

**Performance Report**

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| Name: | Pine Lodge Home for the Aged |
| Commission ID: | 5054 |
| Address: | 18 Balham Road, ROCKLEA, Queensland, 4106 |
| Activity type: | Site Audit |
| Activity date: | 29 October 2024 to 31 October 2024 |
| Performance report date: | 3 December 2024 |
| Service included in this assessment: | Provider: 1240 The Russian Benevolent Association for Homes for the Aged Service: 3411 Pine Lodge Home for the Aged |

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 Pine Lodge Home for the Aged (**the service**) has been prepared by Kimberley Reed, 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 was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers and representatives and others
* the provider’s response to the Assessment Team’s report received 20 November 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **Not 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.

* Assessment and planning processes are required to identify and address consumers’ current needs, goals and preferences.
* The high impact and high prevalence risks associated with consumer care must be effectively managed.
* Risk management systems must be effective to include effective monitoring of clinical systems.

# 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 treated with dignity and respect and felt accepted and valued. Staff had sound knowledge of each consumer’s background, culture, beliefs and relationships and described their actions to ensure consumers’ dignity and respect were upheld during care and service delivery. Consumer care documentation included a spiritual care plan which outlined consumers’ beliefs and ecumenical support needs. Staff were observed interacting with consumers in a kind and caring manner, engaging in conversations reflecting consumers’ backgrounds and interests consistent with information outlined in care plans.

The Site audit report contained information that the service was unable to deliver culturally safe care and services by not respecting, recognising and supporting a named consumer’s ethnicity. The Site audit report documented a named consumer who originated from Serbia and was unable to speak English, did not receive information or correspondence from the service in their native language. Menu options and consumers’ newsletters were not provided to the named consumer in a language they could understand. Staff stated they communicated with the named consumer by using non-verbal cues and hand gestures.

The Approved provider in its written response refutes this information. Photographs were submitted as part of the response; the named consumer was noted to be using flash cards with pictures and translations in Serbian, including food items. A case conference was held with management at the service and the named consumer and named consumer’s representative. Minutes of the case conference were submitted as part of the response and indicated translated documents were provided to the consumer including weekly menus, leisure and wellbeing schedules, complaints information, rules of residency, dietary preferences and the Charter of Aged Care Rights. A translator application has been installed on electronic devices as an improvement opportunity as the Approved provider noted the service is multicultural and there are seven different languages spoken by a variety of consumers at the service.

In coming to a decision regarding compliance for requirement 1(3)(b), I have considered the actions taken by the service to improve communication with the named consumer to be appropriate. While these actions were in response to the Site audit report, it is my decision these actions will support other consumers where English is not their first language. I have also considered feedback recorded in requirement 1(3)(a) which records consumers were treated with dignity and respect. Therefore, it is my decision requirement 1(3)(b) is Compliant.

Consumers and representatives confirmed consumers felt supported to exercise choice and independence and maintain relationships. Staff had knowledge of consumers’ care preferences and described how they supported them to maintain relationships with family and friends. Care documentation identified information regarding consumers’ individual preferences, the people important to them, and who to involve in decisions about their care. The service was guided by a consumer handbook which explained advocacy and consumers’ rights to make informed choices through a diversity, equity and inclusion policy.

Consumers stated the service supported their choices, even if the choice was identified as posing a risk to the safety of the consumer. Staff described how they supported consumers to take risks to enable them to live their best life. The service had policies and procedures to guide staff in supporting consumers to take risks. Progress notes and assessment tools evidenced, when risk was identified staff conducted risk assessments and held discussions with the consumer and their representatives to discuss the risks and strategies to minimise risk of harm.

The service demonstrated current, accurate and timely information was communicated to consumers and representatives. Information provided was clear, easy to understand, and supported consumers to exercise choice. Most consumers and representatives confirmed they were satisfied with the information provided to them by the service. The Site audit report contained information one named consumer who did not speak English was not provided information in their first language. I have considered this information when coming to a decision of compliance in requirement 1(3)(a) and have considered the Approved provider has taken appropriate action to address this deficit.

