Performance

Report

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| Name of service: | Peakhurst Nursing Home |
| Service address: | 18 Henry Lawson Drive PEAKHURST NSW 2210 |
| Commission ID: | 2448 |
| Approved provider: | The Trustees of the Sisters of Our Lady of China |
| Activity type: | Site Audit |
| Activity date: | 13 December 2022 to 15 December 2022 |
| Performance report date: | 17 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 Peakhurst Nursing Home (**the service**) has been prepared by Katrina Platt, 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 on 16 January 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 | **Compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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 4(3)(c) – the Approved Provider ensures services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being including meaningful engagement in activities of interest them and those which mitigate behaviours and provide stimulation. Activities include those within the service and outside the service, which are designed to provide a sense of purpose and identity for all consumers.

# 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

This Quality Standard has been assessed as compliant as 6 of the 6 requirements are compliant.

Consumers and consumer representatives interviewed felt respected and valued and discussed how staff were responsive to their individual preferences by calling them by their preferred names and understanding their personal care and social needs. The Assessment Team observed staff to interact with consumers respectfully and were familiar with consumer backgrounds when interviewed. Care plans acknowledged consumer identities and policies were in place which outlined service provision connected to consumer dignity and respect.

Consumers interviewed described engagement in activities which aligned with their cultural identity including culturally significant meals, music, language newspapers and cultural practices. Consumers were supported to decorate their rooms to reflect individual taste and identity. Staff demonstrated awareness of individual consumer diversity and cultural preferences and described how this influenced care provision. Care plans recognised consumer cultural diversity and preferences.

Whilst the Assessment Team found the service generally supported consumers to exercise choice and independence and maintain relationships of choice, they noted no formal processes were in place to capture consumer choice on who they wished to be involved in their care. Management described verbal discussions occurred prior to admission to the service and information in the electronic care system included first and second contact details only. One consumer representative described a lack of staff understanding of family involvement in the care of their consumer, inconsistent communication about their consumer and their care provision and misrepresentation of the consumer’s condition. The Assessment Team noted errors were evident in the consumer care file and no power of attorney was recorded for this consumer.

In response to the findings from the site audit report, the Approved Provider discussed various policies in place to guide staff on determining the key personnel involved in care partnering and alternate decision-makers for consumers and noted information is captured before and on admission and updated during their residence. Consumers are consulted during case conferences about who is involved in their care. Information is recorded in the electronic care system – person centred care and captures friends and family, professionals and advocates nominated by the consumer. The information is also recorded in the capacity register which is accessible to all staff.

The Approved Provider discussed the ‘Partnership in Care’ program has been implemented to provide consumers with continuous emotional support during COVID-19 and other infection outbreaks in line with their care partners. A copy of the ‘Partnership-in-care register’ was provided for clarification. Copies of several key policies and processes were submitted by the Approved Provider including assessment and care planning, consumers and representatives’ meetings, partnership in care, arranging care conferences and work instructions for new admissions.

The Approved Provider disagreed the service had not established who was involved in the care of the consumer discussed in the site audit report. Consent forms were provided confirming nomination by the consumer of their multiple care supports and care notes evidenced the order of contact preference. Evidence showing family conferences had occurred was provided and care notes from 1 June 2020 to 6 January 2023 showed regular contact with the consumer’s nominated primary contact. A signed advanced care directive was submitted.

Whilst I note the findings of the Assessment Team, I am satisfied the Approved Provider has demonstrated consumers make decisions about who is involved in their care and this information is readily available to staff in multiple formats. Evidence provided supports regular contact with consumer contacts of their choice and preferences and supporting policies and procedures inform deliver of care and services in partnership with consumers and those important to them.

The Assessment Team found risk mitigation strategies were not effectively implemented for two consumers with high falls risks who required assistive equipment. One consumer was observed not wearing their assistive equipment and the other consumer was observed to ambulate regularly without the equipment and without supervised assistance with transfers and mobility as recommended in their care plan. The Assessment Team noted a risk assessment had not been completed for one consumer undertaking risk activities of their choice. Staff interviewed described supports provided to consumers to take risks and dignity of risk documentation supported appropriate risk discussions occurred with consumers.

In response to the findings from the site audit report, the Approved Provider submitted evidence supporting the consumer’s preference to wear assistive equipment under their clothing and care notes showing daily observations of the equipment being worn and other fall prevention strategies in place. For the other consumer, the Approved Provider discussed the consumer’s preference to mobilise independently and dignity of risk forms in place showing discussions had occurred with the consumer about consequences and impacts and other fall prevention strategies in place including a physio care plan and rehabilitation support.

