Riverside House

Performance Report

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**Commission ID:** 4490

**Provider name:** St Vincent’s Hospital (Melbourne) Limited

**Site Audit date:** 11 April 2022 to 14 April 2022

**Date of Performance Report:** 2 June 2022

# Performance report prepared by

Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 23 May 2022.
* other information and intelligence held by the Commission in relation to the service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

Consumers and representatives considered they were treated with dignity and respect, with their identity, culture and diversity valued. Staff were familiar with consumers’ backgrounds and described how the preferences of consumers influenced the delivery of their care. Care planning documentation identified the cultural backgrounds and needs of consumers.

Consumers and their representatives indicated the care and services provided to consumers were culturally safe. Staff demonstrated a shared understanding of consumers’ preferences, culture, values, and beliefs. The Assessment Team observed consumers engaging in religious activities held within the service.

Consumers were satisfied that they were supported to exercise choice and independence, had the ability to make their own decisions and maintain personal relationships. Staff were able to describe the various ways they support consumers to make informed choices about their care and services and maintain relationships with those people who are important to them. The Assessment Team observed consumers spending time together within the service’s communal areas.

Staff demonstrated an awareness of activities that included an element of risk to consumers and could describe the strategies in place to mitigate these risks. Consumers confirmed they were supported to take risks to enable them to live they best life they can. The Assessment Team reviewed the risk assessments for two consumers that outlined their choice to smoke.

Consumers and representatives indicated they received information that was current, accurate and timely, and communicated in a way that was clear, easy to understand and enabled them to exercise choice and control. Management advised that information and updates are provided to representatives via email correspondence, telephone calls, and informal and formal conversations. The Assessment Team observed the weekly activity schedule and menu on display within the service. Staff were able to describe the various ways they provide information to consumers regarding their care and services.

Consumers and representatives confirmed their privacy and confidentiality is respected. Staff outlined the practical ways they respect the personal privacy of consumers, such as, knocking on consumers’ doors prior to entry and closing their doors during the provision of care, this feedback was consistent with observations made by the Assessment Team. The organisation had documented policies and procedures regarding the protection of personal information.

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

Care planning documentation was individualised and included specific risks to each consumer’s health and well-being such as falls, pressure injuries, choking and lifestyle choices. Representatives felt involved and expressed satisfaction with the assessment and care planning process. Staff described how the assessment and planning process informs the delivery of safe and effective care for consumers. The Assessment Team noted a range of written materials to support staff to undertake assessment and planning.

Care planning documentation evidenced that consumers and representatives were consulted throughout assessment and care planning, including advanced care and end of life planning. Representatives confirmed that staff had discussed end of life wishes and involve them in the assessment and planning for consumers. Staff indicated they are comfortable to approach representatives to discuss end of life care where required and they ensure the directives are reviewed on a yearly basis.

Representatives indicated they were consulted throughout assessment and care planning, and when required, input is sought from external health care professionals. Care planning documentation evidenced an ongoing partnership with the consumer and others that the consumer wishes to be involved in their care. Staff outlined the care planning review process and advised there is regular communication between staff, consumers and their representatives. The Assessment team noted that directives and input from other health specialists was incorporated into consumers’ care planning documentation and into their daily care.

The Assessment noted care planning documentation to be readily available to staff delivering care and visiting health professionals. Care planning documentation was stored electronically, however a printed copy is available for consumers and representatives when requested. Representatives were aware of the information contained within care plans and felt comfortable to request a copy from staff when required. Staff outlined how changes to consumers’ care and service needs are communicated throughout the service and how the information is updated within the electronic care planning system.

Care planning documentation confirmed that care plans were reviewed on a regular basis, when consumer circumstances changed, or incidents occurred. Representatives indicated that consumers’ care and services are regularly reviewed when the consumer’s circumstances have changed or when incidents impact on the needs, goals, or preferences of the consumer. Staff were aware of their responsibilities regarding the incident reporting process, escalation of incidents and the requirement to report any change in the consumers condition, needs or preferences which may prompt a reassessment.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The service had processes in place to manage and monitor risks associated with the care of consumers. Care planning documentation outlined the key risks to consumers and the strategies in place to mitigate these risks. Staff described the main high impact and high prevalence risks for consumers and management strategies, this information was consistent with care planning documentation. The organisation had a risk management framework that guided how risks were identified, managed, and recorded by staff.