Consumers and representatives expressed confidence the service protected all personal information collected. Staff respected consumers’ privacy, including consumer information being held on the electronic care management system, by locking computer screens when not in use and not speaking about consumers in public areas. Staff were guided by an organisational confidentiality policy, which outlined how and why consumer information was collected, how it was stored, and who had access.

The Site audit report included information a named consumer’s privacy was not respected as staff maintained a presence when the consumer was using their bathroom. Staff confirmed they supervised the named consumer as they required assistance with mobility. In its response to the Site audit report, the Approved provider presented a letter from the named consumer’s representative which expressed staff respected the consumer’s privacy while in the bathroom. The Approved provider submitted a physiotherapy assessment which identified the consumer required supervision in the bathroom due to their unsteady gait and compulsiveness. A dignity of choice was completed in relation to the named consumer’s wish to have privacy while using their bathroom. Care planning was updated to reflect the consumer’s wishes and staff were notified via memorandum to provide standby assistance outside the bathroom door. In coming to a decision of compliance in this Requirement, I have considered the actions taken by the service to follow the personal care wishes of the consumer, the lack of evidence to support other consumers’ voiced privacy concerns and the information recorded in requirement 1(3)(a) relating to consumers being treated with dignity and respect. Therefore, it is my decision requirement 1(3)(f) is Compliant.

Based on the evidence detailed above, it is my decision this Standard is 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. | Not Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and
2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.
 | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The service completed assessments to inform the delivery of care. Registered staff described the areas of assessment which included skin integrity, wounds, behaviour, pain, mobility, nutrition, diabetes and falls. Registered staff described the assessment and planning process which included involvement from the medical officer and other health professionals such as physiotherapists, speech pathologists and dietitians. Staff accessed consumers’ care documentation through the electronic care system, paper charts and a communication book. The service had a policy and checklists to guide registered staff in completing and reviewing assessments and planning.

The Site audit report contained information assessment and planning processes did not identify or address the current needs of consumers. The Site audit report recorded some care documentation for consumers was incomplete, incorrect or did not have sufficient information to meet consumers’ needs, goals and preferences. For three named consumers with a diagnosis of diabetes, diabetic management plans did not contain directives for staff to follow if the consumers experienced high blood glucose readings. For one of the named consumers, assessment and planning information had not been updated to reflect a change to the management of their diabetes. For two consumers with changed behaviours, strategies known by care staff to manage the changed behaviours were not documented in care planning documents. For another named consumer who had resided at the service for just over a month at the time of the Site audit, care planning had not been completed.

In response to the Site audit report, the Approved provider evidenced care plans for consumers with diabetes named in the report have been updated to include directives to follow when blood glucose readings were high, as per best practice guidelines. Behaviour management strategies were revised for one of the named consumers with changed behaviours to include updated strategies including the use of a translator application on the service’s electronic devices. Education was arranged for registered staff relating to diabetes. Daily monitoring of blood glucose readings is undertaken by a clinical member of staff to ensure appropriate action occurs. A project has commenced to monitor clinical information management, whereby the clinical documentation checklist for new consumers who enter the service will be revised to ensure documentation is completed within four weeks of a consumer entering the service. The roster has been updated to include a dedicated registered staff member to complete and update assessments and care plans. The Approved provider noted documentation was reported as inconsistent and acknowledged this risk this may impact care to consumers, but noted a lack of impact for consumers, or feedback from consumers or representatives that they were dissatisfied with assessment and planning processes.

