, monitored, and reviewed following deterioration or changes to consumers’ physical function in an effective and timely manner.

The provider undertook actions to address the identified issues which included:

* A review of medication management protocols and practices in relation to time specific medications.
* Provided staff education through formal sessions, e-tutorials and assessment of competencies on medication management, restrictive practices, wound care, pain, and weight management.
* Introduction of High Risk Resident management system, including meetings and communication with staff.
* Implementation of processes in the Memory Support Unit (MSU) in response to consumers with high risk behaviours including sexual and physical assault.
* Completing outstanding behaviour support plans and updating existing ones to ensure they are individualised.
* Updating referral processes for Dementia Support Australia and geriatricians.
* Providing education to staff on Serious Incident Response Scheme (SIRS) and use of open disclosure.
* The service reviewed the Recognising and Responding to Clinical Deterioration protocol, introducing a flow chart and return from hospital checklist and education for staff.
* Reviewing handover and care communication processes, particularly to ensure effective management of language barriers and high risk behaviours.
* Undertaking spot checks to ensure all improvements are evaluated and effective.

The Assessment Team now recommends Requirement 3(3)(a) is Non-compliant and 3(3)(b), 3(3)(d) and 3(3)(e) as Compliant.

The Assessment Team stated that for two consumers neurological observations were not completed in line with the service’s policy and two consumers had not been administered psychotropic medication in alignment with care directives or as a last resort.

The report noted that the neurological observation were discussed with the care manager who acknowledged the policy was not followed but highlighted that there was no impact noted for either consumer. In response to the feedback about chemical restrictive practice an email was send to all staff to remind them to document behaviours of concern with description and all non-pharmacological interventions undertaken, with a checklist for staff to update.

The service provided a response to the Assessment Team’s report on the 24 November 2022 which states that chemical restrictive practice is being addressed by the formalisation of a working party to develop, monitor, and evaluate policies to achieve the best possible health outcomes for all consumers living with challenging behaviours. The service have also implemented other actions which include a quick reference guide for the neurological observation protocol provided to nursing staff for their lanyard and an observation regime in nursing stations.

I have considered the information provided by the Assessment Team and the provider and I have come to a different view than the Assessment Team. I acknowledge that for the two consumers the falls protocol in relation to neurological observations wasn’t followed as per the protocol. However, I was not provided any other information that showed me that clinical staff had observed any exception that may have required further follow up or where the consumer needed any extra care.

The report did not clarify the circumstances around why the observation were not completed except to say that one consumer was not cooperative with them. I was provided the progress notes which would have been available to the Assessment Team which showed that whilst one consumer only had 8 of 27 observations recorded, when contacted the representative remained with the consumer overnight and progress notes provided by the service in their response shows the consumer was comfortable and showed not concerning signs. Whilst one of the components of this requirement is ensuring clinical care is best practice and is delivered in line with the service’s policies and procedures, it is also required to tailor and adjust clinical care to each consumer’s needs which the provider demonstrated. This include being flexible and responding to the consumer’s goals, needs and preferences when undertaking neurological assessment following the fall which may cause distress and agitation to the consumer living with dementia. I encourage the provider to continue with the improvements they have been making in relation to neurological observations to ensure all consumers receive optimal care.

In relation to chemical restrictive practice, I consider this information is best considered under Standard 8 Requirement 8(3)(e) relate to following the principals of minimisation of restrain and not providing best practice care.

Accordingly, I find Requirement 3(3)(a) in Standard 3 Personal care and clinical care, Compliant.

Staff could describe how they minimise risks for consumers with high impact high prevalence risks. Staff could identify consumers with risks and could advise how to minimis the risks. Risks were noted to be contained in care plans with mitigating strategies to minimise risks.

Care and clinical staff could explain monitoring and escalation processes when identifying acute changes in consumer’s health. Care plans were reviewed to provide baseline information to allow staff to better monitor consumers in the memory support areas for a deterioration or change in condition.

Staff confirmed handover processes including written and verbal daily handover, memos through the electronic care management system, noticeboards, toolbox trainings, staff meetings, and clinical meetings are effective. Care plans sampled show recommendations from Allied Health professionals have been used to inform the care and services provided to consumers.

