Performance

Report

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| Name of service: | Russian Relief Association of St Sergius of Radonezh |
| Service address: | 1 Gilbert Street CABRAMATTA NSW 2166 |
| Commission ID: | 2819 |
| Approved provider: | Russian Relief Association of St Sergius of Radonezh |
| Activity type: | Site Audit |
| Activity date: | 28 March 2023 to 30 March 2023 |
| Performance report date: | 8 May 2023 |

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

**This performance report**

This performance report for Russian Relief Association of St Sergius of Radonezh (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment conducted 28 March 2023 to 30 March 2023 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 18 April 2023
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances dated 27 January 2023, 11 July 2022, 24 January 2022.

**Assessment summary**

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

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

**Areas for improvement**

There were some gaps identified within the report where ongoing continuous improvement is required. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

**Standard 1**

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

**Findings**

The Quality Standard assessed as Compliant as six of the six requirements have been found to be Compliant.

The Assessment Team found the service demonstrates their staff treat each consumer with dignity and respect throughout their interactions. Most consumers and representatives said consumers are treated with dignity and respect and that their identity, culture, and diversity are valued as individuals. Consumers feedback to the Assessment Team included that they are very happy at the service and the staff are lovely and the care received is good.

The Assessment Team observed staff interactions with consumers to be respectful and caring. Staff interviewed demonstrated they are familiar with sampled consumer’s backgrounds and preferences that influence the day-to-day delivery of their care.

Care planning documents reviewed reflect the diversity of consumers at the service and included information on their backgrounds including previous occupations, spiritual observances, details of family members and things of interest to them.

The Assessment Team identified the service provides culturally safe care and services. While consumers of the service are largely of the Russian and Serbian Orthodox backgrounds, the service has policies welcoming and supporting diversity in place. Information about consumers’ life history including their cultural needs is captured as part of the care planning documentation. All consumers interviewed did not raise any concerns about the service meeting their cultural needs. Staff are aware of and deliver care and services in ways that consider consumers’ preferences and needs in relation to their cultural needs. Consumer care plans include consumer’s preferred names and details about their background including where they were born and what languages they prefer to communicate in. Staff interviewed were aware of consumer’s details about their background.

The Assessment Team found that consumers are supported to make choices and have independence in how their care is delivered to them and when family members are involved in their care needs. Consumers are able to maintain relationships of their choice and make connections with others that are important to them.

The Assessment Team interviewed consumers and representatives who said that were able to have choices in when they receive their shower and how often and the gender of the staff providing care. The Assessment Team observed consumers being supported to maintain relationships with other consumers.

The service supports consumers to take risks to enable them to live the best life they can. Staff could describe the consumers who chose to take risks and how they are supported to understand the benefits and possible harm when they make decisions which is consistent with the services risk-taking policy. The Assessment Team observed a signed dignity of risk form for a consumer who wished to exercise risk.

Most consumers and their representatives expressed satisfaction that the information they receive is current, accurate, timely, communicated clearly, and is easy to understand and enables consumers to exercise choice. The service notice boards in the communal and dining areas were observed to communicate menu options, current activities program and internal feedback forms.

The Assessment Team observed the quarterly newsletters are printed in English, Serbian and Russian. Consumer and resident meetings are held, and consumers and their representatives are informed of updates at the service, for example, current building works about newly renovated areas at the service. Menu options are updated daily and displayed in dining areas. Activity schedules are printed in three languages and provided to consumers in either Russian, Serbian or English. They are also written up on white boards near activity areas in English for each day.

The service has processes which are followed by staff to ensure that consumers’ privacy is respected, and their personal information is kept confidential which is underpinned by the services privacy policy.

The Assessment Team spoke with staff who were able to describe methods on how they respect consumer’s privacy, including each staff member having their own personal login for the electronic care management system and conducting shift handover in the nurse’s station. Staff said that prior to entering a consumers’ room to provide personal or clinical care they knock before entering, wait for a response to enter and close the door behind them ensuring privacy is maintained. The Assessment Team observed this in practice throughout the Site Audit.

Eight consumers and their representatives interviewed; said they had no concerns with how the service manages their how their privacy is respected. Consumers overall were happy with their privacy being respected.

**Standard 2**

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

**Findings**

The Quality Standard assessed as Compliant as five of the five requirements have been found to be Compliant.

