Performance

Report

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| Name of service: | P.S. Hobson Nursing Home |
| Service address: | 302 Gillies Street WENDOUREE VIC 3355 |
| Commission ID: | 4459 |
| Approved provider: | Grampians Health |
| Activity type: | Site Audit |
| Activity date: | 10 January 2023 to 13 January 2023 |
| Performance report date: | 7 March 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for P.S. Hobson Nursing Home (**the service**) has been prepared by S Byers, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 14 February 2023

# Assessment summary

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

* Requirement 3(3)(b) - the approved provider ensures effective management of high impact or high prevalence risks including high impact and high-prevalence risks for each consumer are identified, staff are aware of each consumer with high impact and high prevalence risks and how to manage the risk for the individual consumer in accordance with documented recommendations, assessed needs, directives and protocols, this includes risks in the areas of behaviours, weight loss and medication management.
* Requirement 3(3)(d) – the approved provider ensures effective processes for staff to be able to recognise and respond to deterioration or a change in a consumer’s mental health, cognitive or physical function, capacity or condition, staff have the knowledge to identify changes in individual consumers health status, and when to escalate and make referrals to general practitioners and other medical specialists to ensure at timely response.
* Requirement 3(3)(f) – the approved provider ensures there is timely referral of consumers to other organisations and providers of care, particularly in the areas of clinical care, consumers with ongoing weight loss and where deterioration or change in consumer health status has been identified.
* Requirement 8(3)(d) – the approved provider ensures effective risk and incident management systems and practices including ensuring the service identifies, assesses and manages the high impact and high prevalence risks associated with the care of consumers, staff education and training on high impact and high prevalence risks including incident reporting and incident management systems to ensure incidents are identified, managed, monitored and resolved.

# 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)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers were satisfied they are treated with dignity and respect and that their identity, culture and diversity are valued as individuals. Care plans were individualised and detailed what was important to the consumer, including cultural needs, interests and preferences. Staff demonstrated how they provide culturally safe care and services according to the consumers’ needs and preferences.

Consumers were satisfied that they could exercise choice and make decisions about their care and services, while being supported to maintain relationships that are important to them. Care documents and progress notes detailed relationships of importance for consumers including who they choose to be involved in care making decisions.

Consumers said they are supported by staff to take risks and are encouraged to live the best life they can. Staff described the risk assessment process and how they support consumers to understand the risks and benefits when participating in risk taking activities. Care planning documentation included risks assessments and consultation with consumers and input from allied health providers.

Consumers and representatives were satisfied with how information is communicated to them. The service notice boards in the communal and dining areas displayed menu options, activities program, and advocacy services information.

Consumers and representatives are satisfied their privacy is respected. Staff described how they respect consumer privacy when delivering care and maintain the confidentiality of personal information. All electronic documentation is password protected. Printed or other hard copy consumer information is stored in locked filing cabinets or coded doors within the nurse’s stations. The Assessment Team observed staff consistently knocking on doors prior to entry into consumer rooms. While the Assessment Team observed some instances of staff discussing consumer information in public areas, the Approved Provider submitted evidence to demonstrate that feedback had been provided to staff and the deficits addressed through staff education and training.

# 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 Assessment Team recommended requirement 2(3)(a) was not met, however I have considered the Assessment Team’s findings, the evidence in the site audit report and the Approved Provider’s response and have come to a different view:

While the Assessment Team found assessment and planning considered risk in relation to falls, pressure injuries, dysphagia and responsive behaviours, they provided an example of a named consumer with deficits identified in assessment and planning and consideration of risk in relation to fluid restriction.

The Approved Provider submitted a written response with clarifying information and documentation including fluid balance charting, progress notes and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions taken to address the improvements. Actions include ongoing charting with weekly weighs, care consultations with the consumers and representatives, and staff training and education in fluid restrictions management.

I note from the site audit report that information relating to the consumers fluid restriction was recorded in assessment and planning, staff were aware of the fluid restriction and that overall representatives felt consulted and partnered in the assessment and planning process.

While I acknowledge there were some deficits in assessment and planning documentation, I am satisfied the Approved Provider demonstrated it has systems in place to ensure assessment and planning, including the consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. I encourage the Approved Provider to continue embedding these improvements into usual practice. I find Requirement 2(3)(a) is Compliant.