The Approved Provider discussed the additional supports provided to one consumer undertaking risk activities of their choice, their preference for independence and history of non-compliance with specific risk mitigation strategies implemented. The recently updated dignity of risk record clearly articulates harm that may be caused, mitigation strategies and the consumer’s ongoing preference to participate in the activity at a time of their choosing and without assistance.

I am satisfied the Approved Provider has demonstrated each consumer is supported to take risks to enable them to live the best life they can. Consumers are afforded opportunities to engage in activities of their choice, with full knowledge of the associated risks and appropriate mitigation strategies in place to support that ongoing engagement.

Consumers interviewed described receiving information which supported them to make decisions about their activities and meals. Staff described different ways information was provided to consumers in line with their individual communication needs and preferences, including for those with cognitive impairment. The Assessment Team noted the availability of cue cards to assist staff communication with consumers from Chinese-speaking backgrounds, menu translation into Chinese language and internal and external complaints and advocacy information in Chinese, Mandarin and Cantonese.

Most consumers interviewed confirmed their privacy was respected and maintained and said staff completed personal care activities and discussions about consumer care in private. Staff described practical ways they respected consumer privacy including knocking on consumer room doors and waiting for a response before entering. The Assessment Team observed staff discussions occurred in private, secure computers were located in nurses stations and consumer information stored in lockable cupboards.

Accordingly, I find requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d), 1(3)(e), and 1(3)(f) 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

This Quality Standard has been assessed as compliant as 5 of the 5 requirements are compliant.

The Assessment Team found deficiencies in risk identification and consideration in care planning. Comprehensive risk assessments were not completed for 2 consumers who experienced multiple falls incidents and for one consumer with ongoing skin integrity issues. Whilst general risks and prevention strategies were considered, assessments were not conducted to identify individual contributing factors and risk mitigation strategies.

In response to the findings from the site audit report, the plan for continuous improvement submitted by the Approved Provider indicated all consumer care plans have undergone review and update, in consultation with consumers and consumer representatives. Incidents are being reviewed daily by management to ensure comprehensive assessment, investigation and analysis is completed. These actions are supplemented by an education and training program for January and February 2023 for staff and topics including individualised care planning and risks relating to falls and skin integrity.

In addition, the Approved Provider submitted copies of long term care plans for the 2 consumers with multiple falls incidents. The long term care plans detail consumer care needs and desired outcomes including maintaining mobility independence and improved strength, with associated physiotherapy care plans also in place. Multiple falls prevention strategies were evidenced, including (but not limited to) hourly safety checks, staff monitoring during activities and assistance with mobility, assistive equipment and aids provision and monitoring and ensuring a clutter free environment.

Whilst advanced care planning was demonstrated, end of life planning was delayed for one consumer and did not consider individual consumer needs and preferences for comfort measures including nutrition and pain relief. For one consumer requiring palliative care, care planning documentation did not capture deterioration in consumer condition and care directions were not always followed to support nutritional needs and comfort measures. Other individual consumer needs and preferences were not considered during assessment of one consumer after hospitalisation and for 2 consumers requiring behavioural support.

In response to the findings, the Approved Provider indicated all assessments and care plans were reviewed in consultation with consumers and consumer representatives and updated. For consumers requiring palliative care, care plans have been reviewed and updated. The plan for continuous improvement identified education has been provided to clinical staff in January 2023 and February 2023 on end of life care and the life planning pathways form and associated work instructions have been reviewed and updated. Toolbox talks and brain storming sessions are included in the education calendar for individualised care planning and behaviour management.

Most consumers and consumer representatives interviewed felt they were informed about consumer care and provided input about consumer care needs and this engagement was reflected in consumer progress notes. Care and services plans reviewed demonstrated engagement of other care and services providers including physiotherapists, dieticians and behaviour support specialists. Case conferences were held annually or as required and monitored for scheduled completion and follow-up.

Consumers and consumer representatives interviewed indicated their involvement in care planning, however one consumer representative was unaware of the availability of the care and services plans and could not recall being offered access or copies. Management advised care plans were offered at case conferences, however this was not reflected in care documentation and no further information was provided to the Assessment Team for review.

In response to the findings from the site audit report, the Approved Provider referenced the supporting organisational policies and processes including assessment and planning, consumer and representatives case conference, and ‘Resident of the Day’. A workflow chart for the ‘Resident of the Day’ process was submitted, showing the various checks made during this monthly activity including (but not limited to) care plan evaluation, medications, pain, incidents, vital signs, consumer needs and preferences and well-being conversations. The action plan for continuous improvement referenced increased evidence of consultation with consumers and consumer representatives and availability of care plans, label creation and staff communication.