The Assessment Team interviewed consumers and their representatives who expressed satisfaction with the assessment and care planning process at the service. The service advised each consumer has their care needs assessed on entry to the service by the registered nurse. The service uses a suite of assessments that include risk assessments. Documentation indicated risks are generally identified as part of the assessment and care planning process to inform the delivery of safe and effective care and services. However, incident reviews do not consistently identify ongoing assessment of risk mitigation strategies, and this has been addressed within Standard 3. Documentation indicates the service has policies and processes in place that guides assessment and planning for consumer care and consumers at risk. The clinical manager has oversight, in conjunction with the director of care, for the assessment and planning of the care for each consumer at the service.

The Assessment Team reviewed consumer files which demonstrated that assessment and planning reflect consumers’ goals and preferences. Advance care directives and/or end of life discussion outcomes are in place for several consumers. The management team advised end of life and advance care planning is discussed with consumers and/or representatives at admission and/or care conferences/reviews, and documentation supported this process.

The Assessment Team found that overall, the service demonstrates they have a partnership with consumers and representatives in the assessment and planning of consumer care. Documentation reviewed indicated assessment and planning included other organisations, individuals and providers of care and services that are involved in the care of the consumer. Consent is obtained from the consumer to make referrals to other health providers who provide specialist care where the service itself has been unable to meet the need or preference of the consumer. Consumers and representatives indicated satisfaction with the ongoing partnerships with others involved in the consumers’ care.

The Assessment Team interviewed consumers and representatives who indicated they are well informed about the outcomes of assessment for their clinical and personal care and had no complaints in relation to this requirement. Some consumer representatives had difficulty recalling seeing the consumer’s care plan and if assessments had occurred and said this was not an issue as the service communicated effectively. Some consumer representatives indicated they had been offered a copy of the care plan. However, most consumers and representatives sampled know care plans are readily available and indicated their care is discussed with them regularly and they do not require a copy.

Consumer representatives interviewed said case conferences occur with staff and care and services are discussed. Management advised care plan reviews occur with consumers and representatives every 3 months and case conferences are completed yearly after the initial interim care planning process. A consumer’s care plan is evaluated and at this time and the care and services for consumers are formally discussed. Management advised there is ongoing discussions regarding the outcomes of assessment and planning when consumer needs change or there are changes in the consumers care and services. Staff also reported a daily handover process prior to commencing their shifts to communicate any consumer care changes and needs.

The service regularly reviews the care and services they provide to consumers. The care and services plans are evaluated every 3 months for effectiveness and updated when there is a change in consumer condition. Sampled consumer care planning documents show adjustments are made to care planning documentation including reviewing consumer needs goals and preferences after there are changes in consumer condition or following consumer incidents.

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

**Findings**

The Quality Standard assessed as Compliant as seven of the seven requirements have been found to be Compliant.

The Assessment Team interviewed consumers and representatives who overall indicated satisfaction with the management of risks associated with the care of consumers. The service demonstrated high impact and high prevalence risks are overall effectively managed through clinical governance systems and procedures to identify and manage risk. Management and staff were able to describe the high impact and high prevalence risks for consumers at the service. The service overall demonstrated effective management of those risks. Risks were updated in care planning documents, and planned interventions to minimise risk were implemented.

Management said they monitor key clinical indicators related to incidents, including behaviour, falls, infection, medication management, pressure injuries and other skin injuries/conditions. Data is reviewed by the director of care and the management team on a regular basis.

For the consumers sampled who are nearing the end of their lives, documentation indicates the consumers’ care needs and preferences have been identified by staff. Their wishes and directives (advance care/end of life/case conference) has been incorporated into the consumer’s care plan and associated documents. The service ensures a substitute decision-maker is identified and documented. Consultation occurs with consumers and representatives when referral to palliative care is required or when a consumer commences on a palliative pathway and or is nearing end stage/end of life.

The service demonstrated consumers who have experienced a deterioration or change in their cognition, condition, function and/or mental health have their needs recognised and responded to in a timely manner. The registered nurses liaise with the clinical manager and the consumer’s medical officer when a consumer’s care deteriorates. Communication and consultation with the consumer and their representative occur. For consumers sampled, their care planning documents and/or progress notes reflect the identification of, and response to deterioration or changes in function/capacity/condition.