I am satisfied the remaining four requirements of Standard 2 Ongoing assessment and planning with consumers are Compliant:

Overall, care planning documentation identified and addressed the consumers’ current needs, goals and preferences including advanced care directives. Staff demonstrated understanding of consumers end of life care documentation processes.

Consumers and representatives considered they are partners in the ongoing assessment and planning of their care and services and confirmed being involved in care consultations. Care planning documentation demonstrated involvement by other organisations and services where appropriate such as general practitioners, Residential In-Reach (RIR) services, dietitians, speech pathologists, NDIS services and physiotherapists. Allied health specialists and RIR staff confirmed having ongoing involvement in the assessment and planning of the consumer’s care.

Consumers and representatives were satisfied with how the service communicates outcomes of assessment and planning. Most representatives confirmed they are aware of and can access their care plans upon request. Staff described how they communicate outcomes of assessment and planning and how they record outcomes in care planning documentation.

Documentation demonstrated consumers are reviewed and reassessed following incidents or changes in care needs for consumers. Staff demonstrated understanding of review processes. Consumers and representatives were satisfied that care and services are regularly reviewed and they are kept informed of health changes or incidents.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirements 3(3)(b), 3(3)(d) and 3(3)(f) are Non-compliant:

Requirement 3(3)(b)

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team’s evidence included fluid restriction, nutrition and hydration, weight loss, chronic wound management, medication management and behaviour management.

I have considered the deficits identified by the Assessment Team in relation to fluid restriction under Standard 2 Requirement 2(3)(a) where I consider it more relevant to the consideration of risk in assessment and planning.

I have also considered the deficits identified by the Assessment Team in relation to ongoing weight loss under Requirement 3(3)(f) as I consider the issues more appropriately relate to the actioning and subsequent follow up of referrals to ensure they are timely. I note the site audit report includes information the consumer’s weight loss had been identified by the service, the consumer was commenced on weekly weighs during the Site Audit and nutritional supplements were being maintained.

The Approved Provider submitted a written response with clarifying information and documentation including progress notes, care plans, clinical notes, incident reports, risk reports, dignity of risk policy documents, and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions planned and completed to address the improvements. Actions include reviewing and updating consumer progress notes and care plans, care consultations with the consumers and representatives, implementing improved risk reporting processes, improving staff handover and staff training and education in fluid restrictions and management, wound management and documentation, medication policy and incident reporting.

The Assessment Team presented evidence of a consumer with responsive behaviours. While the consumer’s behaviour support plan detailed comprehensive behaviour management strategies including recommendations from Dementia Support Australia for one on one staff support, the Assessment Team observed strategies were not followed in accordance with the consumers documentation. Staff confirmed the consumer requires high levels of staff supervision to maintain the consumers safety and the safety of other consumers at the service, however they confirmed one on one support was not consistently provided. The Approved Provider acknowledged that some of the consumer’s recommended strategies were not in place at the time of the Site Audit.

During the Site Audit, management provided feedback to the Assessment Team that one on one staff support is no longer required. The Approved Provider in its response to the site audit report, confirmed management’s position, however provided the information in relation to a different consumer and did not provide evidence to verify the change in the consumers care interventions. Based on the evidence available to me, I do not have sufficient evidence to confirm the consumer’s behaviour management strategies have been reviewed, relevant care plans have been updated and one on one staff support is no longer required to manage the consumers behaviours.

The site audit report included information of conflicting information in progress notes and incident documentation that demonstrated staff did not adhere to protocol when a consumer missed several doses of a high risk medication. Resources and material specifically setting out the protocol to be followed were readily available to staff in the consumer’s medical drawer. While all clinical staff interviewed identified the medication as high risk and the specific actions to be followed, they indicated as the medication was missed while the consumer was deteriorating the appropriate follow up occurred at the hospital. While I am satisfied that appropriate follow up was completed at the hospital, and acknowledge that since the Site Audit the consumer is under the clinical supervision of a specialist to monitor the medication, I consider it reasonable to expect staff to follow protocol and complete actions in line with directives when managing high risk medication incidents.