Representatives confirmed the consumer’s end-of-life wishes were discussed with them and were confident the service would support their needs and preferences. Staff demonstrated a shared understanding of their roles and responsibilities in recognising and addressing consumers nearing the end of their life. Care planning documentation included advance care planning and outlined the needs, goals and preferences of consumers.

Deterioration or changes in a consumer’s health is recognised and responded to in a timely manner, as confirmed by care planning documentation reviewed by the Assessment Team. Staff were able to describe their roles and responsibilities of how they identified and reported changes or deteriorations in consumer’s health. Management advised a consumer’s changed care needs are monitored through staff practice, shift handover, daily observations and review of clinical documentation.

Representatives expressed the consumer’s needs and preferences are effectively communicated between staff. Staff described how changes in consumers’ care and services are communicated, such as through verbal and documented handover processes, through meetings, memorandums and review of consumer care planning documentation. The Assessment Team observed a member of staff seeking an advice and feedback regarding the care of a consumer from the nurse.

Care planning documentation evidenced that timely referrals are made to medical officers, allied health therapist and hospitals, and their input is sought to inform the delivery of safe and effective care for consumers. Representatives confirmed that consumers have appropriate access to individuals, other organisations and providers of other care and services. The Assessment Team noted that information and recommendation arising from external referrals are consistently recorded within the consumer’s care planning documents.

The service had documented policies and procedures to support the minimisation of infection related risks through the implementation of infection control principles and the promotion of antimicrobial stewardship. Staff indicated they had received training on infection minimisation strategies, including hand hygiene, the use of appropriate Personal Protective Equipment (PPE) usage and outbreak management processes.

The Assessment Team found the service did not meet Requirement 3(3)(a) regarding the delivery of safe and effective care for each consumer. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint under Requirement 3(3)(a). I have provided reasons for the finding in the relevant requirement below.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team identified that the service was unable to demonstrate that each consumer received safe and effective clinical care that is best practice, tailored to their needs and optimised their health and well-being. Summarised relevant evidence included:

* Five named consumers subject to mechanical restraints, including beds placed against the wall and the use of lo-lo beds and recliner chairs, did not have the appropriate restraint documentation in place.
* All thirty consumers at the service are subject to environmental restraint and did not have the appropriate restraint documentation in place.
* Staff and management were unable to demonstrate a common understanding of restraint assessment through identification and ongoing management.
* The Assessment Team noted that for all restrictive practices used at the service there was an absence of assessment through behaviour charting and non-restrictive best practice interventions as per the services Restrictive Practices – Residential Aged Care document.
* The service was able to provide information on guidelines for pain management for Residential Aged Care. The guideline is currently under review; however, it is available for staff referral via the service’s intranet.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged that the secure environment constitutes environmental restraint and therefore should follow the same process as all other identified restrictive practices.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* The named consumers subject to mechanical restraints; the positioning of a consumer’s bed against a bedroom wall is practiced due to the small bedroom sizes in the facility and is consistent with the consumer’s preference. The positioning allows maximum free space in the room for the consumer and their possessions and for staff to provide care. The positioning of beds against the walls had not been employed to restrict movement.
* Restrictive practice usage within the service; management acknowledged that bed positioning, the use of lo-low beds, recliner chairs and key pad access to the facility may constitute a restrictive practice and a more robust process to assess and monitor will be established with the introduction of the restrictive practice policy. The policy is supported with consent, assessment, behavioural support plan forms and a checklist which support staff to undertake best practice assessments and interventions appropriate to achieving the resident’s intended goal of care.
* Pain management guidelines; the service is a part of the Victorian Public Sector Residential Aged Care Services (PSRACS) program. PSRACS provide a wide range of evidence-based resources on the management of high-risk conditions in Residential Aged Care (RAC) using Standardised Care Processes (SCPSs). Acknowledging the RAC specific Pain Management Policy is under review, management have endorsed and recommended the use of the PSRACS SCPs at the service. The pain management SCP covers comprehensive pain assessment, interventions, referral, evaluation and resident engagement processes. This will be embedded in the new personal and clinical care guidelines.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* The review of all consumer use of restrictive practice with consumer consultation.
* The endorsement and implementation of the restrictive practices policy. This will include procedure for assessment, consultation, consent, monitoring and escalation of concerns.
* Education to remaining staff on restrictive practice legislation and the service’s policy and procedures.
* Maintaining ongoing review schedule of restrictive practices against policy.
* The endorsement and implementation of personal and clinical care guidelines.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues surrounding the completion of restrictive practice assessments, at the time of the Site Audit, the service did not demonstrate that each consumer received safe and effective clinical and personal care that is best practice, tailored to their needs and optimised their health and well-being. I therefore find this requirement Non-compliant.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

Consumers and representatives felt that consumers received safe and effective services and supports for daily living that met their needs, goals and preferences and optimised their independence, health, well-being and quality of life. Care planning documentation outlined the activity preferences of consumers’ and the support required to participate in these activities. Lifestyle staff advised they monitor consumer participation in activities and use observations and feedback from the residents’ meetings to guide further activity choices.