The service communicates the consumer's condition, needs and preferences within the organisation and with others where responsibility for care is shared using the electronic care program, referral system, emails and verbal and written handover communication. All consumers have comprehensive care plans in place. Consumers’ needs, and preferences are documented on admission, reviewed at case/care reviews and whenever it is raised by consumers and their representatives.

The Assessment Team identified that the service has a comprehensive verbal handover between shifts and outstanding matters are followed up by staff. Daily tasks are highlighted in the electronic care program and monitored by the clinical manager. Appointments and special requirements for consumers are documented, so all responsible for the care of the consumer are aware. The Assessment Team identified some inconsistencies in information regarding wound documentation, restrictive practices, and communication of BGLs to medical officers when they are outside the consumers’ diabetic management directives. However, this has been assessed and considered in Standard 3 Requirement (3)(a).

For the consumers sampled, care planning documents evidenced the input of others such as allied health professionals and specialists. Referrals were made when required, for example, there was evidence of referrals to a speech pathologist, dietician, nurse practitioner, wound specialist/clinic and geriatrician. The input from specialists and allied health professionals is generally documented in the consumers’ clinical file.

The Assessment Team found that requirement 3(3)(a) and 3(3)(g) were Non-compliant, I have considered the information from the Assessment Team and the actions that the provider has taken to address this Non-compliance.

The Assessment Team found that the service was not able to demonstrate sampled consumers consistently receive safe and effective personal or clinical care that is considered best practice, tailored to individual needs, and optimises their health and well-being. The Assessment Team identified deficiencies in the use of restrictive practices in relation to psychotropic medications, incident review and wound management.

The service did not demonstrate they have considered psychotropic medications are potentially a chemical restraint particularly in circumstances where a consumer has multiple conditions such as a mental health disorder, combined with dementia.

The service has policies and protocols in place to guide staff on the safe use of psychotropic medications. The service’s protocols highlight the increased risk of potential side effects when psychotropic medications are used and guides staff on the importance of the need for clear documentation to demonstrate the medication is not being used as a chemical restraint. However, documentation does not support that staff are following the service’s protocols. There is no clear reasoning, supporting documentation or clinical criteria used to satisfactorily conclude the medication is not being used as a chemical restraint. The service's psychotropic self-assessment tool contained outdated consumer information and also indicated there are no consumers identified as having chemical restrictive practices in place.

The Assessment Team discussed with management the gaps in the psychotropic medications register and lack of documentation to demonstrate the service is considering psychotropic medications could be a form of chemical restraint. Management acknowledged the feedback provided. Management advised they would address the gaps identified in the psychotropic medication management and included the following in the service’s Plan for Continuous Improvement. This would involve staff training with their pharmacist and external pharmacy consultants on restrictive practices to improve staff knowledge of medicines classified as chemical restraint. Internal training on restrictive practices to be able to recognise the classification of restrictive practices, recognise when medications are used as a chemical restraint and outline monitoring requirements after chemical restraint is used and update the psychotropic medication self-assessment tool to accurately record consumers receiving psychotropic medications and involve external medical specialist in medication reviews.

The Assessment Team reviewed documentation that indicated wound care is not consistently in line with the service’s policy. A review of care documentation indicated wound dimensions, stages of healing and appearance, together with wound evaluation is not consistently identified and/or documented. The policy states the registered nurses are to undertake and report measurement of all open wounds, length and width at every dressing change using a disposable paper ruler. Documentation did not indicate this was occurring for consumers sampled and there are potential risks associated with deficiencies in wound evaluation, (especially pressure injuries or leg ulcers) such as wound deterioration which could impact on consumer limbs.

The Assessment Team also identified that documentation reviewed did not consistently indicate staff are following medical officer’s directions to be notified when consumer’s blood glucose levels are outside set parameters.

While incident investigation and reviews are completed, they are not always identifying contributing factors to the development of the wound/pressure injury or identifying risk mitigation strategies.

The Assessment Team found that the service did not demonstrate precautionary infection control processes were in place to minimise infection related risks. The service had a COVID-19 outbreak in one wing of the service with 2 consumers positive on commencement of the Site Audit. Staff did not demonstrate an understanding of how they minimise the spread of infection. However, staff demonstrated an understanding of how they minimise the use of antibiotics and ensuring they are used appropriately.