The Assessment Team identified deficits in wound documentation and a delay in wound specialist review for a consumer with a chronic wound. Evidence submitted by the Approved Provider demonstrated regular review by a wound consultant with no further recommended changes to wound management strategies or further deterioration of the wound. I am also satisfied the evidence submitted by the Approved Provider demonstrates dignity of risk has been assessed and discussed with the consumer and their representative in relation to nutrition and hydration risks and the concerns in the site audit report have been addressed.

Based on the information in the site audit report, I am satisfied the service demonstrated effective management of risks associated with falls and diabetes.

In making my decision I have considered the site audit report and the Approved Provider’s response. While I acknowledge the actions taken by the Approved Provider since the Site Audit, these actions have not been fully implemented, evaluated, and embedded into usual practice. While I acknowledge the complex needs of the consumers, I am not satisfied the Approved Provider demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer and that risks relating to medication incident management and responsive behaviours are managed effectively. I find Requirement 3(3)(b) is Non-compliant.

Requirement 3(3)(d)

The Assessment Team found consumer care documentation did not reflect the timely identification of, and response to changes in the health status of consumers. The Assessment Team presented evidence of one consumer whose deterioration in respiratory function was not recognised and responded to in a timely manner resulting in hospitalisation. Documentation demonstrated a delay in contacting the consumer’s general practitioner following the onset of symptoms and did not demonstrate medical assessment was completed. A referral to Residential In-Reach services was made several days later with a transfer to hospital required. Staff did not demonstrate sufficient understanding of how to recognise and respond to deterioration for the consumer. The consumer’s representative was dissatisfied with the services management of the deterioration.

The Approved Provider submitted a written response with clarifying information and documentation including progress notes, early warning detection tools and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions planned and completed to address the improvements. Actions include reviewing and updating consumer assessment and care planning documentation, care consultations with consumers and representatives, review of referral processes, increased support from Residential In-Reach and staff training and education in recognising and responding to deterioration and escalating patient safety concerns.

In making my decision I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the service since the Site Audit, these actions have not been fully implemented, embedded, and evaluated. Based on the evidence available to me, I am not satisfied the service has in place effective systems to ensure timely recognition and response to deterioration or changes in a consumer’s physical function or condition. I find Requirement 3(3)(d) is Non-compliant.

Requirement 3(3)(f)

The Assessment Team’s evidence included examples of consumers who have not been referred in a timely manner, to other providers of care and services.

For a consumer experiencing ongoing weight loss, while a referral to a dietitian was initially made, it was not escalated within a timely manner as the consumer continued to lose weight and the referral had not been actioned within a 7-week period. I acknowledge an escalation was actioned during the Site Audit and since the Site Audit the consumer has been referred and reviewed by the dietitian, speech pathologist and the consumers weight is stable.

For a consumer experiencing deterioration that resulted in hospitalisation, referrals to the consumers general practitioner and Residential In-Reach services were not actioned in a timely manner in response to the deterioration.

The Approved Provider submitted a written response with clarifying information and documentation including progress notes, care plans, incident reports, risk reports, dignity of risk policy documents, and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions planned and completed to address the improvements. Actions include reviewing and updating consumer assessment and care planning documentation to identify and follow up relevant referrals to allied health or medical specialists, care consultations with the consumers and representatives, improved referral processes, and staff training and education in weight loss management, timely referrals for escalation of care, recognising and responding to deterioration.

In making my decision I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the actions taken by the service since the Site Audit, these actions have not been fully implemented, embedded, and evaluated. Based on the evidence available to me, I am not satisfied the service has in place effective systems to ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services. I find Requirement 3(3)(f) is Non-compliant.

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

Consumers and representatives said they were satisfied consumers receive safe and effective care in relation to pain management, skin integrity, wound management and restrictive practices. Staff demonstrated understanding of individual consumer care needs that aligned with their assessed needs. The service demonstrated it identifies, assesses and monitors restrictive practices, this was evident for consumers subject to chemical restraint, environment restraint and mechanical restraint. Care documentation detailed regular medical review and informed consent. Pain management assessments and care plans were current for all sampled consumers and included both pharmacological and non-pharmacological strategies to manage pain. Consumers assessed at high risk of pressure injuries have appropriate strategies in place including specialised equipment. For example, pressure air mattresses and pressure relieving cushions.