For one consumer representative noted in the site audit report to provide positive feedback, the Approved Provider submitted copies of care notes detailing the representatives involvement in care and planning. For another consumer representative who said they had not received a care plan copy, a copy was provided to the representative on 11 January 2023. Supplementary case conference documentation was supplied for several consumers which confirmed effective communication of assessment and planning outcomes and copies of care plans were provided.

Whilst care planning documentation suggested reviews occurred regularly, the Assessment Team found comprehensive reviews were not always demonstrated. Incidents or changes in consumer condition were noted, however strategies were not reviewed for effectiveness. This was evidenced for one consumer showing change in condition and deterioration, 2 consumers with skin integrity issues, one consumer with behavioural support needs and one consumer requiring blood glucose monitoring.

In response to the findings from the site audit report, the Approved Provider submitted an action plan for continuous improvement indicating high risk consumers will be monitored daily and incidents will be reviewed daily to analyse causation and trends, with strategies evaluated for effectiveness and actions taken when necessary. Weekly leadership and fall prevention meetings will also occur.

Additionally, care notes were submitted for the consumer noted in the site audit report experiencing deterioration and change in condition and these showed regular monitoring of condition and deterioration was occurring and the detailed long term care plan was reviewed and updated to include social and emotional needs. For the consumer with behavioural needs, the behaviour assessment and care plan was updated to reflect the behavioural support needs of the consumer and specialist recommendations. And for the consumer under blood glucose management, a blood glucose level monitoring directive was in place, signed 21 September 2022, for monitoring levels twice daily and detailed observation history supplied by the Approved Provider evidenced monitoring as per the directive.

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

Findings

This Quality Standard has been assessed as compliant as 7 of the 7 requirements are compliant.

Consumers and consumer representatives interviewed were satisfied with the care and services provided. The Assessment Team found deficiencies were evident in restrictive practices management, with the use of psychotropic medication not identified as a chemical restraint for 3 consumers. For 2 consumers, behaviour support plans were not in place and for another consumer, psychotropic medications were not ceased when no longer required. Informed consent for psychotropic medication use was incomplete for 2 consumers where risks and benefits were not discussed. Management confirmed the new electronic psychotropic register was not always completed by medical officers as required.

Management of clinical care for one consumer identified as high risk of pressure injuries was not tailored to the individual needs of the consumer to ensure appropriate mitigation and prevention. Pain management for one consumer post-fracture was not tailored to meet the needs of the consumer. For another consumer, pain management during palliation was intermittent and not tailored to support deterioration of the consumer during end of life.

In response to the findings from the site audit report, the Approved Provider submitted clinical evidence of medication charts and informed consents in place. Behaviour support plans were developed for consumers where necessary. Review of psychotropic medications ceased when no longer required and documentation was updated accordingly, and last resort measures were identified. Management will conduct daily review of clinical care notes to provide guidance on behaviour management and education on behaviour monitoring and documentation has been provided to staff.

The Approved Provider acknowledged medical officers and staff were still familiarising themselves with the new electronic medication management system, which commenced in October 2022, and some information was pending update in the system. The Approved Provider noted the psychotropic medication self-assessment register has been recently reviewed and updated by medical officers and evidence provided supported same. The psychotropic treatment consent form has been modified to include risks/benefits explanation.

The Approved Provider submitted the action plan for continuous improvement which identified pain management monitoring and review as an area for improvement and noted consumer care notes and clinical practice will be reviewed by management daily, with education provided to staff on pain management, monitoring, workflow instruction and documentation completion. For behaviour and wound management, education has been demonstrated for clinical staff on care and documentation and on the spot education and mentoring is facilitated by management. Complex wounds will be reviewed weekly and specialist referrals made in accordance with the relevant policy.

One consumer was incorrectly identified in the site audit report and as such, the Approved Provider did not offer a tailored response to the lack of behaviour support plan in place for this consumer. However, on review of the psychotropic self-assessment tool, the consumer was identified and it was noted the consumer has a behaviour support plan in place.

The Assessment Team found discrepancies in high-impact and high-prevalence risk management for multiple consumers who experienced multiple falls, 2 consumers with skin integrity issues, one consumer requiring diabetic monitoring and one consumer requiring behavioural management. Contributing factors were not investigated and preventative interventions not developed. Management acknowledged deficiencies in the clinical oversight of the incident management system which had been addressed with changes in management and support from the quality team. Trends data for falls management was unavailable and undergoing update. Management noted some difficulties with monitoring behavioural changes in consumers through the current electronic system, with mitigation measures not yet fully implemented.