In coming to my decision relating to compliance in requirement 2(3)(b), I have considered information recorded in the Site audit report and the Approved provider’s response. It is my decision while there is a lack of documented impact for consumers relating to deficits in assessment and planning, it is the purpose of assessment and planning to guide staff practice in the absence of individualised assessment and planning to guide staff practice relating to consumer care, the risk remains that staff who are unfamiliar with consumers may not have sufficient guidance, particularly when consumers have complex care needs. While the Approved provider has commenced corrective actions relating to this requirement, these actions will take time to implement and test for effectiveness and sustainability. Therefore, it is my decision requirement 2(3)(b) is Not Compliant.

Consumers and representatives confirmed consumers could choose who they would like involved in care planning. The medical officer and allied health professionals provided guidance and recommendations to influence consumers’ care planning. Consumers’ care documentation evidenced input and consideration of recommendations from allied health professionals, medical officers and specialists. Staff were guided by a script when discussing monthly assessment and planning with consumers and representatives which included specific questions about their care.

Consumers and representatives were satisfied with communication relating to the outcomes of assessment and planning for consumers and they received or had access to consumers’ care plans. Staff communicated with consumers and representatives following assessment and review by the medical officer or other health professionals. Consumers’ care documentation recorded when staff communicated with consumers and representatives and care and registered staff stated the handover process included information relating to the consumer including assessments.

Care plans were reviewed regularly for effectiveness and when consumers’ needs changed and registered staff identified when consumers’ care plans were due for review. Consumers’ care documentation demonstrated routine review of care planning occurred and included clinical reassessment and review. Clinical management established a clinical champion program in October 2024 whereby registered staff were responsible for completing and overseeing specific clinical requirements such as wounds, falls or nutrition.

Based on the above information, and the noncompliance outcome for one requirement, this Standard is Not 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. | Not 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

Consumers and representatives confirmed consumers received the care they needed and were satisfied with care delivery. Best practice guidelines were used to manage wounds, pain, falls prevention, skin integrity and complex clinical needs. Care planning documentation evidenced individualised and tailored strategies for managing consumers’ clinical care. Policies and procedures were available to guide staff practice when delivering care. Registered staff were assigned subspecialities of clinical nursing to champion, such as nutrition, diabetes and wounds. Registered nurses increase their knowledge and expertise in these narrower areas to ensure clinical care is best practice.

The service did not demonstrate effective management of consumer risks related to restrictive practices, dysphagia, post fall neurological observations, behaviour management, weight loss and time sensitive medication administration. While registered staff were aware of the service’s expected processes in relation to high impact, high prevalence risks, processes were not always maintained. Behavioural incidents which were not physical altercations between consumers and the late administration of time sensitive medication were not recorded as incidents.

While the clinical care needs for consumers were effectively managed, for four named consumers noted to have high impact or high prevalence risk associated with their care including changed behaviours; behaviour support plans did not provide sufficient information in relation to possible triggers for the changed behaviours, or individualised strategies to guide staff in managing the behaviours. Incidents of changed behaviour have not consistently been recorded as incidents or evaluated to determine if the severity of the incident met the threshold to escalate to the Serious incident response scheme.

The Approved provider in its response to deficits relating to behaviour management, has documented in its plan for continuous improvement, two of the four named consumers with changed behaviours will be referred to Dementia Services Australia, although no dates were provided for the review. Behaviour support plans for the four named consumers were reviewed and updated. While behaviour support plans have been reviewed, some strategies recorded were noted by staff during the Site audit as not effective or unable to be always achieved, for example, having male staff or mature female staff to care for one of the named consumers. For one named consumer, the reason for them to reside in the secure support unit was noted to be increased staffing levels as they were a falls risk, this does not support an effective assessment of the need for the consumer to be environmentally restrained. For one named consumer, their behaviour support plan identified attention seeking behaviour as a trigger for their changed behaviour, this does not support a mature understanding of behaviour triggers. Pain management reviews are in progress for the four named consumers; however, results of pain assessment were not included in the Approved provider’s response.