The service demonstrated it has systems in place to effectively support consumers nearing the end of their life in a respectful and dignified manner. Consumers and representatives confirmed that discussions had occurred with the service regarding their goals and preferences should their health deteriorate. Care planning documents reflected the delivery of care in accordance with consumers end of life wishes and comfort was maximised. Advance care directives were documented to guide staff practice.

The service demonstrated it has processes in place to ensure care needs of consumers are well communicated within the service and others where responsibility is shared. Consumers and representatives said staff knew them and they did not have to repeat information often. Information is shared with external services involved in the consumers care, as required.

The services has an outbreak management plan to guide staff practice in the event of an infection related outbreak. The service has appointed an infection prevention and control lead (IPC) and other staff members are enrolled in IPC lead training to provide support. All staff interviewed demonstrated a good understanding of the principles of antimicrobial stewardship and infection control practices consistent with their scope of practice. Staff confirmed completing infection control training. The Assessment Team observed most staff wearing appropriate Personal Protective Equipment in line within current guidelines.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team recommended requirement 4(3)(a) was not met, however I have considered the Assessment Team’s findings, the evidence in the site audit report and the Approved Provider’s response and have come to a different view:

Most consumers and representatives were satisfied consumers are provided with support to optimise their independence, health, well-being and quality of life. Social and lifestyle care plans for most consumers sampled included individual goals and preferences. Lifestyle staff described how the activities programme is tailored to the interests, mobility and cognitive levels of consumers and individual support is available for consumers who do not wish to participate in group activities.

The site audit report included information that the service did not provide services and supports of daily living to meet the needs and preferences of two consumers. Deficits were identified in lifestyle assessment and care planning documentation for one consumer, and the Assessment Team observed limited engagement with both consumers during the Site Audit.

I have considered the deficits in behaviour management under Standard 3 Requirement 3(3)(b) as I consider it more relevant to the management of high impact and high prevalent risks associated with the care of consumers.

The Approved Provider submitted a written response with clarifying information and documentation including care plans, recommendation reports, progress notes and staff education records. The Approved Provider submitted an action plan and education plan demonstrating the actions taken to address the improvements. Actions include review and update of lifestyle care plans, referrals to and reviews by allied health specialists to reassess recommendations, care consultations with the consumers and representatives, and staff training and education.

I have placed weight on the Approved Provider’s response and the primarily positive feedback from consumers in relation to supports for daily living. I am satisfied the Approved Provider has taken appropriate action to address the deficits in relation to the two consumers named in the site audit report. I encourage the Approved Provider to continue embedding these improvements into usual practice. I find Requirement 4(3)(a) is Compliant.

I am satisfied the remaining six requirements of Standard 4 Services and supports for daily living are Compliant:

All sampled consumers and representatives expressed satisfaction that consumers’ emotional, spiritual and psychological well-being is supported. Staff demonstrated understanding of consumers needs and provided examples of how they support consumers when they are feeling low. External services including pet therapy and religious services are available to support consumers. Local church representatives attend the service to visit consumers and recorded church services are projected on a big screen for consumers to view. Care planning documentation details information about consumers’ individual emotional, spiritual and psychological needs.

Consumers and representatives were satisfied the service supports consumers to maintain relationships, participate in the community and do things that interest them. Consumers provided examples of participating in bus outings, shopping and visiting friends and family. Staff described the relationships and interests of consumers, both within and outside the service. Care planning documents contained information about the consumer’s significant relationships, and information about their participation in activities of interest at the service and within the local community.

Overall, consumers and representatives were satisfied that information regarding the consumers’ needs and preferences is effectively communicated between staff and others where responsibility of care is shared. Care plans and progress notes demonstrated the safe and effective sharing of consumer information with most lifestyle care plan’s up-to-date and relevant to the consumers current needs and preferences. Care planning documents detailed communication from other service providers including the physiotherapist to support the safe use of mobility aids and a dietitian to support consumers’ nutrition. Staff said they are informed of changes to consumer needs through written notes, handover sheets and ‘huddle’ meetings.