Accordingly, I am satisfied that Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) in Standard 3, personal care and clinical care are Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| 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)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The service was found to be Non-compliant in a Site Audit conducted from 7 to 10 March 2022 in Requirements 4(3)(b), 4(3)(c) and 4(3)(e).

The service was unable to demonstrate that each consumer was being provided with the spiritual services they require for their emotional well-being, and one consumer not receiving emotional support following an incident. Consumers were also not being provided with activities of interest to them with many not have their lifestyle interest assessed since 2019, and they could not demonstrate referrals to other organisations and providers of care were not completed in the twelve months prior to the audit.

The provider undertook actions to address the identified issues which included:

* Updating of the emotional, spiritual, and psychological well-being plans for all consumers.
* A review and updating of the pastoral care program, with considerations for lockdown periods.
* Process for consumers involved in incidents which may impact emotional well-being to be placed on register for monitoring, and where applicable supported by staff, medical officer, or other additional support.
* Updating of the Lifestyle assessments and care plans for all consumers to assist in knowledge of consumers histories and interests.
* Changes to the lifestyle program with input from consumers and families which are monitored for attendance and consumers satisfaction.
* Developed and implemented specific lifestyle programs for people living with dementia with the assistance of Dementia Support Australia (DSA).
* The service has a regular occupational therapist on site for 32-40 hours per week and other Allied Health professionals are available upon referral.
* The Lifestyle coordinator has implemented various engagement opportunities with external organisations and clubs.

The Assessment Team now recommends these Requirements are Compliant. Consumers and representatives confirmed their emotional, spiritual, and psychological needs are supported and they enjoyed speaking with their families, staff, and their friends they have made at the service. Consumers described most staff as caring and supportive of their wellbeing. Staff provided examples of supporting consumers in relation to their wellbeing and care planning records demonstrated individualised needs and strategies, including how these are to be undertaken.

Consumers stated they felt supported to participate in activities, their community and maintain relationships of choice. Staff could describe what consumers like to do and care documentation showed a range of activities, pastimes, and people of importance to support consumers daily living. Regular evaluation is now undertaken to ensure activities are of interest to consumers and they are encouraged to become involved in clubs and association outside of the service.

The service has engaged a regular occupational therapist and access to a variety of Allied Health and other specialist such as Physiotherapist, Dieticians, Speech Pathologists and Geriatricians. A review of consumers care records reflect updated well-being plans and identified referrals to other organisations and services.

The service provided a response to the Assessment Team’s report on the 24 November 2022 but did not provide any response specifically in relation to Standard 4.

I have considered the evidence provided and I consider the service has made sufficient improvements with the three Requirements. Consumers are now satisfied their emotional and spiritual well-being needs are now being met and they feel supported to do the activities they like to do. The service undertakes evaluation to ensure that activities provided are what consumers like and they are of interest to them. Review of care documentation confirmed the involvement of external organisation and providers of other services were involved in consumer well-being.

Accordingly, I am satisfied Requirements 4(3)(b), 4(3)(c), and 4(3)(e) in Standard 4, Services and support for daily living are Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |

Findings

The service was found to be Non-compliant in a Site Audit conducted from 7 to 10 March 2022 in Requirement 5(3)(a).

It was found the service’s environment did not encourage a sense of belonging or encourage consumers to be themselves. The environment, including communal spaces, were not reflective of consumers’ cultural identity and navigational aids were all in English and not Italian to support those who only speak and read Italian. The service did not seek consumer input when decorating communal spaces.

The provider undertook actions to address the identified issues which included:

* Provided signage in Italian.
* Provided notice board information in Italian and other relevant languages.
* Established a resident/family ‘advisory group’ to plan improvements to the living environment to reflect the Italian culture.
* Developed a staged workplan to implement a culturally appropriate living environment.
* Engaged with consumers and families to evaluate the improvements.

The Assessment Team now recommends this Requirement is Compliant.

Observations showed signage throughout the service were available in both English and Italian, including a welcome to the service at its entrance, monthly menus and activity schedule posters, decorative posters, and pictures with Italian themes. Consumer rooms contained personal items and possessions, and consumers were also observed interacting during meals and activities.