Consumers expressed that the service provides support for daily living to promote the emotional, spiritual and psychological well-being for each consumer. Care planning documentation included information about the services in the community the consumers enjoy participating in and relationships of importance to them. The Assessment Team observed staff encouraging and assisting consumers to attend activities.

Care planning documentation included information about the interests of consumers and detailed the supports that assisted consumers to participate in their community, within and outside of the organisation's service environment, have social and personal relationships and do the things of interest to them. Staff outlined the supports provided to consumers to participate in the community and keep in contact with friends and family. The Assessment Team observed consumers interacting and engaging with each other within the service’s communal areas.

Consumers and representatives reported that information about their daily living choices and preferences was effectively communicated throughout the service, and staff understood their needs and preferences. Care planning documentation provided detailed information regarding the consumer’s needs and preferences and the strategies in place to support the delivery of safe and effective care. Staff explained how they are updated on changing conditions, needs and preferences of each consumer through handover meetings, progress notes and changes in the care plans.

Care planning documentation demonstrated the occurrence of timely and appropriate referrals to individuals, other organisations and providers of other care and services. Staff demonstrated a shared understanding of the external supports utilised by consumers and could identify the supports and external organisations available to consumers.

Consumers and representatives expressed positive feedback regarding the quality and quantity of the meals provided by the service. Care planning documentation detailed consumers’ needs, preferences, and dietary requirements. Kitchen staff advised menus are changed in collboration with consumers, chefs and dieticians and consumers are encouraged to provide their feedback. The Assessment Team observed staff assisting and encouraging consumers to eat their meals.

Consumers were observed using a variety of mobility equipment and resources that were clean and well-maintained. Consumers outlined they have access to all their equipment needs and the service is safe, clean and well maintained. Staff indicated there are processes in place for reporting and monitoring maintenance issues.

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

Consumers expressed that the service was welcoming, and consumers felt at home within the service environment and expressed positive feedback regarding the service’s outdoor areas. The Assessment Team observed some rooms to be personalised and decorated with the consumer’s belongings. Management advised there are further plans to develop the facility.

The Assessment Team observed the service to be safe, clean, well maintained and comfortable, consumers were able to move freely throughout the facility, both indoors and outdoors. Consumers expressed the communal areas as well as their rooms are clean, and furniture and equipment are well-maintained. A review of the maintenance log by the Assessment Team evidenced regular maintenance of the service environment.

Consumers and representatives were satisfied with the furniture and equipment within the service and indicated their needs are met. Staff described how equipment utilised for moving and manual handling of consumers is cleaned and maintained. The Assessment team observed consumers using a range of equipment including a variety of mobility aids.

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Consumers and representatives stated they felt encouraged and supported to provide feedback and make complaints. Staff were aware of the avenues available to consumers and representatives to provide feedback and could describe the ways they would support a consumer to lodge a complaint. The service is guided by a complaints management policy that specifies the process around the management of lodging a compliment, complaint, or suggestion.

Representatives expressed that the service takes appropriate action in response to complaints. Management demonstrated their understanding of open disclosure principles in relation to complaints and said they apologise to consumers when they express any dissatisfaction with care and services. Management advised that Open Disclosure training is being considered as mandatory and included online learning for all staff members.

The Assessment Team found the service did not meet Requirement 6(3)(b) and Requirement 6(3)(d). I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is Non-complaint under Requirement 6(3)(d) and Compliant under Requirement 6(3)(b). I have provided reasons for the finding in the relevant requirement below.

