Performance

Report

**1800 951 822**

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| Name: | Polish Retirement Home |
| Commission ID: | 3189 |
| Address: | 3 Percival St, BAYSWATER, Victoria, 3153 |
| Activity type: | Site Audit |
| Activity date: | 13 March 2024 to 15 March 2024 |
| Performance report date: | 3 May 2024 |
| Service included in this assessment: | Provider: 294 Australian-Polish Benevolent Association of Victoria Inc  Service: 1948 Polish Retirement Home |

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 Polish Retirement Home (**the service**) has been prepared by Denise McDonald, 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 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 17 April 2024, acknowledging the findings and submitting a plan for continuous improvement.
* other information and intelligence held by the Commission relating to the performance of the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not 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 | **Not Compliant** |
| **Standard 7** Human resources | **Not 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.

* **Requirement 1(3)(e)** – The service ensures all information provided to consumers is reviewed to ensure it contains current and accurate.
* **Requirement 2(3)(a)** – The service ensures its assessment and care planning processes consider the risk of environmental and chemical restrictive practices.
* **Requirement 2(3)(c)** – The service ensures consumers, and their representatives are actively involved in ongoing care consultations to assess, plan and review the care and services provided to the consumer, including when restrictive practices are considered.
* **Requirement 2(3)(d)** – The service ensures consumers, and their representatives know what is included in the consumer’s care plan, they know they can access a copy of the consumer’s care plan and when requested, care plans are provided.
* **Requirement 3(3)(a)** – The service ensures best practice approaches to the management of restrictive practices and wounds is adopted and embedded into the provision of clinical care.
* **Requirement 3(3)(g)** – The service ensures each staff member has consistent understanding and applies standardised practices to prevent and control infection related risks to consumers, including during infectious outbreaks and staff have appropriate guidance on antimicrobial stewardship.
* **Requirement 6(3)(b)** – The service ensures consumers and representatives access to external complaints, advocacy and language services are promoted and if required consumers are supported to access these services.
* **Requirement 6(3)(c)** – The service ensures systems and processes are in place to register and respond to consumers, their representatives and others, when feedback is given or when complaints are made, the principles of open disclosure are used during resolution processes and actions taken in response are timely.
* **Requirement 6(3)(d)** – The service ensures continuous improvement processes are driven by feedback or complaints received from consumers, their representatives and others.
* **Requirement 7(3)(c)** – The service ensures systems and processes are implemented to monitor that the workforce is appropriately qualified and has demonstrated they are competent to perform their duties.
* **Requirement 7(3)(d)** – The service ensures it develops, deploys and monitors the workforce’s completion of an appropriate training program that equips staff to understand and deliver the outcomes of the Quality Standards, which include restrictive practice and antimicrobial stewardship.
* **Requirement 7(3)(e)** – The service ensures processes and procedures are implemented to assess, monitor and review the performance of each member of the workforce, including for management personnel and committee members.
* **Requirement 8(3)(b)** – The governing body ensures it is provided with sufficient information to inform their oversight of the quality of care and services provided and they understand their accountabilities in relation to the operations of the service.
* **Requirement 8(3)(c)** –The service ensures organisational systems are adopted and implemented to improve access to consistent and current information, continuous improvement processes, financial governance, feedback and complaint management, regulatory compliance and workforce governance.
* **Requirement 8(3)(d)** –The service ensures a risk management framework is adopted and implemented which provides appropriate guidance to staff of their roles and responsibilities in responding to risks and the management of incidents, including serious incidents.
* **Requirement 8(3)(e)** – The service ensures a clinical governance framework is adopted and embedded to provide guidance to staff, on but not limited to, antimicrobial stewardship and minimising the use of restrictive practices.

# 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. | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Quality Standard is assessed as non-compliant, as one of the 6 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 1(3)(e), the site audit report evidenced consumers were not provided with accurate or current information as the consumer handbook and accommodation agreement included outdated, obsolete and incorrect information.

The accommodation agreement had not been updated since 2014. Additionally, the resident handbook did not accurately advise consumers of their rights as a resident of an aged care service and directed them, if they wished to raise a complaint, to contact a service which had not been operational for 5 years.

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure accurate and updated information is provided to consumers, including reviewing both the resident handbook and the agreement. I note the residential agreement is still with solicitors for review and this action remains outstanding.

