Performance

Report

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| Name: | Southern Cross Care St Michael's Residential Aged Care |
| Commission ID: | 0038 |
| Address: | 62 Centre Street, CASINO, New South Wales, 2470 |
| Activity type: | Site Audit |
| Activity date: | 15 October 2024 to 17 October 2024 |
| Performance report date: | 14 November 2024 |
| Service included in this assessment: | Provider: 305 Southern Cross Care (NSW & ACT) Limited  Service: 54 Southern Cross Care St Michael's Residential Aged Care |

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 Southern Cross Care St Michael's Residential Aged Care (**the service**) has been prepared by Kimberley Reed, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved provider’s response to the Assessment Team’s report received 11 November 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

* Consumers with high impact risk including unexplained weight loss, restrictive practices and requiring time sensitive medication are required the be effectively managed.
* Consumers must have the ability to move freely within the service environment, including the ability to re-enter the service independently. The service environment must be safe for consumers.

# Standard 1

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

Findings

Consumers and representatives confirmed consumers were treated with dignity and respect and felt accepted and valued. Staff demonstrated sound knowledge of individual consumer backgrounds, cultures, beliefs, and relationships and described their actions to ensure consumers’ dignity and respect were upheld during care and service delivery. Consumer care documentation included spiritual care plans which outlined individual consumers’ beliefs and ecumenical support. Staff were observed interacting with consumers in a kind and caring manner, and engaging in conversations reflecting consumers’ backgrounds and interests consistent with information outlined in care plans.

Consumers and representatives confirmed the service recognised and respected the consumer’s cultural background and provided care which was consistent with their preferences. Staff identified consumers from culturally diverse backgrounds and provided information relevant to ensuring each consumer received the care required that aligned with cultural preferences outlined in their care plan. Consumers’ care documentation evidenced consumer dignity and choice, pastoral and spiritual care, and life history information to guide culturally safe care and services. Staff orientation and training records evidenced staff were required to complete cultural safety training at commencement of employment and annually during continued employment.

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

Consumers confirmed the service supported their choices, even if the choice was identified as posing a risk to the safety of the consumer. Staff supported consumers to take risks to enable them to live the best life they can and were guided by policies and procedures to support consumers to take risks. Progress notes and assessment tools evidenced, when a risk was identified staff conducted risk assessments and held discussions with the consumer and their representatives to discuss the risks and strategies to minimise risk of harm. Management and consumers confirmed the dignity of risk process was discussed and explained during entry to the service and as individual needs change. Staff completed consumer risk assessments to support consumer choice and identify strategies to mitigate risk, which were documented in care plans to guide staff during care and service delivery.

The service demonstrated current, accurate and timely information was communicated to consumers and representatives. Information provided was clear, easy to understand, and supported consumers to exercise choice. Consumers and representatives confirmed they were satisfied with the information provided to them by the service. Posters and flyers were observed of upcoming activities or other information on noticeboards throughout the service, and in consumers’ rooms.

Consumers confirmed their personal privacy was upheld and respected by staff and expressed confidence the service protected all personal information collected. Staff described how they respected a consumer’s privacy when providing care and maintained confidentiality of personal and sensitive consumer information being held on the electronic care management system by locking computer screens when not in use and not speaking about consumers in public areas. Clinical staff explained how they kept handover sheets confidential by not leaving them in communal areas or in consumers’ rooms and how they subsequently destroyed handover sheets at the end of each shift.

Based on the information recorded above it is my decision this Standard is compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | 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

While consumers and representatives provided positive feedback regarding assessment and planning processes, the site audit report records the service was unable to demonstrate assessment and planning processes were inclusive of individual strategies relating to behaviour management. Incidents relating to changed behaviours have not been consistently recorded to guide assessment and planning processes.

For one named consumer five incidents of physical and verbal aggression and refusal of care had not been recorded as incidents. The consumer’s behaviour support plan did not contain effective strategies to guide staff practice. Strategies to manage the consumer’s behaviours suggested by their representative had not been considered in planning.

The Approved provider in its response reviewed the incidents recorded in the site audit report for the named consumer, and determined one incident met the threshold of the organisation’s behaviour support procedure. Staff were reminded of their responsibility to record incidents at a general staff meeting held 28 October 2024. The other four incidents recorded in the site audit report for the named consumer were determined to be examples of known behaviour and were appropriately recorded in the named consumer’s progress notes, according to the Approved provider’s response. The site audit report included information that staff stated the consumer’s behaviour was inappropriate. This information was challenged by the Approved provider in its response and this wording was not included in progress notes submitted as part of the response. Information submitted by the Approved provider as part of the response included the named consumer’s behaviour support plan which comprised individual strategies to support staff in managing the named consumer’s behaviours. In coming to my decision regarding compliance in Requirement 2(3)(a) I have not given weight to the information recorded in the site audit report relating to incidents of behaviour and the named consumer. It is my decision; the service is managing the named consumer’s behaviour appropriately.

Behaviour support plans for seven other consumers who were subjected to restrictive practices or exhibited changed behaviours did not contain individual strategies and for another named consumer strategies suggested by a specialist service were not included in their care planning.