The service had a system for monitoring the timely delivery of time sensitive medication specifically related to Parkinson’s disease. The service did not record incidents when time sensitive medication was administered outside of 30-minute parameters or analyse the incident to determine if it met the threshold for reporting to the Serious incident response scheme. For one named consumer diagnosed with Parkinson’s disease, medication records indicated 21 occasions in October 2024 whereby medication was administered outside therapeutic timeframes. A second named consumer had seven occasions in October 2024 when their time sensitive medication was administered outside therapeutic timeframes.

The Approve provider in its response to deficits relating to time sensitive medication, stated registered staff have been counselled regarding the administration of time sensitive medication. Training will be provided to registered staff from the pharmacist in January 2025. A weekly audit of time sensitive medication, with results provided to registered staff at handover. An incident report and progress note will be written when a consumer does not receive medication. No examples of audit results or incident reports were submitted as part of the Approved provider’s response.

Neurological observations for four named consumers that sustained either unwitnessed falls or falls with head strikes were not completed in line with the service’s policy. Registered staff confirmed observations were not completed as per the guidelines.

The Approved provider in its response to deficits in falls management, stated registered staff have been counselled regarding observations following falls. Falls management training has been scheduled for 3 December 2024. Post falls observations to be monitored by clinical management staff for compliance. No examples of registered staff completing neurological observations were provided in the response from the Approved provider.

For four named consumers assessed as requiring nutritional supplements to manage unplanned weight loss, documentation did not support the supplements were administered as prescribed. Two of the consumers were noted to have continued unplanned weight loss.

The Approved provider in its response to the administration of nutritional supplements stated registered staff have been counselled in relation to completing records appropriately. On 25 November 2024 a dietitian will review the consumers that continue to lose weight. Clinical management will monitor documentation completed by registered staff daily, an audit will be conducted weekly, and results will be provided to registered staff at handover. Documentation processes will be reviewed to avoid duplication. Audit results were not submitted as part of the response.

The service did not demonstrate a process to ensure environmental restraint was used as a last resort or based on an assessment as to an individual consumer's risk to leave the service. Forty-three consumers were subject to an environmental restraint including consumers residing in the memory support unit and all other consumers residing at the service who are not immobile due to the locked front door. Two consumers subject to environmental restraint did not have documented informed consent to the restraint.

The Approved provider’s response to information relating to restrictive practices included consumers assessed as not being at risk of absconding and can safely go out on their own have access to the code for the front door. The Approved provider noted security of the front door is included in a refurbishment program currently underway at the service. Signed consent was obtained for the two consumers noted to have informed consent absent in their care documentation.

In coming to my decision regarding compliance in requirement 3(3)(b), I have considered the information recorded in the Site audit alongside the response submitted by the Approved provider. While the Approved provider has committed to actions to address deficits in this requirement, a root cause analysis was not included in the Approved provider’s response, and as such these actions, which are yet to commence or conclude, have not been tested for their relevance, effectiveness and sustainability. Given the breadth of deficits identified in this requirement, clinical monitoring was not effective at the service at the time of the Site audit, neither was evidence submitted to support an improvement in the ability of the service to identify deficits independently. Therefore, it is my decision requirement 3(3)(b) is Not Compliant.

Consumers and representatives were confident the service understood consumers’ end of life goals, and how these would be implemented. Care documentation included information for staff to assist consumers when nearing end of life and documented collaboration with the medical officer and consumers’ families. Clinical and care staff described the palliative care pathway and supports provided to consumers, which included comfort cares, pain management and regular repositioning. The service’s palliative care kit included music, aroma diffusers, slide sheets, shampoo, end of life charts, bibles and orthodox prayer books.

The Site audit report stated some consumers were not satisfied their preferences were effectively communicated. This evidence relates to a named consumer who expressed staff were not recognising their preference for privacy in the bathroom. I have considered this information previously in requirement 1(3)(f) and have not placed weight on this evidence in requirement 3(3)(e). Other evidence in this requirement recorded in the Site audit report includes an occasion when a consumer did not receive the correct diet. This evidence was refuted by the Approved provider. I do not consider the evidence presented related to a systemic breakdown of information management.