While the PCI confirms the consumer handbook has now been reviewed to ensure accurate information is provided to consumers, evidence to substantiate the closure of the action was not provided. I consider the ongoing review processes required to ensure information, is accurate and remains current, is yet to be demonstrated, given the length of time inaccurate information provided to consumers, went undetected and other planned actions are yet to be finalised.

Based on the evidence detailed above, I find Requirement 1(3)(e) non-compliant.

In relation to the remaining 5 requirements of this Quality Standard, I find them compliant, as:

Consumers, who are of predominantly Polish backgrounds, said staff treated them with dignity and respect, valued them as individuals, were familiar with their identities and what was important to them. Staff explained they showed respect to consumers by respecting their choices when providing care, particularly when consumers wished to be as independent as possible with their self-care. Care documentation evidenced consumers’ diverse backgrounds and personal care preferences.

Consumers confirmed staff were respectful of consumers’ cultural identities and provided care consistent with their preferences. Staff confirmed consumers’ cultural needs influenced the delivery of care and services to ensure it was personally and culturally safe. Care documentation evidenced consumers’ cultural backgrounds were recognised, respected and care was provided consistent with their preferences.

Consumers confirmed they were supported to be their own decision maker, had choice in how their care was delivered, who should be involved in their care and how they wanted to maintain relationships with people of importance to them. Staff explained consumers’ independence and important relationships were encouraged and supported by providing comfortable areas where they could spend time with loved ones who visited the home. Care documentation evidenced how staff supported consumers to exercise choice and maintain their independence.

Consumers confirmed they were supported to take risks. Staff gave practical examples of consumers not being checked overnight as a way in which they supported consumers to live life as they chose. Care documentation evidenced chosen risks were initially assessed, however, re-evaluation of the consumers safety when engaging with risk, had not been completed as scheduled.

Most consumers said their information was kept confidential and their privacy was respected, however, one consumer felt uncomfortable with nurse’s having to translate their intimate health details when they were reviewed by non-Polish speaking medical officers. Staff explained consumers’ privacy was respected by seeking consent prior to entering their rooms and care discussions were held in private areas. Consumers’ personal information was observed to be kept confidential in a secure electronic care management system (ECMS).

# 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. | Not 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. | Not 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. | Not 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 Quality Standard is assessed as non-compliant, as 3 of the 5 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 2(3)(a), the Site Audit report evidenced assessment and planning processes had not identified or considered the risk of inappropriate environmental or chemical restrictive practice for individual consumers. Management did not demonstrate knowledge of the number of consumers who were subject to environmental restrictive practice, despite a consultant advising them that the secured perimeter constituted a restrictive practice and therefore all consumers were restricted. Care documentation did not evidence impact of the secured perimeter on individual consumers was assessed. Policies and procedures to guide staff in assessment and care planning processes were outdated.

In relation to Requirement 2(3)(c), the site audit report evidenced consumers and their representatives were not consulted in the assessment, planning and review of care or services, particularly in relation to restrictive practices. Care documentation did not evidence consumers, their representatives or an approved health practitioner had been involved in the assessment or planning of restrictive practices as forms were unsigned. Additionally, informed consent for environmental restrictive practice to be applied had not been given, with consumers confirming they had not discussed environmental restrictive practice with staff.

In relation to Requirement 2(3)(d), the site audit report evidenced consumers, or their representatives, were not provided with copies of the consumer’s care plan. Care documentation for three named consumers did not support the outcomes of assessment and care planning had been communicated to either the consumer or their representative during routine reviews. A named consumer confirmed staff had not spoken to them regarding the care provided. Policies and procedures to guide staff on communication of information were not in place.

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure all consumers have been assessed for environmental restrictive practices, informed consent has been obtained and behaviour support planning initiated, where restrictive practice was identified. Additionally, staff are to be provided with training on restrictive practices and a suite of policies and procedures is being purchased to guide staff.

While the PCI confirms restrictive practices assessment and planning has been undertaken for all current consumers, no evidence was provided to support the closure of the action. Additionally, other actions to support the sustainability of assessment processes, ongoing consumer involvement in the assessment and planning of their care and communication of assessment and planning outcomes are still to be completed. I consider these actions will take time to embed into ongoing practice and to demonstrate their effectiveness.

Based on the evidence before me, I find Requirement 2(3)(a), Requirement 2(3)(c) and Requirement 2(3)(d), non-compliant.