In response to the findings from the site audit report, the Approved Provider referred to the action plan for continuous improvement and noted fall prevention meetings have been occurring monthly from October 2022 and weekly from December 2022. Data analysis occurs, with the number of falls and falls with major injuries trending down as evidenced in the falls matrix for the same period. Equipment audits commenced prior to the site audit were completed on 19 December 2022 and all discrepancies corrected, with all care plans updated by the physiotherapist as required. Monitoring of equipment including air mattresses was evidenced, with daily monitoring occurring and manual instructions placed next to control units for staff to check settings and report malfunctions.

For one consumer identified as a high risk of falls, the Approved Provider discussed dignity of risk forms associated with non-use of assistive aids and wellness programs provided by the physiotherapist, and an intensive rehabilitation program currently underway with the consumer. Alternate measures for fall prevention and risk mitigation strategies for the consumer were also evidenced. For the remaining 4 consumers identified as high falls risks, the Approved Provider referred to the action plan for continuous improvement which identified areas of improvement including risk assessment and planning and incident management under Standard 2 Requirements (3)(a) and (3)(e). Those actions include daily monitoring and investigation and analysis of incidents, which was supplemented by additional education and brain storming sessions for effective fall prevention and comprehensive incident investigation.

For the 2 consumers with skin integrity issues, the Approved Provider referred to the action plan for continuous improvement which highlighted wound management under Requirement 3(3)(a) and management of incidents and risks discussed under Standard 2. Care notes for one consumer show monitoring of pressure injury every second day as required and their chronic wound care management plan identified a treatment plan, associated nutrition and hydration actions and some wound pain management strategies. The care plan for skin integrity identified the consumer as a high risk of impaired skin integrity, with prevention and proactive strategies identified for ongoing comfort care. For the second consumer, no additional documentation about skin integrity was provided.

For the consumer with inconsistent diabetic monitoring, the Approved Provider submitted the blood glucose monitoring observations which showed the consumer was monitored in accordance with the medical directive. The Approved Provider referred to the action plan for continuous improvement, believed to be the actions identified under Standard 2 Requirements (3)(a) and (3)(e) for risk and incident management.

For the consumer noted in the site audit report with behavioural needs, the care plan and behaviour assessments were updated to reflect the needs and preferences for the consumer. The behaviour assessment captured primary and secondary interventions for ongoing management, however no last resort measures were identified. Behaviour monitoring was identified in the action plan for continuous improvement and actions included reinforcement for staff to follow consistent practice to monitor and record behaviours, ongoing monitoring by management and additional education and toolbox talks outlined in the January 2023 and February 2023 education plan.

On review of consumer care documentation, the Assessment Team found the needs, goals and preferences of consumers nearing end of life were not always recognised and addressed. End of life plans were generic and were not considerate of appropriate interventions to maximise comfort and preserve consumer dignity, with generalisations about nutrition, mouth care and pain relief. Insufficient guidance was demonstrated in clinical documentation to assist staff with care provision for consumers requiring end of life intervention.

In response to the findings from the site audit report, the Approved Provider submitted updated care plans for end of life care pathways which included comfort care interventions consistent with consumer needs and preferences. The action plan for continuous improvement identified education for staff on palliative care and end of life planning pathways, with management to conduct daily review of clinical notes and monitoring of care conferences and handovers. The education plan for January 2023 and February 2023 provides for staff with training on end of life care planning and palliative pathways.

Deficiencies were noted by the Assessment Team in responsiveness to deterioration and changes in consumer conditions, including for one consumer where pain assessments were not completed when required. Delays were experienced by one consumer who required assistive supports for management of multiple unwitnessed falls. For another consumer, delayed removal of bed rails contributed to further skin injuries.

In response to the findings from the site audit report, the Approved Provider submitted evidence of regular pain assessments occurring for the referenced consumer when required. The delay in provision of assistive equipment was rectified during the site audit. The Approved Provider referenced the action plan for continuous improvement, which referenced improvements in review and care of services of consumer deterioration under their response to Standard 2 Requirement (3)(e) and the education plan provided training for staff on early detection of deterioration. No specific comments were provided by the Approved Provider about removal of assistive equipment to prevent skin injuries.