The Site audit report records registered staff experienced difficulties identifying where consumer information was located, as the service used both a hard copy and an electronic system to record care directives and information relating to consumers.

In coming to a decision of compliance for requirement 3(3)(e), I have relied on other requirements which indicate information about consumers’ condition is documented and communicated, including requirement 3(3)(a) which evidenced consumers receive safe and effective personal and clinical care. Therefore, it is my decision requirement 3(3)(e) is Compliant.

Consumers and representatives were satisfied the service facilitated referrals to other providers of care in a timely manner. Care documentation evidenced review and recommendations for consumers’ care from other health professionals. Registered staff were aware of the process for identifying consumers who required referrals and the pathways to do so. While registered staff were aware of the process to refer consumers, four consumers with changed behaviours were not referred to dementia behavioural specialist services prior to the site audit, despite noted difficulties in effectively managing their behaviours.

Consumers and representatives were satisfied the service was effectively managing and implementing processes to minimise risks relating to infections and outbreaks. Staff understood their role in infection control management and antimicrobial stewardship. The service demonstrated systems were in place which included vaccination programs for staff and consumers and an outbreak management plan and policies. The service had an infection prevention control lead who monitors infections and manages outbreaks.

Based on the above information, and the noncompliance outcome for one requirement, this Standard is Not 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.
 | 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

Consumers and representatives were satisfied with supports provided for consumers’ daily living to optimise their independence and quality of life. The service’s activities programs supported consumers to be as independent as possible and met their needs and preferences. Care planning documentation recorded consumers’ personal history, needs, goals and preferences. Consumers were observed participating in various activities throughout the service and in the memory support unit, and lifestyle staff were engaging with consumers in Russian and English. The activities calendar contained a range of activities which included games, current affair discussions, men’s group, community access trips, exercises, religious activities, and access to volunteers.

Consumers and representatives stated the emotional, spiritual and psychological well-being of consumers was supported. Lifestyle staff supported consumers with one-on-one activities and religious activities. Consumers’ care documentation included details of their spiritual and emotional needs. A volunteer confirmed they spent time one on one with consumers to support their emotional well-being through conversation, providing books or doing crafts with them. Consumers were confident staff would identify if there was a change in their psychological well-being.

Consumers described the various activities they were involved with in the community, the relationships they developed or maintained and the activities which interested them. Lifestyle staff supported consumers to maintain and build relationships and identified and supported consumers with their interests. Consumers’ care documentation recorded relationships which were important to consumers and their interests. Consumer and activities meeting minutes recorded opportunities for consumers to recommend activities.

Consumers and representatives were satisfied staff had relevant information regarding consumers’ condition, needs and preferences. Hospitality and care staff had access to consumers’ information including dietary profiles. Consumers’ care documentation included consumers’ dietary profiles, diagnoses, assistance requirements for mobility and areas of interest. Care staff used the communication book and handover to identify any changes or consumer needs such as assisting consumers to be ready to be picked up and attend medical appointments with family.

Consumers confirmed the service connected them to other organisations and services such as volunteers and the local library, and lifestyle staff connected consumers with volunteers, community and religious organisations. Consumers’ care documentation recorded activities where consumers had been connected to other providers of care. Systems were in place to identify consumers who might benefit from connections or referrals to services in the local community such as religious or volunteer programs.

Consumers confirmed they enjoyed the meals; they were provided a choice and meals were sufficient. Management sought input from consumers in developing the menu which considered consumers’ preferences and food focus meeting minutes recorded opportunities for consumers to provide feedback and suggestions. Hospitality staff understood consumers’ dietary needs and preferences. Consumers had multiple choices each meal relating to soup, meat, starch and vegetable.