The service provided a response to the Assessment Team’s report on the 24 November 2022 but did not provide any response specifically in relation to Standard 5.

I have considered the evidence provided and I consider the service has made sufficient improvements with this Requirement. The signage has been changed to suit consumer demographics along with the decorative pictures which display Italian themes. Consumers’ rooms are now personalised with their own possessions.

Accordingly, I am satisfied that Requirement 5(3)(a) in Standard 5, Organisation’s service environment is Compliant.

# Standard 6

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

Findings

The service was found to be Non-compliant in a Site Audit conducted from 7 to 10 March 2022 in Requirements 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d).

Consumers and representatives indicated they had a lack of trust and confidence in the service’s feedback and complaints processes. Some who expressed a reluctance to provide honest feedback for fear of retribution. Consumers and staff could not describe how consumers and representatives had access to advocates, language services and other methods for raising complaints and information was only available to them in English. The service could not demonstrate that appropriate follow up and action of complaints was not consistently undertaken. Consumers and management confirmed not all complaints have been actioned. The services processes did not that all feedback is captured and documented or analysed and trended to enable improvements to the quality of care and services to be identified and implemented.

The provider undertook actions to address the identified issues which included:

* Improved the complaints management and feedback systems, addressing reporting, responding, resolution and communication.
* Built complainant trust by management engagement and demonstrating positive resolution and improvements.
* Provided staff education on feedback and complaints management including advocacy services.
* Implemented written and verbal processes to address language barriers preventing Italian residents from providing feedback.
* Provided translated information about complaints processes (internal and external).
* Provided translated Resident Handbooks, including information about feedback and complaints.
* Resident Liaison Officer appointed to facilitate feedback and complaints processes.
* Provided translated information about Aged Rights Advocacy Service (ARAS), Commission and Charter of Aged Care Rights.
* Established and monitor protocols for recording complaints in the electronic clinical management system.
* Developed analysis and trending reports on feedback and complaints.
* Engaged with consumers and families to evaluate the improvements.

The Assessment Team now recommends this Standard is Compliant.

Consumers and representatives confirmed they feel comfortable and confident to provide feedback and make complaints to the service. Documentation shows that complaints are encouraged and discussed at public meetings with improvements being implemented from these meetings.

Consumers and their representatives could describe the external services advocacy and external complaint resolution services available to them. Management provided documentation showing consumers’ preferences for translation assistance was assessed and recorded. Staff could describe how the service provides support to communicate with consumers in Italian via bi-lingual language cards for common objects and services used at the facility and coaching on the use of basic Italian words.

Consumers and representatives confirmed appropriate action is taken to address feedback and complaints and felt the service has a transparent approach when things go wrong. Management and staff could explain the service’s complaints management process to gather, address and review feedback and complaints. The service has feedback, complaints and open disclosure policies and procedures in place which guides management and staff in how to identify, manage, escalate, document, and resolve complaints.

Feedback and complaints are now reviewed and used to improve the quality of care and services. Management provided analysis and trending of data collected around feedback and complaints which is used to identify areas for improvement. Surveys and meetings have been used to identify improvements to the delivery of care and services.

The service provided a response to the Assessment Team’s report on the 24 November 2022 but did not provide any response specifically in relation to Standard 6.

I have considered the evidence provided and I consider the service has made sufficient improvements with this Standard. Consumers now feel comfortable to make a complaint or provide feedback and information on how to do this is now provided to them in a format they can understand. They know how to access advocates and make external complaints. All internal complaints are now recorded, monitored and resolved in timely fashion and they feed into continuous improvement to provide better care and services for consumers.

Accordingly, I am satisfied that Standard 6, Feedback and complaints is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(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 |

Findings

The service was found to be Non-compliant in a Site Audit conducted from 7 to 10 March 2022 in Requirements 7(3)(a), 7(3)(c) and 7(3)(d).