The Assessment Team found care and services plans were generic in nature and contained information about consumer needs, goals, preferences and care interventions which was unclear for staff. Wound documentation was difficult to follow, wounds were not clearly described and monitoring of wound healing was limited and confusing. Deficiencies in information communication about consumer incidents, behavioural and pain within the organisation were noted by the Assessment Team. Management discussed the issues with the current electronic clinical documentation system and staff commented antibiotic monitoring was not always flagged in the electronic work instruction system.

In response to the findings from the site audit report, the Approved Provider disagreed with the comments made about the electronic clinical documentation system and impacts on consumers. The Approved Provider discussed successful management of consumer care and services provision under the current system, with care plans developed for each consumer in accordance with individual assessments and at no risk to consumers. The Approved Provider referenced the action plan for continuous improvement which indicated several measures were in place including mentoring and education for staff on care planning and review and update of all care plans to ensure individualised interventions were documented in detail. The education Plan for January 2023 and February 2023 noted training and toolbox talks including individualised care plans, quality wound documentation and behaviour documentation.

The Assessment Team observed documentation which evidenced timely and appropriate referrals were made to a range of individuals and care services providers including wound consultants, palliative care services, dieticians, behaviour specialists, geriatricians and physiotherapists. Care and services plans were updated with relevant referral information, noting some behavioural specialists recommendations not always detailed.

The Assessment Team found implementation of several measures for infection control including appropriate antibiotic use, vaccinations programs, effective environmental cleaning and appropriate measures for risk prevention and management of infections including COVID-19 and influenza. Staff demonstrated awareness of antimicrobial stewardship and described consumer monitoring during antibiotic use for urinary tract infections. The Assessment Team observed appropriate infection control measures were generally practiced for hand hygiene and use of personal protective equipment.

Accordingly, I find requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) are compliant.

# 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. | Non-compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement 4(3)(c) is non-compliant.

Most consumers and consumer representatives interviewed felt supported to engage in social and personal relationships and participate in their community within and outside the service environment. Three consumers indicated there were not many activities they could participate in. The Assessment Team noted limited activities were available for one consumer with challenging behaviours and for another consumer approaching palliation.

In response to the findings from the site audit report, the Approved Provider discussed the continuous improvement action raised in October 2022 to improve the leisure and lifestyle program. The supplied activity report confirms engagement of a team leader (lifestyle coordinator) and a qualified diversional therapist lifestyle manager to review activity programs and include innovative and more interactive activities using technology. The need to pursue more individualised programs for consumers was recognised, with a focus on consumer engagement to ensure the lifestyle and wellness programs are tailored to consumer needs. Other actions include review of lifestyle policies and procedures, gap analysis, redesign of the training program and trials of dementia-specific innovative projects. Brain storming sessions have included meaningful leisure and lifestyle activities.

I have considered the intent of the requirement to support consumers to engage in activities that are meaningful and provide a sense of purpose and identity, and the feedback from consumers that limited activities are available for their participation. Whilst I acknowledge the actions of the Approved Provider and the identified improvements, I find engagement of new staff and implementation of a new leisure and lifestyle program will take time to have effect across the service and on the well-being of consumers. As such, I find requirement 4(3)(c) is non-compliant.

I am satisfied the remaining requirements of Standard 4 Services and supports for daily living are compliant.

Consumers interviewed generally expressed satisfaction with the supports received for daily living. One consumer discussed participation in activities preparation and support received from staff. The Assessment Team observed communication strategies in place to support consumers with hearing difficulties to participate in activities including religious services.

Most consumers and consumer representatives interviewed described services and supports available which supported their emotional, spiritual and psychological well-being. On review of care planning documentation, the Assessment Team found services and supports which promoted the emotional, spiritual and psychological well-being of consumers were generic in nature and the same information was observed across multiple plans. For one consumer with physical and psychological impairments, lifestyle goals were not being met as social engagements were minimal. For another consumer, attempts were not made to connect them with community-based spiritual and emotional supports. The Assessment Team found inadequate emotional and spiritual supports provided to 2 consumers, including at end of life.

In response to the findings from the site audit report, the Approved Provider discussed impacts on consumer social activities during the COVID-19 outbreak in November 2022 and how these activities were resuming. For the consumer with limited social engagement, the Approved Provider submitted activity charts showing engagement in church services, exercise, emotional support and special events. For the consumer where community-based connections were not indicated, the Approved Provided noted spiritual and emotional connections were met through regular family connections, staff rapport and social interactions within the service community which is consistent with the needs and preferences of the consumer. Clarification was provided of the emotional and spiritual supports provided to 2 consumers consistent with their needs and preferences.