Consumers and representatives were satisfied the equipment provided was suitable for consumers’ needs and well maintained. Staff accessed suitable equipment to support consumers, ensured it was clean and escalated any maintenance requirements. Maintenance staff ensured any issues raised were resolved within suitable timeframes.

Based on the evidence detailed above, it is my decision this Standard is Compliant.

# Standard 5

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| Organisation’s service environment |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| 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 were satisfied with the environment which provided them space to spend time with their visitors in multiple areas and personalise their rooms. The environment was observed to be well signed, consumers’ rooms were personalised, and the environment supported consumers’ independence and socialisation. Signs were placed throughout the service to guide consumers and visitors to the various wings and rooms. A large common area included a dining room and activities space and smaller spaces in each wing facilitated social interaction. Wide corridors with hand railings supported consumers to mobilise and maintain their independence. Consumers were observed mobilising throughout the service with various mobility aids, with staff assistance or independently.

Consumers and representatives confirmed the environment was well maintained and they were satisfied with the cleaning. Cleaning and maintenance staff had processes to ensure the service was clean and well maintained and the service was observed to be clean and well-maintained. However, a malodour was present in one area of the service, cleaning staff said they regularly cleaned the area identified as malodourous with specific chemicals. Maintenance staff were observed addressing the overgrown garden areas during the Site audit. Consumers were observed freely moving throughout the indoor and outdoor spaces of the service. The Site audit report references the inability of consumers to exit the service independently however, as there was an opaque cover over the access code at the front door. The Approved provider refuted this information when responding to requirement 3(3)(b) and stated consumers assessed as being safe to leave the service independently had access to the code for the front door.

Consumers and representatives were satisfied with the furniture, fittings and equipment and how maintenance issues were communicated. Cleaning and maintenance staff had processes for ensuring furniture and equipment was maintained and cleaned regularly. The service had a wide range of furniture and equipment which was clean and well-maintained. Maintenance staff ensured the maintenance of furniture, fittings and equipment through scheduled preventative maintenance and reactive maintenance requests were actioned.

Based on the evidence detailed above, it is my decision this Standard is Compliant.

# Standard 6

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

Findings

Consumers and representatives felt encouraged, safe and supported to share feedback and make complaints. They described the various methods available, including speaking to management or staff directly, during consumer meetings, surveys and through written feedback forms. Staff had a shared understanding of the service’s complaint handling system and the actions taken to lodge and encourage feedback or a complaint. Feedback and complaints posters were observed throughout the service, as well as feedback forms and return boxes. Meeting minutes evidenced consumer meetings were held monthly and provide a forum for consumers to provide feedback or raise concerns and minutes of these meetings were distributed to all consumers.

Consumers and representatives were encouraged and were aware of external advocacy organisations and language services available to assist in providing feedback and making complaints. Staff understood the external services available, and they promoted and supported the consumer or representative to access these services. The consumer handbook contained information on complaint escalation through the organisational hierarchy, details of the Commission, advocacy services and details of translation services.

Consumers and representatives expressed confidence management would address complaints and attempt to resolve any concerns promptly. Management and staff had a shared understanding of processes to follow when a complaint was received. Staff initially tried to resolve any issues and reported it to registered staff or management. The service had embedded policies, procedures, education material addressing feedback, complaint management, and open disclosure processes.

Consumers and representatives expressed confidence the service used feedback and complaints to improve the quality of care and services, and consumers were involved in the improvement process. The service trended and analysed complaints; feedback and concerns raised by consumers and representatives and used this information to inform improvement activities across the service which were documented under the service’s plan for continuous improvement. The service’s plan for continuous improvement evidenced feedback and complaints were used to influence planned actions to improve the quality of care and services provided.

Based on the evidence detailed above, it is my decision this Standard is Compliant.