The Quality Standard is assessed as Non-compliant as one of the four specific requirements have been assessed as Non-compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

The Assessment Team identified that consumers were not made aware of, nor had access to advocates, language services and other methods for raising and resolving complaints. Summarised relevant evidence included:

* Staff and management were not able to demonstrate how consumers and their representatives are informed of advocacy and language services.
* Information about advocacy services and language services was not observed to be on open display at any location around the service.
* Representatives were aware of other avenues for raising a complaint, however they stated they were comfortable raising their concerns with management.
* The Assessment Team raised the above issues with management during the Site Audit, management contacted all consumer representatives via email to provide them with information on both advocacy and language services. In addition, management printed advocacy information and displayed it throughout the service.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* Access to advocacy services; consumer access to advocacy services is supported on a need’s basis. Consumers and representatives can access advocacy services independently or through discussion with the service’s manager. The Office of the Public Advocate Community Visitors Program undertake monthly site visits to the service to observe and interact with consumers and staff to identify any consumers and ensure consumers are treated with dignity and respect.
* Access to language services; the service’s Interpreter Services Department provides interpreter services to consumers and on request, delivers timely support and resources to residents and their representatives. Interpreter services information and resources are accessed via the intranet page and includes translated information in a broad range of languages as well as information on how to use telephone-based interpreter services. Management acknowledged information on how to access these resources was not in place at the time of the visit, however these issues were resolved when brought to the attention of the manager. Information regarding interpreter services access will be embedded in the personal and clinical care guidelines.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* Reviewing admission information provided to consumers and their representatives.
* Reviewing signage and accessibility to information resources for consumers and their representatives.
* Providing education to staff on documentation/standardised referral content to interpreter and/or advocacy services, and progress notes, and when to refer.
* The endorsement and implementation of personal and clinical care guidelines.

Whilst I acknowledge that the Assessment Team identified that staff and management were unable to demonstrate how consumers and representatives were informed of advocates, language services and other methods of resolving complaints. On the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate overall Non-compliance. In addition, the service has provided a satisfactory explanation as to the issues identified by the Assessment Team. Therefore, I find the service Compliant with this requirement.

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team identified that feedback and complaints were not effectively reviewed and used to improve the quality of care and services. Summarised relevant evidence included:

* Complaints and feedback received through verbal channels were not always documented or recorded as per the service’s documented procedures.
* Quality improvement actions taken by the service in response to feedback and complaints are not documented, nor did the continuous improvement register reflect different avenues of feedback and complaint received from consumers.
* The Assessment Team’s review of the service’s continuous improvement register outlined that it did not contain information about how complaints are resolved, the actions taken to improve outcomes and how the service aimed to prevent a recurrence of the identified issues. In addition, the register did not reflect different avenues of feedback and complaints provided by consumers.
* Management acknowledged that the consumer and representative meetings had not been held since November 2021.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged that complaints and feedback provided verbally is not captured or evaluated within the service’s continuous improvement system and further acknowledged the continuous improvement register was lacking consumer input.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* Feedback management; all feedback received is expected to be captured in the service’s organisation-wide incident and feedback system, *RiskMan*, in addition staff will undergo training on how to complete this. Management acknowledged there is an opportunity to improve capturing feedback and this will also be added as an agenda item in the resident and representative meetings.
* Consumer and representative meetings; the consumer and representative meetings was held every month for 2021, excluding December, due to resident-based activities and Christmas visits resuming post COVID-19 lockdowns. Management acknowledged alternative means needs to be in place to support residents and their representatives to provide feedback when regular channels are not available.
* Monitoring feedback trends; an audit results matrix will be introduced to aid the monitoring of performance trends and actions required in response to resident feedback. A continuous improvement planning board will be set up to outline work that has been planned, in progress or undertaken.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* Reinstating the monthly resident and representative meeting with a standard operating procedure to support consumers and their representatives to communicate their feedback.
* Implementing an audit matrix to monitor performance trends and trigger continuous improvement actions.
* Implementing continuous improvement planning board to outline any continuous improvement work that has been planned, in progress or undertaken.
* Expanding staff training for capturing all feedback within the service’s incident and feedback management system.

I have considered the information presented by the Assessment Team and the Approved Provider. Whilst I acknowledge the actions taken by the Approved Provider to address the issues with the way feedback and complaints are reviewed and used to improve the quality of care services. At the time of the Site Audit, the service did not demonstrate that complaints were consistently documented and used to improve the quality of care and services. I therefore find this requirement Non-compliant.

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

Consumers and representatives were satisfied the workforce was planned to enable the delivery and management of safe and quality care and services. Staff advised that they are comfortable with the rostering and do not feel under pressure when a team member is missing and their position unable to be filled. A review of call bell data by the Assessment team indicated the average call bell response time was one minute and four seconds across the service. Rosters inspected by the Assessment Team confirmed planned and unplanned leave is filled for staff.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful manner. Consumers confirmed staff are kind and respectful when providing care services. The Assessment Team noted the service had a code of conduct form that had been signed by all reviewed staff.