In relation to the remaining 2 requirements of this Quality Standard, I find them compliant, as:

Care documentation mostly evidenced consumers’ current needs, goals and preferences, as well as advance care planning, had been captured. However, one consumer’s showering preference required updating in response to their feedback of wanting a daily shower. The ECMS provided a summary of information about consumers’ care, including their advance care plan, where it had been provided, with management confirming cultural beliefs and past trauma made this information difficult to obtain.

Staff said consumers were reviewed quarterly and through a rotating ‘resident of the day’ review process. Care documentation mostly evidenced consumers’ care and services were reviewed regularly, and in response to deterioration in their condition. However, care documentation also evidenced inconsistent clinical charting following incidents, such as a sustaining a wound. This has been considered under Requirement 3(3)(a).

# 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant, as 2 of the 7 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 3(3)(a), the site audit report evidenced best practice approaches were not adopted or implemented in the management of restrictive practices and wounds. Care documentation did not support pain monitoring processes were undertaken as described by management.

For restrictive practices, all consumers were identified to have an environmental restrictive practice applied as they were unable to exit the service, through a secured gate, without staff assistance. Care documentation did not support informed consent had been given by either the consumer or their representative. A further named consumer was identified to have a chemical restrictive practice applied, as the medication was prescribed in response to behaviours of calling out overnight. Care documentation did not support informed consent had been given and the behaviour support plan was not individualised to guide staff to understand triggers for the associated behaviour.

For three named consumers, their care documentation evidenced staff were not applying best practice wound monitoring procedures, with wound photographs being taken irregularly, when taken, wound photos were not in focus to enable accurate visualisation of the wound, wound charting was not completed as required and wound measurements were not recorded. Additionally, for a named consumer, their wound sites (skin tears) were inconsistently recorded and wounds dressing regimes were not being followed with documentation supporting the wound was not dressed or reviewed for 10 days, despite directives requiring 3rd daily dressing and review.

For the named consumer, whose care documentation did not evidence their pain was monitored for the full period described by staff as part of the pain management protocol, I consider that pain monitoring did occur for the minimum period prescribed and when no pain was detected, pain monitoring was ceased appropriately and as clinically indicated.

In relation to Requirement 3(3)(g), the site audit report evidenced staff knowledge on and application of processes to monitor for, control and prevent transmission of infection were inconsistent. Management and staff descriptions of best practice infection prevention and control processes differed in relation to screening of staff and visitors and isolation processes during an active outbreak. An antimicrobial stewardship policy or related procedures has not been developed to guide staff practice as reflected in Requirement 8(3)(e).

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to address deficiencies outlined in the Site Audit report including the review of restrictive practice and wound management. The providers response queried deficiencies in pain monitoring and I consider the evidence provided within the Site Audit report demonstrates the consumer was monitored for the minimum period required and when no pain was identified, a clinical decision was made that the full period of monitoring was not required.

While the PCI outlines some actions have been completed, no evidence was provided to support the closure of the action. Additionally, other actions to support the sustainability of best practice approaches to the management of wounds and restrictive practices are still to be completed. I consider these actions will take time to embed into ongoing practice and to demonstrate their effectiveness.

Based on the evidence before me, I find Requirement 3(3)(a) and Requirement 3(3)(g), non-compliant.

In relation to Requirement 3(3)(b), the Assessment Team recommended this requirement was not met based on poor incident management monitoring and reporting, including for serious incidents, I have considered this evidence under Requirement 8(3)(d) where it is more relevant. I consider the evidence presented within the Site Audit report on falls management satisfactory in demonstrating how high impacts risks to consumers were managed. Care documentation evidenced when a fall occurred the consumer was assessed, monitored, reviewed by allied health and medical professionals and care strategies were updated to prevent or minimise the impact of future falls. The provider in their response, gave further context on how consumer falls were managed. Based on the totality of evidence before me, I therefore find this Requirement compliant.

In relation to the remaining 5 requirements of this Quality Standard, I find them compliant, as:

Management advised a palliative care pathway was used to monitor the provision of end of life care. Care documentation, for a consumer nearing end of life, evidenced they were kept comfortable through provision of regular repositioning, comfort cares and pain management medications, as per the consumer’s wishes. Staff understood how to care for consumers nearing end of life to ensure their comfort and to meet their needs and preferences.