The Assessment Team found care planning documentation contained limited or outdated information about emotional and lifestyle supports required for 2 consumers and lifestyle plans were not developed for 2 consumers. Information about emotional and spiritual needs were largely generic and support interventions did not always correlate with consumer interests. Staff generally demonstrated knowledge of individual consumer conditions, needs and preferences and said information was communicated well during handovers.

In response to the findings from the site audit report, the Approved Provider discussed the continuous improvement action raised in October 2022 to improve documentation and acknowledged some members of the lifestyle team require additional training on consistently documenting activities in consumer care plans. The newly recruited team leader and consumer engagement and lifestyle manager will ensure timely documentation completion and training and support to the lifestyle team, with ongoing monitoring and evaluation to be conducted.

For the 2 consumers without lifestyle care plans, they have subsequently been developed in consultation with the consumers and consumer representatives and copies were submitted as confirmation. For one consumer referenced, their lifestyle care plan indicates the consumer’s preferences for individual quiet time and evidence was provided showing provision of newspapers and books in their preferred language, with ongoing support from the lifestyle team to engage in group activities. Two other consumers mentioned in the site audit report had their plans reviewed and updated to reflect consumer interests, lifestyle goals and well-being supports.

Consumers interviewed were confident appropriate referrals to external providers were available when required. The Assessment Team found care planning documentation evidenced collaboration with external providers to support the diverse needs of consumers and included referrals to library services, pastoral care services and pet therapies.

Most consumers interviewed said meals were varied and of suitable quality and quantity. Meals were prepared and cooked fresh onsite and included seasonal offerings like fresh fruit. Consumer feedback, dietary requirements and preferences were considered in menu planning and alternate meal options were provided which included sandwiches, soups and salads.

Consumers interviewed felt safe when using equipment, which was easily accessible and suitable for their needs. Consumers felt comfortable raising issues when equipment required repair, were familiar with the reporting process and said items were replaced when necessary. The Assessment Team observed equipment for daily living including mobility aids and shower chairs were suitable, clean and well-maintained.

# 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

This Quality Standard has been assessed as compliant as 3 of the 3 requirements are compliant.

Consumers interviewed said they were comfortable with the homely service environment. Consumer rooms included personalised memorabilia, family photographs, artworks and personal furniture including fridges and microwaves. In the dementia specific unit, sensory wall hangings and enhanced signage assisted consumers with cognitive impairment to move around the service.

Consumers interviewed said the service was clean, comfortable and well-maintained. The Assessment Team found the second floor outdoor balconies were unclean and contained slip hazards like debris and weeds. Risks associated with stairwell use for consumers with mobility issues were identified and discussed with management, who confirmed prioritisation of continuous improvement actions with installation of a code pad to limit access. Clinical bins were unlocked and some were observed close to a street entrance and an open gate. Oxygen tanks were unsecured and observed outside the oxygen storage cage. A decommissioned hot water boiler tap was still functional and observed to pose a risk to consumers. The Assessment Team observed wet floors in multiple areas including hallways and walk through areas between the lounge and dining areas which represented a significant risk to consumers. Cleaning staff lacked knowledge about infection control.

In response to the findings in the site audit report, the Approved Provider noted no adverse incidents had occurred in the stairwell in 39 years. Nevertheless, a risk assessment has been undertaken and consultation with the fire service provider advised locks on the second floor would interfere with fire evacuation protocols and increase the risks to consumers. A digital pad has been installed on the ground floor, with no impacts on fire evacuation.

The Approved Provider indicated weather events prior to the site audit contributed to the debris on the balconies. All external areas, including balconies, are included in the planned cleaning schedule and managed by the maintenance officer. Some delays to planned cleaning had occurred during the COVID-19 outbreak as the service concentrated efforts on maintaining internal cleaning regimes to minimise infection transmission.

The Approved Provider disagreed with the observations of the Assessment Team about clinical bins being stored near the oxygen cage, noting only blue confidential bins were stored opposite the oxygen cage. The cytotoxic bin and others were all empty at the time of the site audit. The Approved Provider noted the waste management system has subsequently been reviewed, with plans to reduce the waste bins on site, relocate the waste storage beings away from the front of the service and reminders to staff of waste requirements.

The Approved Provider indicated the 3 oxygen bottles observed by the Assessment Team were empty and awaiting replacement. Rust rings have been removed, the area cleaned and clear signage evidenced and number locks installed for staff convenience. Education on oxygen cylinder safety and oxygen cylinder procedures was conducted with staff and the area will undergo regular monitoring and auditing.