The Assessment Team observed during the Site Audit, there were not clearly identified donning and doffing stations outside the affected wing. Visitors and staff were using the red zone as a thoroughfare to get to where they needed to go as there were building works going on in other parts of the service. When this was followed up by management, they advised the donning and doffing stations were outside the affected consumer’s rooms and the area was used as a thoroughfare as there were building works going on in other areas of the service that could not be accessed. A delay in isolating a consumer with Covid-19 was also observed by the Assessment Team with the consumer’s room door open with consumers being served lunch, and no communication signage or donning and doffing stations were observed. This issue was raised with management. Management acknowledged the gap in infection control protocols and advised signage, PPE and donning and doffing stations would be implemented immediately, and consumers representatives and PHU would be notified.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement and evidence to support their compliance with these requirements including updated medication charts, behaviour assessments, anti-psychotic medication assessment, consents and evidence of education provided to staff. Education was provided to management and registered nurses on identification of causal factors in incident management and evaluation of recommendations for risk mitigation. The issues identified with infection control were addressed within the Plan for Continuous Improvement and included additional individual education, reassessment of staff competency and observation of demonstrated compliance, non-compliance will also be added to the Outbreak Management Plan and performance improvement will be monitored.

I have considered the providers response and the evidence of the actions that have been taken in response to the gaps identified during the Site Audit. I am satisfied that the provider is taking actions to effectively address these deficiencies with their compliance.

I find that the approved provider is Compliant with Requirements 3(3)(a) and 3(3)(g).**Standard 4**

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

**Findings**

The Quality Standard assessed as Compliant as seven of the seven requirements have been found to be Compliant.

The Assessment Team found the service provides consumers with services to support their daily living such as laundry service and clothes steaming service that is done onsite. Consumers interviewed are happy with the service provided. The service had a Russian speaking hairdresser, and it was requested by consumers to have a hairdresser that spoke in Serbian. The service now has a hairdresser who speaks Serbian. It was observed throughout the Site Audit consumers waiting outside of the hairdressers to have their hair done.

The service has two religious’ priests (Russian and Serbian Orthodox) who visit weekly to provide religious services. The service also supports consumers of different spiritual needs. Staff were aware of two consumers who have lost close relatives who emotionally struggle with the loss. The staff were able to provide examples of how they support these consumers with emotional support around the anniversaries and when they require not to be disturbed.

Consumers are supported to participate in outside organisations where they are able to maintain social and personal relationships. Within the service consumers are able to participate in activities which are of interest to them in group settings or if they chose to do things of interest to them alone. The Assessment Team identified thar there are activities available within the service for consumers to participate in.

The service demonstrated the use of their electronic systems to ensure that information on the consumer’s condition, needs and preferences is communicated effectively. This included in relation to the communication of consumers’ spiritual, emotional and lifestyle needs. Review of consumer documentation demonstrated the conditions, needs and preferences are recorded in detail and staff were familiar with information.

The Assessment Team found the service demonstrated they provide timely and appropriate referrals to meeting the needs of individuals through other organisations or providers or individuals to support the diverse needs of consumers. The lifestyle coordinator said they assist and arrange for consumer’s to be provided with one-on-one time with the priest from the Orthodox church upon request.

Consumer’s meals are cooked in-house by an external contractor who works closely with the service to meet the needs of the consumers dietary requirements and to ensure the meals are of suitable quality and quantity. This is achieved by offering 2 options for lunch and dinner with salads or sandwiches available on request. Consumers have access to additional nutritional supplements as requested or required and were positive in relation to their feedback about the food. The service conducts food surveys along with their external contractor. Currently they have not been running food focus groups and the catering contractor discuss meal options with management. The meals are based on previous requests. It was demonstrated the service is seeking feedback from consumers via surveys conducted by the catering contractor.

The Assessment Team observed all equipment for daily living was safe, clean, and well maintained. Staff were interviewed on maintaining and keeping equipment clean.One staff member said if equipment is shared, they should be wiped down between use. Any equipment they notice is damaged they have damaged and out of order labels in the nurse’s station and log a maintenance request to have it rectified.

Lifestyle equipment has been laminated where possible to ensure ease of cleaning. The service has a cleaning schedule for the soft toys used by consumers. The toys are sent to the laundry for a deep 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**

The Quality Standard assessed as Compliant as three of the three requirements have been found to be Compliant.