Staff explained when a consumer’s condition deteriorated, monitoring and clinical charting commenced, care documentation was reevaluated and the consumer may be escalated to relevant health care professionals for review or reassessment, where required. Care documentation evidenced deteriorations in consumer’s condition were identified and responded to in a timely manner.

Consumers gave positive feedback about how information was shared between staff and others involved in the consumer’s care. Staff confirmed information on consumers’ conditions, needs and preferences were documented in the ECMS, and if consumers changed preferences, care documentation, including showering lists, were updated. Staff were observed to handover information on consumers changed conditions and preferences between shifts.

Staff explained the referral process and said consumers had access to allied health professionals, such as a physiotherapist who visited weekly, to ensure their needs were met. Care documentation evidenced consumers were promptly referred for review when an incident, such as a fall, had occurred.

# 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been found Compliant, as:

Consumers said they were encouraged and supported to pursue their activities of daily living including practicing yoga and going to the shops. Staff explained consumers’ independence was promoted by tailoring activities to their needs, such as engaging volunteers to conduct Tai Chi classes. The activities calendar was observed to promote a range of activities such as exercise classes, book club, philosophy club, a Polish cultural program and a prayer group.

Consumers confirmed their emotional, psychological and spiritual needs were supported by staff. Staff said they supported consumers’ emotional needs by observing for changes in their mood or daily routines and spending one on one time with them when their mood was low. Care documentation evidenced consumers’ emotional and spiritual needs, as well as strategies on how staff could provide support.

Consumers gave practical examples of how they were supported to maintain important relationships and participate in the service and wider community, by receiving visits from family, attending external church services with friends, going out for lunch and shopping. Staff supported consumers by providing transport and accompanying them to local shops when mobility assistance was required. Consumers were observed receiving visitors, whilst others left the service independently, after staff had facilitated the release of the secured gate.

Consumers said information about their daily living needs were effectively communicated, particularly as staff understood their daily routines. Staff explained changes in consumers’ care and services were communicated during shift handovers and they accessed care documentation in the ECMS. Care documentation evidenced information was consistently recorded and shared between care and catering staff.

Consumers described, and staff confirmed referrals were made to volunteers who facilitated exercise classes and another who presented Polish movies to consumers. Care documentation did not evidence consumers had been referred to other organisations, however, no consumer expressed a need to be referred elsewhere. I have considered information regarding supporting a consumer to access advocacy services under Requirement 6(3)(b) where it is most relevant.

Consumers gave positive feedback about meals and said they were of good quality; portion sizes were suitable and staff listened to their feedback about the menu. Staff understood consumers’ individual dietary needs and preferences and explained how these were accommodated. Consumers were observed to receive meals aligned to the choices, preferences and readily ate the meals offered.

Consumers confirmed they had access to clean equipment, some of which they cleaned themselves, as per their preference. Staff said they had access to well-maintained lifestyle equipment and were responsible for cleaning consumers’ mobility aids. Equipment used for activities of daily living was observed in good condition, suitable for consumers’ use and clean.

# 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 is assessed as Compliant as 3 of the 3 Requirements have been found Compliant, as:

Consumers said the environment was easy to understand and it felt like home. Consumers’ sense of belonging was promoted by personalising their rooms, whilst their independence was supported by design features such as handrails in wide corridors, appropriate lighting, clear directional signage in Polish and English, and communal lounge areas facilitated their interaction with others. The environment was observed to be welcoming and designed to promote consumers’ sense of belonging and independence.

Consumers confirmed the environment was safe, clean, well maintained and they were supported to move freely indoors and to access internal courtyards. However, consumers were only able to access the community with assistance, as they were not able to release the gates securing the perimeter. This is further considered under Requirements 2(3)(a), 3(3)(a) and 8(3)(e). Staff said high use areas were cleaned daily and consumers’ rooms deep cleaned regularly. The environment was observed to be clean, though excess equipment and furniture was stored in communal areas and the external grounds.

Consumers confirmed equipment was clean and suitable for their use. Staff explained their roles and responsibilities for cleaning personal care equipment. Furniture and equipment were observed to be clean, and fittings were in working order.