The Approved Provider disagreed with the observations of the Assessment Team about the decommissioned hot water boiler tap, noting signage was in place indicating the tap was not to be used and the hot water was disconnected. A work health and safety audit conducted on 25 November 2022 identified the hazard and appropriate paperwork had been completed, with a plan to remove the tap. The Approved Provider advised a new safe hot water tap is expected to be installed in January 2023.

The Approved Provider detailed the responsibilities of the cleaning service provider and noted discussions with the account manager on the wet floor hazards. Cleaning equipment has been reviewed, with the cleaning provider to purchase a new mop trolley to minimise overall floor wetness and reduce the time floors are wet. These actions are captured on the action plan for continuous improvement and include daily monitoring of cleaning practices by management.

Consumers interviewed were satisfied with the furniture, fittings and equipment and the cleaning and maintenance systems. The Assessment Team observed furniture in communal areas was clean, in good condition and in plentiful supply. Consumers were observed using suitable mobility aids, electric beds and recliner chairs. Effective systems were in place for the cleaning and regular maintenance of furniture, fittings and equipment.

As such, I find requirements 5(3)(a), 5(3)(b) and 5(3)(c) are 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

This Quality Standard is compliant as 4 of the 4 requirements have been assessed as compliant.

Consumers and consumer representatives interviewed said they were supported to provide feedback and make complaints and felt comfortable raising issues with management and staff. Staff described support provided to consumers to complete feedback and complaints forms. Complaint forms were available at reception and information about providing feedback and making complaints was available in multiple languages including English, Chinese, Italian, Greek and Filipino.

Consumers and consumer representatives demonstrated awareness of advocacy and language services available to them. Staff described support provided to consumers with cognitive impairment or communication difficulties including assistance with form completion, use of communication aids including cue cards and translator devices and contact with the consumer representative.

Consumers and consumer representatives felt confident management would address and resolve any concerns raised. Staff demonstrated an understanding of open disclosure principles and explained actions taken to rectify issues and apologies provided to consumers when things go wrong. The complaints register contained details about complaints made, actions taken, resolutions and associated timeframes and any additional follow-up required for complaint completion.

Management described how feedback and complaints were reviewed for trends identification and care and service improvements. Improvements in food and consumer dining experiences were made after complaints were received and a consumer survey conducted. Feedback about access to consumers during COVID-19 resulted in implementation of a family members training program for infection control and use of personal protective equipment. Management discussed feedback and complaints were incorporated into staff training and discussed at staff meetings, with all high risk complaints escalated to the board.

# 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

This Quality Standard is compliant as 5 of the 5 requirements have been assessed as compliant.

Consumers and consumer representatives interviewed said there were enough staff and they received the care and services needed. All staff interviewed reported sufficient time to complete their work and provide care and services to consumers. Call bell data evidenced consistent average response times under 3 minutes and investigation and staff training occurred when average times were exceeded. Contingency plans were in place to replace staff when required and rosters were reviewed to ensure staff allocations were meeting the changing needs and preferences of consumers.

Consumers and consumer representatives said staff interactions were kind, caring and respectful of consumer identity, culture and diversity. Staff discussed examples of treating consumers with dignity and respect and several staff members acknowledged the need for patience when supporting consumers to complete tasks independently. The Assessment Team observed all staff interactions were respectful and considerate of consumer privacy and preferred language preferences.

Consumers and consumer representatives said the workforce was competent and staff were knowledgeable in consumer care and services delivery. Review of staff recruitment files confirmed availability of professional qualifications, registration documentation, reference checks and confidentiality agreements. Clinical staff were knowledgeable about a range of clinical care areas including infection control measures for cytotoxic medication use, antimicrobial stewardship and restrictive practices. Buddy shifts were available for new staff.

The Assessment Team noted alignment between workforce roles and positions descriptions. Staff interviewed confirmed training was undertaken in restrictive practices, serious incident response scheme and incident management. Mandatory training programs were evidenced and included annual competencies for pressure area care, manual handling, hand hygiene and personal protective equipment donning and doffing. Staff training records confirmed completion of mandatory training, non-mandatory online modules and face-to-face training within organisational timeframes.

Management discussed staff performance feedback mechanisms included audits, consumer and consumer representative feedback and staff feedback and observations. Policies and procedures were in place to support performance management processes and management demonstrated an understanding of these processes. Review of staff files confirmed completion of performance appraisals within the preceding 12 month period.