The Assessment Team observed the service environment to be welcoming and comfortable. Consumers said there is adequate private areas, both indoors and outdoors for consumers and visitors to utilise when socialising. Consumers were able to decorate and fit out their room with their personal belongings. Consumers names and some consumer photos were located next to their room doors. There are large living areas for consumers to use which can facilitate large group activities. There are several outdoor areas where consumers and representatives are able to enjoy. Centrally located within the service is a doctor’s room, allied health room and a salon available for consumer to make bookings.

The service has an electronic maintenance system for staff to lodge service requests. Staff are aware of the process in how to lodge a request for work to be completed. Preventative maintenance is managed through a spreadsheet, and while work being completed is not always recorded as completed, the maintenance manager was able to provide supporting documents of the work completed.

Cleaners were observed cleaning consumers rooms and common areas. Some consumers interviewed expressed satisfaction with the cleaning and maintenance systems at the service. Consumers were able to move throughout the facility both indoors and outdoors except for an area which was currently in lockdown under Public Health directives due to a COVID-19 outbreak. Consumers enjoy the gardens in the service and the Assessment Team observed staff and consumers utilise the outdoor areas.

Consumers are able to access different areas of the service using swipe card access or with assistance from a staff member, this was observed by the Assessment Team during the Site Audit. The Assessment Team observed numerous consumers doors with locks on them. The doors were able to be locked from the inside and required a key to be opened from the outside.

The Assessment Team observed the furniture, fittings and equipment to be safe, clean, well maintained and suitable for consumers. Consumers interviewed were satisfied with the furniture, fittings and equipment. Management and staff demonstrated effective systems are in place for cleaning and regular maintenance of furniture, fittings, and equipment.

Furniture in communal areas were observed to be clean, in good condition, oxygen cylinders are kept securely when not in use and regularly inspected. Equipment including walkers are well maintained, clean and safe for consumers. Consumers said they felt their equipment was suitable for their needs.

**Standard 6**

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

**Findings**

The Quality Standard assessed as Compliant as four of the four requirements have been found to be Compliant.

The Assessment Team found the service demonstrated consumers and their representatives are encouraged and supported to provide feedback and make complaints. There are processes for complaints to be made internally and externally. Staff were able to describe complaints processes and how they can assist consumers to provide feedback. Internal processes to provide feedback and complaints include feedback forms, a secure mailbox at the service for anonymous complaints, consumer meetings and verbal communication to staff, management, or the board members when they visit the service.

The Assessment Team interviewed consumers and their representatives who said they are aware of advocacy and language services that are available to them and referenced the promotional material displayed at the service. Most consumers and representatives interviewed advised they preferred to raise their concerns directly with staff and/or management and these were addressed. Management reported that they did not currently have any consumers who required any advocacy or interpreter services.

The Assessment Team observed brochures and posters displayed around the service and in the services handbook which provide information on external complaints agencies, advocates, and language services.

The service’s feedback and complaints policy include a section explaining open disclosure. Staff interviewed were able to explain how they applied open disclosure should they receive feedback or a complaint. Most sampled consumers and representatives said they had no need to make formal complaints as the service addressed any concerns they had in a timely manner and acknowledged when there was an issue and provided an apology.

The Assessment Team reviewed the service’s complaints and compliments register that showed that feedback, compliments, and complaints have been managed in accordance with the service’s feedback and complaints policy which included the use of open disclosure.

The service demonstrated feedback and complaints are reviewed and used to improve the quality of consumer care and services. Staff confirmed the service has an effective quality system and feedback is used to identify improvements. The service has a plan for continuous improvement which is used to log improvement actions from different sources including complaints and feedback. Management and staff described the processes in place to escalate complaints, staff were able to describe improvements, which were driven by consumer feedback.

**Standard 7**

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

The Quality Standard assessed as Compliant as five of the five requirements have been found to be Compliant.

The Assessment Team found that the service effectively demonstrates that the workforce is planned to enable, the delivery and management of safe and quality care and services. The number and skills mix of staff is maintained and managed effectively. Consumers said their needs are met in a timely manner and staff said they can complete their workloads during their rostered shift.

Whilst the service has recently experienced some vacant shifts required to be filled by permanent staff doing double shifts or by casual staff when staff are sick or on extended leave, overall, the workforce was found to work together to ensure the delivery of care was safe for consumers and needs were met. The service was able to demonstrate staffing allocations adequately meet consumer needs and ensure the delivery of safe and quality care and services.