The service has processes in place to ensure consumers can access and are referred to appropriate individuals, other organisations and providers of care and services in a timely manner. Care planning documentation demonstrated consultation and collaboration with external providers to support the diverse needs of consumers.

Most consumers and representatives provided positive feedback about the quality and quantity of meals. Staff demonstrated knowledge about individual consumers’ preferences and dietary requirements. Care planning documents reflected consumers meal requirements, dietary preferences, staff assistance and equipment needs and are communicated to the kitchen. The service offers a seasonal 6-monthly menu that is reviewed by a dietitian. Consumers through residents meeting can give input to what meals they would like on the menu. The service demonstrated it has processes in place to regularly seek consumer feedback on the meals, and this is incorporated into the menu. Staff were observed assisting and encouraging consumers with meals during the Site Audit.

# 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 |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers said they feel at home and comfortable at the service and are encouraged to personalise their rooms. The service offers several suitably furnished communal areas that optimise consumer interaction and engagement.

Consumers and representatives said the living environment is comfortable, clean and well maintained. Consumers can access internal and external areas of the service, with some consumers providing examples of accessing the courtyard or visiting the community. Maintenance and cleaning staff described the service’s preventative and reactive systems, processes and schedules. Consumers were observed freely mobilising throughout the service either independently or with staff assistance.

Consumers and representatives were satisfied the furniture and equipment available is suitable for their needs. Overall, furniture, fittings, and equipment were observed to be safe and clean and in good working order. Management explained there are plans for service environment improvement including decluttering and disposing equipment that is no longer in use and enhancing access to courtyards. Maintenance records demonstrated ongoing monitoring and timely response to maintenance requests and repairs.

# 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

Consumers and representatives were satisfied that they are encouraged and supported to provide feedback and make complaints. Consumers and representatives provided examples of complaint mechanisms including feedback forms, communicating directly with staff or management. Staff demonstrated understanding of external organisations and advocacy services available to consumers to raise concerns. Feedback forms and a secured locked box was observed to be readily available and easily accessible. The Charter of Aged Care Rights and written information about external methods for raising complaints including advocacy services were on display throughout the service.

Consumers and representatives were satisfied that appropriate action is taken in response to complaints. While staff were unaware of the term open disclosure, they demonstrated understanding of open disclosure principles in practice. Review of the complaints register demonstrated complaints are recorded, open disclosure practiced and investigations completed to the satisfaction of the complainant.

Management provided examples where feedback and complaints had improved care and services. For example, review and update of visiting hours to the service enabled consumers increased access to family and friends. Quality reports reflected complaints made and the actions taken.

# 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)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Assessment Team recommended requirement 7(3)(c) was not met, however I have considered the Assessment Team’s findings, the evidence in the site audit report and the Approved Provider’s response and have come to a different view:

The site audit report included information the service did not ensure staff attending to indwelling catheters (IDC) changes for male consumers had completed relevant competencies. At the time of the Site Audit, in response to Assessment Team feedback, management advised that IDC changes would only be actioned by a continence nurse or Residential In-Reach services until training and competencies were completed for all nursing staff at the service.

The Approved Provider submitted a written response with clarifying information and documentation including policy documents and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions taken to address the improvements. Actions include embedding the practice that only competent staff including continence nurses, Residential In-Reach services or medical practitioners are permitted to change catheters for male consumers, and staff training and education in routine IDC changes.

I have placed weight on the Approved Provider’s response and the action taken by management at the time of the Site Audit. I am satisfied the Approved Provider has taken appropriate action to ensure the workforce is competent and have relevant qualifications and knowledge to perform their roles. I encourage the Approved Provider to continue embedding these improvements into usual practice. I find Requirement 7(3)(c) is Compliant.

I am satisfied the remaining four requirements of Standard 7 Human resources are Compliant:

While consumers, representatives and staff said the service is short staffed, the Assessment Team did not find an impact to the delivery of safe and quality care and services resulting from insufficient staffing. Management acknowledged there are staff shortages at the service and described the ongoing strategies implemented to fill shifts including offering additional shifts for internal staff, accessing staff from other services in the group and the use of agency staff. Recruitment is ongoing for the service. In its written response, the Approved Provider submitted information outlining further workforce planning strategies including the use of student nurses and arrangements have been made to sub-contract cleaning to external services. The Approved Provider advised the call bell system will be replaced and upgraded to enable the running of reports and improve monitoring of call bell response times. I have considered deficits identified by the Assessment Team in relation to one on one staff support for behaviour management under Standard 3 Requirement 3(3)(b) where I consider it more relevant. Based on the evidence available to me, I find Requirement 7(3)(a) is Compliant.