The service was unable to demonstrate they planned the workforce to allow quality care and services to be delivered. Deficits included, staff were unable to assist consumers to finish their meals, not enough staff to manage consumer behaviours and provide adequate supervision and consumer continence issues as staff were unable to assist them in a timely manner. Staff stated they could not attend to all things for consumers which impacted on their care, including with hygiene and continence matters. Staff did not display competency in their roles including, hydration, pain management and the administration of time sensitive medications. The service did not ensure the workforce is supported to undertake training, learning and development opportunities to meet the requirements of their role.

The provider undertook actions to address the identified issues which included:

* A roster review, including memory support unit staff allocation.
* Reduced the use of agency staff and reviewed night shift start times.
* Implemented daily monitoring of call bells.
* Improved engagement with consumers and representatives regarding staff numbers.
* Education in key competency areas such as nutrition and hydration, incident reporting, pain, behaviours, and risk.
* A personal care worker checklist for staff to do before they leave a consumer's room.
* Reviewed and updated the training and education framework.
* Reviewed and updated staff duty statements.
* Provided education on restrictive practices and behaviour support plans.
* Sourced education and written materials for using the electronic clinical management system.

The Assessment Team recommends these Requirements are now Complaint.

Consumers confirmed they did not have to wait long for staff to attend to them, including when they use the call bell. Consumers and representatives interviewed were generally satisfied with the number of staff, however some consumers said there is sometimes a shortage of staff, but this did not impact on their care needs. Overall staff confirmed have enough time to conduct their duties and there are enough staff rostered each day but did state they sometimes have to work a bit short, but it did not affect consumer care. Call bells are actively monitored and trended with extended call bell waits reviewed and investigated by clinical staff.

Consumers and representatives confirmed staff know what they are doing, and they have confidence in them to perform their role effectively and safely. Staff stated they feel supported in their roles and the service provides additional training if requested. Staff are required to complete competency assessments relevant to their role during their employment. Management have responded to identified deficiencies in care and services by educating staff and monitoring their ongoing performance.

The service has a recruitment process to ensure the workforce is competent to maintain a required standard of knowledge through training and further education opportunities. Documentation showed the service has reviewed its training regime to meet the needs of consumers and performs competency assessments where relevant to review the effectiveness of training. There are induction and development programs for new employees across all areas of the service.

The service provided a response to the Assessment Team’s report on the 24 November 2022 but did not provide any response specifically in relation to Standard 7.

I have considered the evidence provided and I consider the service has made sufficient improvements with the Requirements.

Consumers confirmed they are satisfied with staffing levels and are confident staff know what they are doing, and they perform their roles effectively and safely. Staff are satisfied with staffing levels, and they fell supported in their role with training development opportunities available to them. Staff have undergone additional training to ensure they have the knowledge and capabilities to fulfil their roles and new induction and development programs have been introduced.

Accordingly, I am satisfied Requirements 7(3)(a), 7(3)(c), and 7(3)(d) in Standard 7, Human Resources are Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(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. | Non-compliant |

Findings

The service was found to be Non-compliant in a Site Audit conducted from 7 to 10 March 2022 in Requirements 8(3)(a),8(3)(c), 8(3)(d) and 8(3)(e).

It was found that while there were avenues for consumers to engage in development, delivery and evaluation of the care and services, the service has not tailored these avenues to the consumer cohort. Meetings, surveys, and feedback forms are all in English which the majority of the consumers do not understand so they were not engaged in the development of care and services. The service could not demonstrate it had effective governance systems relating to information management, regulatory compliance, continuous improvement, feedback and complaints and workforce. It did not have effective risk management systems in place for the management of high impact or high prevalence risks or recording and reporting incidents and it did not demonstrate a clinical governance system that was effective, specifically in ensuring staff practice and knowledge aligned with legislative requirements relating to minimisation of restrictive practice and antimicrobial stewardship.

The provider undertook actions to address the identified issues which included:

* Review the ‘Consumer Engagement Strategy’ and implement effective processes.
* Undertake a Consumer Experience Survey (translated and English) based on the Quality Standards.
* Update the routine Plan for Continuous Improvement (PCI) to include feedback from residents and representatives.
* Improve how information for High Risk Residents is communicated through meetings, handover and electronic communications.
* Education of staff on the use of the electronic clinical management system.
* Update policies and procedures.
* Education regarding reporting through the serious incident response scheme (SIRS).
* Incident management training.
* Improved handover sheets for staff in the memory support unit.
* High risk resident meetings and associated consumer action plans.