The Assessment Team interviewed consumers and representatives who felt they were very well cared for by the staff and had no complaints about the care they receive. Some consumers acknowledged that staff are busy at times but indicated they felt they were very well cared for. Consumers and their representatives interviewed confirmed that staff attend to consumer needs in a timely manner, and those consumers usually do not wait long to have their call bells answered.

Management confirmed that call bells are reviewed regularly and investigated if required. Management stated that call bell response times average between 5-10 minutes. This was corroborated by a review of call bell reports and documented evidence of investigations and follow up with staff by management, if call bells were not answered within the services call bell response time policies. Management have recently completed recruitment processes and are in the process of onboarding 2 registered nurses and one registered nurse will commence in April/May 2023.

Most consumers and their representatives interviewed said staff are kind and caring. However, one consumer and a representative said particular staff speak loud and rudely at times and one consumer said a night duty nurse will often leave their call bell out of reach. These issues were raised with management, the director of care manager said the service would investigate the matter further with the consumer and the alleged staff involved.

The service was noted to have a staff culture of inclusiveness and advocacy for consumers. Staff respect for all consumers identity, culture and diversity was apparent. The Assessment Team observed staff assisting consumers with their meals exercising patience, assisting consumers moving through the service and speaking to consumers in a kind and caring manner.

Feedback from consumers and their representatives identified that they felt the workforce is competent and that staff have the knowledge to deliver care and services that meet the needs and preferences of consumers. Management said staff competencies are monitored on an annual basis and are determined depending on the staff member’s role. Management said staff can be required to undertake a competency test earlier than planned if performance issues are identified or upon staff requests.

All consumers sampled expressed satisfaction with the skills of the staff, no concerns were raised in relation to the competency or knowledge of staff to effectively perform their role.

The Assessment Team noted that each staff role had specific competencies and training involved, and agency staff also complete an induction and orientation training before commencement at the service (however, currently not requiring the use of agency staff at the service). Management advised the service monitor staff competencies and ensure staff are trained and qualified in their roles, and regular performance appraisals and reviews are completed annually or as required as a result of any performance issues.

The Assessment Team found the service demonstrated the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. Staff complete training on a regular basis. Staff at the service had appropriate experience and skills to perform the roles required. The organisation has processes to ensure staff complete mandatory training.

The Assessment Team interviewed staff who said they had no concerns with training and said they get sufficient training to effectively perform their role. Management advised new staff are placed on buddy shifts, and staff performance is monitored. New staff have a probationary performance review after 4 to 6 months. If any issues are identified, additional training would be arranged. The service demonstrated training records completed by staff that were non-mandatory online learning modules across a range of topics.

The service demonstrated assessment, monitoring and review of the performance of each member of the workforce is undertaken. Management said consumer feedback is considered and addressed when monitoring and reviewing staff performance. Staff confirmed they have been requested to undertake a performance appraisal process and have been provided with notice, and documentation to complete before undertaking the formal process with management. Staff interviewed said they received regular training and areas for further improvement are discussed at the performance appraisal process and staff feel supported.

Management advised that feedback about staff performance is captured in different ways, through audits, consumer and representative feedback, staff feedback and observations. Management explained the services’ disciplinary process and stated policies and procedures are available to guide management through performance management processes where required.

**Standard 8**

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

**Findings**

The Quality Standard assessed as Compliant as five of the five requirements have been found to be Compliant.

The Assessment Team found the service was able to demonstrate it supports consumers and their representatives to be involved in the development, delivery and evaluation of care and services. Management provided examples of different ways the service incorporates consumer feedback and suggestions into changes implemented to care and services at the service and organisational level.

Management said the service encourages consumers to engage in the development, delivery, and evaluation of care services through different means, for example, through meetings, verbally and surveys. Management advised consumers and their representatives are encouraged to participate and provide feedback directly to the organisation’s board; for example, a board member will regularly attend meetings with consumers and consumers are encouraged to attend the annual general meeting.

Board driven changes of the service as a result of consumer feedback, experience, and incidents, for example, the service has recently sought approval from the board and are now finalising renovations to the services outdoor undercover balconies, relocation of air-conditioning units (were located on balconies) and to implement new planter boxes for recreational gardening for consumers. This improvement was the result from direct feedback from consumers that complained the communal outdoor balcony areas were not welcoming and the crackling sound of the previous roofing structure and air-conditioning unit were noisy and not fit for purpose.