# 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. | Not Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant, as 3 of the 4 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 6(3)(b), the site audit report evidenced access to external complaints and advocacy services were not promoted. Consumers confirmed they were unaware of how to access external complaints mechanisms or advocacy services and one named consumer, had not been supported to access these services when needed. Staff said brochures and bulletins were available or given to consumers to promote access to these services, though none were observed available during the Site Audit and the consumer handbook and accommodation agreement contained outdated, obsolete or omitted to include contact details for these services.

In relation to Requirement 6(3)(c), the site audit report evidenced ongoing complaints for one named consumer were not resolved. Complaints documentation did not evidence this ongoing complaint, or that other feedback provided by consumers through scheduled meetings, had been registered, responsive action taken, or open disclosure practiced. Staff were unable to demonstrate knowledge of open disclosure but were aware of escalation processes if they were unable to resolve complaints themselves. Staff advised when they had raised complaints, management did not respond.

In relation to Requirement 6(3)(d), the site audit report evidenced consumers feedback and complaints, were not registered, reviewed, analysed or used to improve care and services. Staff confirmed feedback was not recorded, with complaints documentation registering the latest feedback or complaint as given in December 2022. Management demonstrated awareness of 3 other complaints that had been received, however, these were not documented to inform improvement. Continuous improvement documentation did not contain any action items, derived from consumer feedback or complaints.

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure all consumers have been made aware of their ability to access advocacy and language services, implement processes to ensure all feedback and complaints are recorded, provide staff with training on open disclosure and implement processes and reports to trend and inform where improvement is needed.

While the PCI confirms some of these actions have been undertaken or completed, no evidence was submitted to support closure of the action. I consider other actions are yet to be embedded into ongoing practice and their effectiveness and sustainability over time is yet to be demonstrated.

Based on the evidence before me, I find Requirement 6(3)(b), Requirement 6(3)(c) and Requirement 6(3)(d) non-compliant.

In relation to the remaining requirement of this Quality Standard, I find it compliant, as:

Consumers said they were comfortable to provide feedback and make complaints and gave practical examples of speaking with staff directly or through the discussion groups held each morning. Staff explained consumers could provide feedback or make complaints directly to them, through surveys and during meetings. Consumers’ meeting minutes evidenced feedback and complaints were a standing agenda item and while, information displayed guided consumers to provide feedback through feedback forms, no forms were observed to be available.

# 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant, as 3 of the 5 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 7(3)(c), the site audit report evidenced the staff member performing the duties of the infection prevention and control lead does not have the required qualification. A staff member who was new, was not appropriately orientated to ensure they were competent to provide consumer’s care. Management and staff did not demonstrate consistent understanding of restrictive practices, resulting in consumers being restricted to the service environment without informed consent and complete behaviour support plans being in place. Staff did not demonstrate competence in antimicrobial stewardship.

In relation to Requirement 7(3)(d), the site audit report evidenced that staff had not been trained in elements of the Quality Standards including restrictive practices, antimicrobial stewardship and the service’s incident management systems, which is a legislated requirement. Continuous improvement documentation evidenced, due to high levels of antibiotic usage, a training need for antimicrobial stewardship was identified, however, no evidence was available to support this training had occurred. Management advised, agency staff were to be monitored by clinical staff, to ensure they complete the required training, however, no evidence of their training completion was able to be produced. I have considered the lack of evidence to support training is planned, delivered and monitored under Requirement 8(3)(c).

In relation to Requirement 7(3)(e), the site audit report evidenced documentation did not exist to support that each member of the workforce, despite management and care staff saying annual assessment occurred. While staff said their performance was assessed, there was no evidence to support those holding management positions and the members of the management committee were regularly assessed, monitored or reviewed. Care staff said they didn’t have a direct supervisor to monitor their performance informally or who they could seek on the spot education from when needed. I have considered the lack of evidence to support workforce performance is regularly, assessed, reviewed and monitored under Requirement 8(3)(c).

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure all staff have been provided with restrictive practice, antimicrobial stewardship and incident management systems training. Additionally, actions proposed aim to increase access to online training, improve training documentation including appraisal and competency registers and survey staff to understand further training needs.

While the PCI confirms some of these actions have been undertaken or completed, however further evidence to support the completion of these actions was not provided. I consider as other actions are yet to be finalised or embedded into ongoing practice, the effectiveness of and sustainability of these actions, is yet to be demonstrated.

Based on the evidence before me, I find Requirement 7(3)(c), Requirement 7(3)(d), and Requirement 7(3)(e) non-compliant.