The Assessment Team now recommends Requirement 8(3)(e) is Non-compliant and 8(3)(a), 8(3)(c) and 8(3)(d) as Compliant.

The Assessment Team found Requirement 8(3)(e) to be Non-Compliant as the service’s policies and procedures did not identify some consumers who were being prescribed psychotropic medications as being consumers who should be considered as chemical restrictive practice. Information provided in Standard 3 Requirement 3(3)(a) outlines two consumers who were provided with psychotropic medications to alter the consumers behaviour. The Assessment Team also stated in questioning staff they were unaware the prescription of anti-psychotic medication for a diagnosis other than psychosis was a chemical restraint and should be included on the register.

The service provided a response to the Assessment Team’s report on the 24 November 2022 stating they take the responsibility of restrictive practice seriously and have taken the opportunity to fully review with a ground zero approach. The service now indicates that all consumers have been identified as required. They have reviewed all consumers and identified 20 with as required psychotropic medications, that have not been used and are in the process of a medical review for all consumers prescribed as required medications with a view to reduce or as required medications or eliminate all together. The reports used to review restrictive practice have been also under review along with education for clinical staff to show the consideration that should be undertaken when determining chemical restrictive practice and the associated protocols.

I have considered the information provided by the Assessment Team and the response from the provider, including the information provided by both parties in Standard 2 Requirement 2(3)(a) and Standard 3 Requirement 3(3)(a) and I agree with the Assessment Team that at the time of the Site Audit this requirement was Non-compliant.

My first consideration is the guidance on chemical restrictive practice which states ‘Chemical restraint is a practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a consumer’s behaviour, but does not include the use of medication prescribed for; the treatment of, or to enable treatment of, the consumer for a diagnosed mental disorder, a physical illness or a physical condition; or end of life care for the consumer.’ I disagree with statement from the Assessment Team where it states the prescription of anti-psychotic medication for a diagnosis other than psychosis was a chemical restraint and should be included on the register. Psychosis is a symptom of many diagnosed conditions, or it can present without a diagnosed condition so the consideration for chemical restrictive practice must be considered as per the above quotation.

Both consumers as outlined in Standard 3 Requirement 3(3)(a), that were reviewed by the Assessment Team displayed behaviours of concern and were provided psychotropic medications to influence their behaviour. Therefore minimisation of restraint was applicable and the service should ensure through the governance procedures that each consumer has documentation showing the alternatives to restrictive practices that have been considered and used, and why they have not been successful, monitored for signs of distress or harm, side effects and adverse events, must be regularly reviewed by the provider with a view to removing it as soon as possible or practicable and a behaviour support plan for every consumer who exhibits behaviours of concern, or changed behaviours, or who has restrictive practices considered, applied or used as part of their care. There is also the requirement to have informed consent from the substitute decision maker.

Whilst the service has undertaken actions to review restrictive practice since the Site Audit, at the time of the Site Audit the governance process for minimisation of restraint were not correctly identifying chemical restrictive practice or ensuring the minimisation of restraint was being practiced as it should.

Accordingly, I find, Requirement 8(3)(e), in relation to minimisation of restraint Non-Compliant.

Consumer and representatives confirmed they are engaged with the organisations service delivery through care planning, resident meetings, consumer surveys and day to day discussions they have with staff and management. The service has structures in place to support consumer engagement and findings are reported back to consumers and families and to the boards sub-committee for their oversight.

The service provided information to show they have effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The service manages high impact high prevalence risk through high risk meetings, registers, and clinical indicator reports. The service’s incident management system informs management of any trends or risks and is used to improve care and services. There are polices and process and staff are trained to manage risk. Consumers are supported to live the best life they can by undertaking risk activities that are managed through the risk management system. The service provided examples of respecting consumers’ wishes and how they have identified and reduced risks to support their independence as safely as possible.

Accordingly, I am satisfied that Requirements 8(3)(a), 8(3)(c) and 8(3)(d) in Standard 8, Organisational governance are Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)