The service was able to demonstrate its governing body promotes a culture of safe, inclusive, and quality care and services. The Assessment Team interviewed management and a representative from the organisation’s executive, the chief executive officer, who provided examples of how the governing body monitors that the service is compliant with the Quality Standards, and how the governing body ensures it is accountable for the delivery of care and services across the organisation.

The organisation has a board that meets on a regular basis containing members with a variety of skills and qualifications. The board is supported by a number of sub committees, who monitor and implement changes, such as changes to policies and procedures to align with new legislative requirements.

The organisation’s executive advised ways in which the governing body satisfies itself the Quality Standards are being met. For example, the board are engaged in regular meetings, clinical governance meetings (4 monthly), monthly board meetings and financial meetings. The service provides updates to the board about risks, restraints, falls, weight loss, infections, high prevalence risk register and clinical risk indicators (e.g., medication errors), pressure injuries and progress and satisfactory of services. The executive ensures that the board is provided with all current information and is well informed, so the board have oversite of what’s happening at the service and can contribute to making improvements.

The Assessment Team found the service was able to demonstrate it has effective governance systems in place relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Management advised, and staff corroborated that all staff could access current policies and procedures from the organisations intranet page and this information is updated, maintained, and overseen by management. Staff advised that consumer information is shared verbally through staff handovers and have access to handover notes which are reviewed before each shift.

All feedback and information reported are used for opportunities for continuous improvement at an organisational level and is reported to the board.

The service has an established financial governance policy to guide the management of financial resources for the delivery of safe, quality care and services. Including delegation arrangements for out of budget expenses to support expenses relating to the changing needs and preferences of consumers. All applications for expenditure are approved by the board and signed by the CEO before submission. The CEO provided several examples where feedback and complaints from consumers and out of budget expenses were used to improve to the quality of care and services including a new call bell system installed due to the call bell alert system being too loud and staff having to manually check at the nurse’s station to find which room needed attending to. Beds were included on the budget yearly for airbeds and bed rails to meet the ongoing changing needs for consumers and motorised wheelchairs were purchased to assist with mobility up a steep ramp to access the neighbouring church frequented by consumers.

Information on changes to legislative requirements and changes to policies and procedures are filtered down to the service through the organisations management system. Management said staff follow the Commission’s SIRS guideline flowchart and escalated through their reportable incident system before incidents are reported to the Commission and/or Police. Incidents are logged through the service’s systems which alerts the CEO and management at the service. Incidents are reviewed and actioned and reported to the board. The Assessment Team reviewed the services incident reporting documentation, noting the service has reported incidents in line with SIRS legislative requirements within specified timeframes.

The service provided evidence to show it has effective risk management systems and practices in place to manage high impact and high prevalence risks, identify abuse and neglect of consumers and support consumers to live the best quality of life they can. The Assessment Team reviewed the services incident management system which demonstrated how the service effectively manages and acts to prevent future incidents.

The Assessment Team received the organisation’s policies and procedures in relation to high impact and high prevalence risks, which is used to guide staff on how to understand the need to minimise and manage high impact clinical risks. The service assesses consumers at the time of entry to the service and looks for trends in incident information to identify high impact or high prevalence risks. The director of care, quality and compliance manager, clinical manager and registered nurses create strategies to mitigate risk and inform staff at regular handover meetings and through education training sessions. For example, the service has implemented strategies to prevent pressure injuries by implementing the use of high-quality wound dressings to improve wound management and infection control and high-tech air mattresses to prevent pressure injury sores.

The Assessment Team found the service has a Clinical Governance Framework in place that is underpinned by policies and procedures to guide staff.

The Assessment Team interviewed staff who all demonstrated knowledge surrounding the principles of open disclosure. Management and registered nurses interviewed, referenced that when an incident occurs, it is important to say sorry and keep consumers and families informed during a complaints process.

Staff were aware of antimicrobial stewardship and what that meant for consumers. Registered staff advised that in relation to the principles of antimicrobial stewardship, this is discussed regularly at meetings to remind staff of the importance of hydration and monitoring for changed behaviours that may indicate an infection. Registered nurses and some care staff were aware of the need for appropriate pathology testing prior to medical officers ordering antibiotics to ascertain any resistant pathogens.

Staff said that they have received education on restrictive practices and all staff interviewed were able to provide examples of restrictive practices as defined under the new legislation and how they use behaviour support plans. However, the service requires further improvement in recognition/identification and understanding of the use of chemical restraint.

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