In relation to the remaining 2 requirements of this Quality Standard, I find them compliant, as:

Most consumers gave positive feedback about staffing levels, confirming their needs were promptly met, however, others said at times staff appeared rushed and there were not enough staff to provide care to consumers who have high needs due to their diagnosis of dementia. Management explained staffing levels were determined according to consumers’ needs, and confirmed nursing and care minute targets were being met. Staff said they had enough time to complete their duties and all shifts were observed to be filled.

Consumers said staff were kind, caring, gentle and described their interactions with staff as pleasurable. Staff were familiar with consumers’ individual needs, identities and spoke about them respectfully. Staff were observed to interact with consumers in a respectful and gentle manner.

# 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. | Not 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant, as 4 of the 5 specific requirements were assessed as non-compliant. In coming to my finding, I have considered the information contained in the Site Audit report and the provider’s response submitted on 17 April 2024.

In relation to Requirement 8(3)(b), the site audit report evidenced the organisation’s committee of management (governing body) was not able to demonstrate how they met the legislated skill mix within its membership. Reports provided to the governing body were limited to the quality indicator reports, did not provide members with sufficient information to have oversight or be accountable for the quality of care or services provided. Meeting minutes did not evidence how this information was used to promote a culture of safe and quality care. Policies and procedures had been changed, revised and reviewed without evidence these changes had been ratified by the governing body, which is further considered under Requirement 8(3)(c).

In relation to Requirement 8(3)(c), the site audit report evidenced governance systems were ineffective. For information management, policies, procedures and written resources had not been systematically reviewed and were found to be out of date, contained inaccurate information and did not reflect the Quality Standards. Continuous improvement documentation evidenced when improvements were needed these were not always identified, and when identified, implementation of responsive actions were not monitored for completion and no outcomes were recorded. While management confirmed the service’s financial position was monitored, they advised there was no budgetary or expenditure approval processes implemented. Workforce governance and systems to support feedback and complaints management were ineffective and are supported by findings of non-compliance within Standard 6 and Standard 7. Systems and processes were not able to evidence regulatory compliance with changed legislative requirements in relation to restrictive practices, recent governance reforms, incident management, infection prevention and control.

In relation to Requirement 8(3)(d), the site audit report evidenced incident and risk management systems were ineffective, particularly as staff did not understand their responsibilities under the Serious Incident Response Scheme (SIRS), could not explain how they would respond to abuse and neglect of consumers and advised they had not received training in incident management, which included how to use the incident management system. Clinical incidents had not been reported to enable identification of trends or investigation of root cause to inform implementation of strategies to prevent reoccurrence.

In relation to Requirement 8(3)(e), the site audit report evidenced a clinical governance framework was unable to be produced when requested. Policies and procedures to guide staff on their roles and responsibilities in antimicrobial stewardship, restrictive practices and use of open disclosure were either not available, were inconsistent or staff were not familiar with policy or procedural requirements. Staff confirmed they had not been trained in these areas and their practices did not support the outcomes expected under the Quality Standards. Management and staff were unable to demonstrate they understood their obligations in relation to environmental restrictive practices and how a secured perimeter impacted the free movement of individual consumers.

The providers response acknowledged these findings, confirmed there were areas which required improvement and submitted a plan for continuous improvement (PCI). The PCI outlined their actions taken, commenced, and forecast, including purchasing a suite of standardised policies and procedures to implement within the service. Additional actions proposed include changes to reporting templates and monitoring systems to ensure greater oversight over staff training, performance reviews, feedback and complaints management and continuous improvement.

While the PCI confirms some of these actions have been undertaken or completed, however further evidence to support the completion of these actions was not provided. I consider as other actions are yet to be finalised or embedded into ongoing practice, the effectiveness of and sustainability of improvement actions, is yet to be demonstrated.

Based on the evidence before me, I find Requirement 8(3)(b), Requirement 8(3)(c), Requirement 8(3)(d), and Requirement 8(3)(e) non-compliant.

In relation to the Requirement 8(3)(a), I find it compliant, as:

Consumers gave positive feedback about how the service was managed and said they contributed to the operations of the service through questionnaires, speaking to staff and during consumer meetings. Management explained consumers evaluated their care and services through written and verbal means including consumer advisory body meetings. Meeting minutes evidenced consumers were engaged in providing feedback about aspects of their care, however, continuous improvement was not discussed.

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)