Consumers and representatives are satisfied staff are competent and are knowledgeable. Management advised they monitor staff practices and speak to consumers in relation to any issues raised through feedback or observations. Staff are required to hold minimum qualifications for each position in the service and this is outlined in position descriptions.

The Assessment Team found the service did not meet Requirement 7(3)(d) regarding workforce being recruited, trained, equipped and supported to deliver the outcomes required by these standards, and Requirement 7(3)(e) regarding the regular assessment, monitoring and review of the performance of each member of the workforce. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response, and found the service is compliant under both requirements. I have provided reasons for the findings in the relevant requirements below.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team identified that the service was unable to demonstrate that the workforce is recruited, trained, equipped and support to deliver the outcomes required by these standards. Summarised relevant evidence included:

* The Assessment Team observed training records that confirm the completion of mandatory and additional training by staff, although a training plan or system for monitoring training organised directly from the unit, with a focus training already completed and on future training needs, is not in place.
* A monitoring system that provides evidence of each Unit’s in-house training status and prompts a review of training requirements was not identified to be in place.
* The Assessment Team raised the above issues with management during the Site Audit, management acknowledged there is no monitoring system in place to prompt training and indicated they will address this issue in the near future.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* The monitoring system for training requirements; the service’s Required Learning Policy outlines the approach to learning and development across all clinical disciplines. The service had defined the required training for each staff group and training is delivered via the *Workday* training program. Once courses are successfully completed, this is recorded in the *MyTraining* system which is accessible by managers and they can generate reports which outline the training completion records for their direct line staff. Moreover, in-service training is captured at a local level using attendance lists or read and sign memos. Maintenance of evidence of attendance training delivered externally is the responsibility of the individual.
* The monitoring of mandatory training; training is further monitored through the service’s weekly ‘huddle’ whereby a *MyTraining* completion report is displayed. The service acknowledged the weekly practice of huddling is in transition at the service and identify there is an opportunity to improve the visibility of training completed by reporting to the monthly Residential Aged Care Clinical Quality Safety Committee (RAC CQSC) meetings.
* Assessing training needs; the performance of the service against key clinical performance indicators is another process in place to identify education requirements of staff. The service have a range of Clinical Risk Committees that monitor the key clinical performance indicators. Identified underperformance can result in additional training for staff.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* Providing education to all staff on antimicrobial stewardship, restrictive practices, open disclosure, Serious Incident Response Scheme and elder abuse, and including these topics within the annual mandatory training.
* Implementing service policy and procedures regarding the topics listed above.
* Reviewing mechanisms for recording education, external to service’s training delivery program, *Workday*, for ease of training and monitoring for follow up.

I acknowledge the additional information and evidence provided by the Approved Provider to demonstrate how the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. On the balance of all evidence brought forward by the Assessment Team, these examples were insufficient to indicate overall Non-compliance. In addition, the service has provided a satisfactory explanation as to the issues identified by the Assessment Team. Therefore, I find the service Compliant with this requirement.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The Assessment Team identified that the service was unable to demonstrate the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

* Management indicated that, although the current staff performance appraisal system flags to management when staff have received their appraisal there is no monitoring system to follow up on the status of appraisals.
* Several staff members were unclear when they were due for a performance appraisal
* A review of staff files did not evidence an analysis of training needs is identified following staff appraisals.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* The monitoring of performance appraisals; managers can monitor the performance appraisals of their direct line staff, and staff can access their own information and performance review through *Workday.*
* The occurrence of performance reviews; the performance review and plan process are undertaken annually. The process includes identification of goals for the upcoming year as well as the resources and support required to achieve these goals. The service’s performance review and plan process are supported by an organisation wide policy and manager and staff toolkits.
* Identified underperformance; the service’s code of conduct describes the mission and values of the organisation and outlines the expectations on how staff should act, treat each other and conduct themselves. Underperformance or non-compliance with this code is addressed by the manager as soon as practical.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* Monitoring and tracking performance review and plan status at monthly meetings.
* Supporting managers with education and training so they can access performance reviews and plans through *Workday*.
* Reviewing mechanisms for recording education, external to *Workday*, for ease of training and monitoring for follow up.

Whilst I acknowledge the evidence brought forward by the Assessment Team in relation to the assessment of staff performance. I am of the view that these examples were insufficient to indicate overall Non-compliance. In addition, the service has provided a satisfactory explanation as to the issues identified by the Assessment Team. Therefore, I find the service Compliant with this requirement.