# 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. | 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

This Quality Standard is compliant as 5 of the 5 requirements have been assessed as compliant.

Consumers and consumer representatives were engaged in development, delivery and evaluation of care and services and have provided input into improvements to the dining experience, dining room linen preferences and recent renovations. Weekly visits from the administrator afford consumers and consumer representatives opportunity to provide feedback and suggestions, which was escalated to the board when required.

The Assessment Team found the board was supported by several subcommittees which monitored and reviewed areas including finance, organisational risk, care provision and continuous improvement activities through monthly meetings and performance reporting to stakeholders through the annual report. Board oversight of care and services was evidenced during the COVID-19 outbreak, with continued guidance and monitoring of personal protective equipment, rapid antigen testing and antiviral stock supply conducted through daily sub-committee meetings when required.

The Assessment Team found information management systems were ineffective in information provision and care and services monitoring, with continuous improvement ineffective in identifying deficiencies across multiple Quality Standards. Effective governance systems were in place for financial governance, workforce governance and feedback and complaints. Regulatory compliance was generally effective, with some deficiencies identified in legislative reporting under the Serious Incident Response Scheme.

In response to the findings from the site audit report about information management, the Approved Provider referred to their response provided under Standard 3 Requirement (3)(e) about the person centred software used by the service and its effectiveness. The Approved Provider reiterated how these systems provide staff access to consumer information and support consumer care provision. The Approved Provider referenced the action plan for continuous improvement, however the copy provided did not include any specific action items for Standard 8.

Evidence of continuous improvement was provided by the Approved Provider in the form of monthly clinical indicator trends analysis reports, home leadership meeting minutes, ‘10@10’ meeting minutes and falls prevention meeting minutes. The Approved Provider discussed the quality assurance and risk management systems and policies in place and the support of the clinical governance committee in clinical risk management. The systems identify risk and deficiencies in the Quality Standards, with plans for continuous improvements and actions implemented accordingly.

The Approved Provider discussed recruitment and retention and acknowledged the continuous process of human resource management and performance review and feedback from consumers about the management changes. The Approved Provider referenced the challenges faced with workforce retention during the COVID-19 outbreaks and discussed their commitment to providing a steady leadership team and building a stable and competent workforce.

For regulatory compliance, the Approved Provider discussed the effective incident management system in place which ensures incidents are investigated and risks mitigated for consumer safety. Evidence was provided to show reporting under the serious incident response scheme occurred for an incident identified in the site audit report, with evidence of risk mitigation considered for other similar incidents and strategies implemented for consumers.

Whilst I note the findings of the Assessment Team, I am satisfied the Approved Provider has demonstrated effective organisation wide governance systems are in place.

The Assessment Team found an effective risk management system was not evidenced. Incidents were not always reported, investigations were limited for current and previously reported incidents and delays occurred for implementation and review of risk interventions for consumers. Investigation and follow through of incidents and reportable incidents under the serious incident response scheme were not always demonstrated, with clinical impacts discussed under Standard 3 Requirement 3(3)(b). Policies and procedures were in place for consumer risks and living their best life, with some deficiencies noted in their practical implementation as discussed in Standard 1 Requirement 1(3)(c).

In response to the findings from the site audit report, the Approved Provider discussed systems in place for risk management and investigation of incidents, including risk mitigation and reporting to the serious incident response scheme. For the serious incident referenced in the site audit report, documentation was provided showing appropriate reporting and investigation was undertaken promptly to facilitate a timely resolution. Deficiencies in implementation of the policy and procedure supporting consumers to live their best life were adequately addressed and supported by additional training and education identified in the January 2023 and February 2023 training plan.

I am satisfied the Approved Provider has effective risk management systems in place to ensure the diverse range of risks which may impact consumers are appropriately managed, investigated and resolved.

Whilst a documented clinical governance framework was in place and staff understood their requirements under antimicrobial stewardship, minimal restraint use and open disclosure, deficiencies were noted by the Assessment Team in the application of the clinical governance framework in staff practices for assessment and planning, blood glucose monitoring, palliative care, wound and pain management and consumer deterioration.

In response to the findings from the site audit report, the Approved Provider discussed the clinical framework in their response to Standards 2 and 3 which support a clinical framework is in effect at the service. I note the information provided by the Approved Provider, discussed in more specific detail under Standard 2 and Standard 3, and the knowledge confirmed by staff about antimicrobial stewardship, minimal restraint use and open disclosure has sufficiently demonstrated a clinical governance framework is in place.

Accordingly, I find requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) are compliant.

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