# Standard 7

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

Consumers and representatives stated staffing levels enabled the provision of care and services in a timely manner. Master rosters and allocation sheets evidenced vacant shifts were filled and staff confirmed they had enough time to meet the demands of their roles and the needs of consumers. The service commenced an extensive recruitment drive in 2024, resulting in registered nurses being employed between January and October 2024. Staffing levels were determined by consumer acuity, care needs and regulatory requirements, to ensure a balanced approach to safety, quality care and consumer well-being.

Workforce interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity. Management stated, and survey documentation evidenced, the service used consumer and representative feedback through complaints and surveys to monitor staff behaviour and to ensure interactions between staff and consumers met the organisation’s expectations.

Consumers and representatives felt the workforce was competent and staff had the knowledge to deliver care and services to meet the needs and preferences of consumers. Staff received support and assistance to ensure they had the skills and knowledge to undertake their roles. New staff provided evidence of qualifications to the service prior to commencement. Police checks and Australian Health Practitioner Regulation Agency expiry dates were recorded within a register, and the service’s police check register identified all staff and volunteer criminal record checks were up to date. Ongoing staff competency was determined through care coordinator feedback, performance assessments, consumer and representative feedback, surveys and reviews of clinical records and care delivery.

Consumers and representatives were satisfied staff are trained to provide safe and effective care to consumers. Staff considered they were appropriately trained, supported, and equipped to perform their roles. Management monitored staff compliance with mandatory training through an electronic learning management system and provided staff with additional training when indicated. All new staff completed a five-day orientation program in a central location and were required to complete mandatory training modules on commencement and on an annual basis.

The service had established systems to effectively monitor and evaluate the performance and capabilities of the workforce. Additionally, the service ensured ongoing support and professional development opportunities were provided to each staff member to foster continuous growth and improvement. Ongoing performance management was conducted on an annual basis, with regular performance ‘catch ups’ with staff throughout the period. An electronic management system was used for monitoring compliance with performance appraisals, which were contemporaneous and reviewed by management. Staff could provide feedback on peer performance and opportunities for improvement based on their experiences at the service.

Based on the evidence detailed above, it is my decision this Standard is Compliant.

# Standard 8

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| Organisational governance |  |
| Requirement 8(3)(a) |  Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(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.
 | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:1. antimicrobial stewardship;
2. minimising the use of restraint;
3. open disclosure.
 | Compliant |

**Findings**

The service supported consumer and representative involvement in the development, delivery and evaluation of care and services. Consumers voiced their opinion in how care and services were delivered, and the service incorporated consumer feedback and suggestions to implement changes in care and services locally and at an organisational level. Consumers were supported to be engaged in the development, delivery and evaluation of care and services, including monthly consumer and representative food focus meetings, consultative forums, consumer and representative surveys and through feedback forms.

The governing body promoted a culture of safe, inclusive, and quality care and services. The governing body monitored the service’s compliance with the Quality Standards, and ensured it was accountable for the delivery of care and services across the organisation. The service’s governance framework consisted of a leadership structure with the Board retaining overall accountability for quality and safety in the organisation. Organisational framework documents evidenced, roles and responsibilities of the executive leadership team, governance committees, and service management were established. The service conducted monthly quality audits against the Quality Standards and used this information in conjunction with clinical data to identify deficiencies in care, policies, or procedures. While the service conducted monthly audits against the Quality Standards, it is noted the service’s monitoring processes did not identify the deficits recorded in requirements 2(3)(b) and 3(3)(b).