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Consumers and representatives were encouraged to be involved in the development, delivery and evaluation of care and services. A named consumer confirmed their involvement within the residents’ meetings and noted they can freely discuss ideas for service improvement. However, the Assessment Team noted a residents’ meeting had not taken place since November 2021. In discussing this issue with management, a new calendar of meetings had since been completed, indicating that the residents’ meeting will start again from April 2022.

The organisation’s governing body promoted a culture of safe, inclusive and quality care and services and took accountability for their delivery through a range of central policies and procedures. Management and staff spoke of a culture within the organisation that provides safe, inclusive quality care. The Assessment Team observed a variety of organisation policies, procedures, work instructions and documents that support and guide management and staff to provide a safe and inclusive culture for consumers and stakeholders.

There were organisation wide governance systems to support effective information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaint management.

The organisation provided a documented risk management framework, including policies describing how to manage high impact or high prevalence risks, identifying and responding to consumer abuse and neglect, supporting consumers to live the best life they can and how to manage and prevent incidents. Staff confirmed they had been educated on these policies and could provide practical examples of their relevance to their work and responsibilities. Management described a culture of transparency with consumers and relatives. They stated that all incidents are reported to relatives and an apology is given where appropriate and methods to avoid further incidents are implemented.

The Assessment Team found the service did not meet Requirement 8(3)(e), regarding the service’s clinical governance framework. I have considered the evidence brought forward by the Site Audit Report and the Approved Provider’s response and found the service complaint. I have provided reasons for the finding in the requirement below.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

The Assessment Team identified that the service was unable to demonstrate their antimicrobial stewardship clinical governance framework. Summarised relevant evidence included:

* The Assessment Team noted that a document regarding antimicrobial resistance, applicable to the service’s hospital stream was not available to those at the service for practice guidance.
* The service was not able to demonstrate regular Medication Advisory Committee (MAC) meetings. Management acknowledged this, and advised the last MAC meeting was in 2018. Management advised the MAC Meeting agenda had been created and the next meeting is due to take place at the end of April 2022. The Assessment Team sighted the agenda for the proposed meeting.
* The Restrictive Practices – Residential Aged Care document is currently pending endorsement, however, is active for staff reference on the service’s intranet.
* Management advised that open disclosure training is being considered as mandatory and included in online learning for all residential aged care staff.
* The service was not able to demonstrate antimicrobial stewardship as a long-standing agenda item in either the Clinical Governance or Quality Risk and Safety sub-committees. Management acknowledged that antimicrobial stewardship should be included and will work to incorporate these into the agendas.

The Approved Provider’s written response, received 23 May 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider had outlined that in relation to:

* The antimicrobial resistance policy: this policy is in the final review process before being endorsed by the service’s MAC and Medication Safety Clinical Review Committee.
* The occurrence of MAC meetings; these meetings were paused in 2021, and commencing in early 2022 the service’s leadership team reviewed the membership and Terms of Reference and reinstated the meetings. The first meeting, following the recommencement, was held on 21 April 2022.
* The use of restrictive practices; The RAC restrictive practices policy has been developed and is pending final endorsement and publication by the service’s Clinical Policy Review Committee. Management is confident that the publication and communication of this policy will result in full compliance with restrictive practice legislative requirements.
* Open disclosure training; open disclosure education has been part of the services mandatory training for many years and is mandatory for all managers and associate nurse unit managers. The service acknowledged the benefit of expanding this training to all staff.

The Approved Provider further outlined the actions taken and prospective actions within their continuous improvement plan, these include:

* The endorsement and implementation of an antimicrobial stewardship policy, including education for staff.
* The implementation of audit procedures that ensure ongoing sustainability.
* Reinstating Medication Advisory Committee meetings.
* The endorsement and implementation of a restrictive practices policy.
* Including and implementing antimicrobial stewardship, restrictive practices and open disclosure topics to orientation and annual mandatory training.
* Adding antimicrobial stewardship as a standing agenda item to weekly staff huddles and monthly RAC CQSC meetings.

Whilst I acknowledge the service has demonstrated discrepancies with their clinical governance framework, these examples alone were insufficient to indicate significant deficits in the overall efficacy of the service’s governance framework. Therefore, I find the service Compliant with this requirement.

# Areas for improvement

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

* Requirement 3(3)(a) – The service ensures that each consumer gets safe and effective care that is best practice, is tailored to their needs, and optimises their health and well-being.
* Requirement 6(3)(d) – The service ensures feedback and complaints are reviewed and used to improve the quality of care and services.