Consumers were satisfied staff are kind, caring and respectful and this was supported by Assessment Team observations. Staff demonstrated understanding of the consumers’ needs and preferences and spoke respectfully about consumers. Staff are reminded of the code of conduct during ‘huddle’ meetings.

Management described the organisation’s recruitment and selection processes. The service has recently been acquired by a new Approved Provider, this has resulted in some recent IT issues impacting the monitoring of mandatory training and the development of new policies and procedures including orientation packages. Staff were satisfied they were progressing well with their mandatory training, however highlighted IT challenges. The Approved Provider submitted an education plan that demonstrates it has access to resources to support staff with ongoing training, and education is being delivered to address the areas of improvement identified during the Site Audit.

The service has a formal performance appraisal process in place. Staff confirmed they have participated in a performance review in the last 12 months.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied Requirement 8(3)(d) is Non-compliant:

While the organisation has a risk management framework supported by policies and procedures, the systems have not been effective at the service level in managing high impact or high prevalence risks. This is supported by the non-compliance identified in this report in Standard 3. While the organisation demonstrated it has an incident management system to record incidents and staff could describe incident reporting processes, staff said they have not needed to record any SIRS incidents. The Assessment Team identified two incidents not reported through SIRS as per legislative requirements and deficits in the investigation and associated documentation of a high risk medication incident. While all clinical staff were aware of the high risk medication and the specific actions to be taken if doses were missed, these were not completed in accordance with documented protocol.

The Approved Provider submitted a written response with clarifying information and documentation including a ‘High Impact High Prevalence’ reporting tool, incident reports, general practitioner notes, SIRS reports and staff education documentation. The Approved Provider submitted an action plan and education plan demonstrating the actions planned and completed to address the improvements. Actions include auditing of SIRS reports to ensure accuracy, improved high impact and high prevalence risk reporting practices and staff training and education in incident reporting and SIRS. The Approved Provider submitted evidence to demonstrate the two incidents have since been reported to SIRS and the incident report updated in relation to the high risk medication incident. During the Site Audit the service implemented a risk reporting tool to improve reporting processes, the Approved Provider submitted evidence to support the reporting tool’s use in practice.

I am satisfied staff could describe how they would identify, respond and escalate abuse and neglect and how they support consumers to live the best life they can.

I have reviewed all of the information provided. While I acknowledge the actions taken by the service since the Site Audit, these actions have not been fully implemented, evaluated, or embedded. I am not satisfied the service has in place effective risk and incident management systems and practices to ensure the delivery of safe and quality care and services that meets the Quality Standards. I find requirement 8(3)(d) is Non-compliant.

I am satisfied the remaining four requirements of Standard 8 Organisation governance are Compliant:

While consumers and representatives provided feedback that they are not engaged in the development and evaluation of care and services, they also said they were aware of resident and representative meetings and choose not to attend. In relation to feedback from consumers that they had not been advised of the recent amalgamation with another organisation, the Approved Provider submitted information to demonstrate that this was communicated through resident and representative meetings and community forums. I have also considered information in relation to Standards 2, 4 and 6 that demonstrates consumers and representatives are engaged and encouraged in the development, delivery and evaluation of care and services through the assessment and planning process, input into the menu and complaints and feedback processes.

The governing body is supported to promote a culture of safe, inclusive and quality care and services through established committees and governance frameworks supported by systems, policies and procedures.

While the Assessment Team identified some deficits in financial governance that were addressed during the Site Audit and IT challenges that have impacted the monitoring of mandatory training, overall, the organisation demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Staff demonstrated understanding of the policies and processes that supported each of the governance systems.

The organisation demonstrated it has a clinical governance framework in place which includes antimicrobial stewardship, minimising the use of restraint and open disclosure policies and procedures. Staff confirmed receiving education about the policies and procedures and were able to provide examples of the relevance to their work.

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