The Site audit report contains information the service did not have effective organisational wide governance systems in relation to information management and regulatory compliance. Deficits recorded in the site audit report relating to information management included the storage of clinical information, and the accessibility of clinical information to guide staff practice. The Site audit report recorded clinical information was stored in several areas and formats including an electronic care management system and hard copy notes. Two consumers were named, and it was noted their blood glucose level instructions were not recorded in the electronic care system and were in hard copy. In its response, the Approved provider in its response committed to an audit and review of hard copy documents in use at the service and a project was underway to reduce the need for hard copy documents. In coming to a decision regarding compliance for requirement 8(3)(c), I have considered while it is beneficial to have a single repository of information, I have not considered the deficiencies relating to information management recorded in the site audit report to be systemic across other information systems in place at the service. I have considered evidence recorded under other requirements relating to the sharing, currency, communication and documentation of information, support an effective information management system.

In relation to regulatory compliance, the site audit report contains information the monitoring of regulatory responsibilities was not effective in relation to serious incident reporting and obligations. While the service completed incident reports, analysis of incident reports has not consistently occurred to ensure the escalation of incidents that meet the threshold for the Serious incident response scheme. The site audit report contains information the service had not considered the delay in the administration of time sensitive medication and an episode of emotional distress for a consumer had been considered for escalation to the scheme. While the Approved provider did not specifically respond to this information as recorded under requirement 8(3)(c), the Approved provider committed to actions relating to incidents, including the daily review of behaviour charting and incident reports by a member of the clinical management team, to capture potentially serious incidents. The service’s plan for continuous improvement submitted as part of the Approved provider’s response to the site audit report, indicates three serious incidents were submitted retrospectively following the site audit. I have not considered the deficiencies relating to regulatory compliance to be of a systemic nature and have considered this information is better suited in requirement 8(3)(d) relating to the incident management system.

It is noted effective organisational governance systems were in place relating to continuous improvement, financial governance, workforce governance and feedback and complaints. Therefore, it is my decision requirement 8(3)(c) is Compliant.

The site audit report contains information monitoring of clinical risk was not effectively identifying deficits relating to high impact or high prevalence risks and the incident management system. Deficits and potential risks were identified relating to behaviour support plans, diabetes management and time sensitive medication. The service had not identified medication errors for one named consumer who received their time sensitive medication outside therapeutic timeframes on 21 occasions, this does not support effective management of high impact risks to consumers, responding to neglect of consumers or effective incident management. Incidents relating to consumer behaviour were not captured unless it involved physical aggression between consumers, this does not support effective management of behaviour support plans or the prevention of incidents recurring. Monitoring of clinical documentation failed to identify deficits in diabetic management plans that did not include instructions for blood glucose readings outside acceptable parameters. This does not support the effective management of diabetes, which is considered a high impact risk to consumers.

In its response to the Site audit report, the Approved provider indicated care planning deficits identified in the site audit report have been rectified and a review of all consumer care plans and profile pages commenced in November 2024, to ensure the accuracy of documentation. While the Approved provider submitted revised diabetic management plans for three consumers, behaviour support plans for four consumers and a revised lifestyle care plan for one consumer, results of any audits conducted to ensure the accuracy of clinical documentation were not submitted as part of the response.

It is my decision the service did not have effective systems to capture medication and behavioural incidents to identify and mitigate risks to consumers. There was insufficient monitoring and oversight of high impacts risks to consumers to identify these deficits. Processes to ensure incidents are consistently identified, recorded and escalated as required, will need time to be implemented and tested for effectiveness and sustainability. Therefore, it is my decision requirement 8(3)(d) is Not Compliant.

The service had a clinical governance framework in place to help guide staff on provision of safe care including outlining core elements of antimicrobial stewardship, restrictive practices, and open disclosure. The service had policies, procedures, and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control, and the management of infectious outbreaks. Staff understood the process of acquiring pathology results prior to the administration of antibiotics. Staff understood the importance of open disclosure, including being open, transparent, and apologising when things went wrong. Chemical restraint practices were minimised at the service through use of employing non-pharmacological strategies. Information was not included in the Approved provider’s response relating to reducing the use of environmental restraint through the assessment of consumers’ abilities to safely leave the service.

Based on the above information, and the noncompliance outcome for one requirement, this Standard is Not 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)