The Approved provider in its written response refutes that care planning directives did not include strategies as suggested by a specialist service and provided evidence of behaviour support plans incorporating specialist service recommendations for the named consumer. In coming to my decision regarding compliance in Requirement 2(3)(a), I have not given weight to the information recorded in the site audit report that specialist service recommendations were not included in behaviour support plans and considered other care planning guidance such as lifestyle support plans provided staff with individualised strategies to manage the named consumer’s changed behaviours. While the site audit report stated seven other consumers subjected to restrictive practices or changed behaviours did not have individualised behaviour support plans, two named consumers were raised. For the second named consumer noted above and the third named consumer, I am satisfied the service had effective management strategies to guide staff in assisting with the consumers’ changed behaviours. While I note in the Approved provider’s response the third named consumer had a lack of prescribed medication to assist with their sleeping for a month, I am not convinced the service was proactive in communicating with the service’s pharmacy to ensure the timely delivery of prescribed medication.

Consumers and representatives confirmed they were involved in care planning for consumers which included discussions of current needs and end of life planning. Registered staff ensured consumers’ current needs and end of life planning were recorded in care plans. Care documentation identified consumers’ current needs, goals and preferences including those relating to end of life planning were recorded in care documentation. End of life wishes including advance care plans were also stored in hard copy in nurses’ stations for easy access during an emergency.

Consumers and representatives stated consumers could choose who they would like involved in care planning. The medical officer and allied health professionals provided guidance and recommendations to influence consumers’ care planning and consumers’ care documentation evidenced input and consideration of recommendations from allied health professionals, medical officers and specialists.

Consumers and representatives were satisfied with communication relating to the outcomes of assessment and care planning for consumers and they had received or had access to consumers’ care plans. Staff communicated with consumers and their representatives following assessment or review by the medical officer or allied health professionals. Consumers’ care documentation recorded when staff had communicated with consumers and representatives. Any outstanding communication was documented and discussed at handover and handover records identified when communication was to be completed with consumers’ representatives.

Consumers and representatives confirmed care plans were reviewed for effectiveness or when consumers’ needs changed. Registered staff identified when consumers’ care plans were due for review including periodic review or when circumstances changed. Consumers’ care documentation demonstrated care planning was reviewed as scheduled and when consumers’ circumstances change. Registered staff were allocated a number of consumers to complete their care plan review and associated assessments each month. Clinical management ensured registered staff completed reviews in a timely manner.

Based on the information recorded above and my review of the Approved provider’s response to the site audit report, it is my decision this Standard is compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Consumers and representatives confirmed consumers received the care they needed and were satisfied with care delivery. Clinical staff utilised best practice guidelines to manage wounds, pain, skin integrity, restrictive practices, complex clinical needs and diabetes. Care documentation evidenced individualised and tailored strategies for managing consumers’ clinical care and policies and work instructions guided staff practice when delivering clinical care. Clinical management ensured clinical care was best practice and tailored to individual consumers’ needs through attending handover and reviewing incidents to identify educational needs of staff.

The service demonstrated effective management of falls and appropriate assessments, and consent was completed for consumers who they identified as subject to a restrictive practice. However, the service did not demonstrate effective management of unexpected weight loss and time sensitive medication, as well as identification of restrictive practices. The service could not demonstrate assessment or review was undertaken to identify when consumers were prescribed regular anti-psychotic medication to influence behaviours, and consideration had not been given to this constituting a chemical restraint.

The psychotropic register identified eight consumers who were prescribed regular anti-psychotic medication were diagnosed with psychosis. The service did not demonstrate evaluation or assessment had been completed to identify if the medication was used to influence consumers’ changing behaviours and therefore constituted a chemical restraint. Clinical management said they had not identified the anti-psychotic medication as a chemical restraint as the medical officer advised regular anti-psychotic medication is not a chemical restraint.

The Approved provider, in its written response, stated the eight consumers noted in the report had a confirmed diagnosis of psychosis, and as psychosis is an approved indication for the consumers to receive anti-psychotic medication it was not considered chemical restraint. Following receipt of the site audit report a review was undertaken by a pharmacist in relation to consumers diagnosed with psychosis to determine if the anti-psychotic medication was used for managing behaviours associated with the psychosis. Six consumers were identified through this process as requiring anti-psychotic medication to influence behaviours associated with their diagnosis of psychosis. Restrictive practice authorisations have been completed for these consumers and referral to a Geriatrician occurred 07 November 2024 to review their diagnosis. While action has occurred to identify these six consumers who are subject to chemical restraint, this was a response to the site audit report and not evidence of the service’s ability to accurately determine the purpose of the psychotropic medication was to influence the consumers’ behaviours.

The service was not appropriately managing weight loss for four consumers with identified unexpected weight loss while awaiting a review by a dietitian. Clinical management and registered staff said while awaiting a dietitian review, consumers were weighed weekly, commenced on a food and fluid chart and reviewed by the medical officer more frequently for any consumer with more than 5% weight loss. However, the Assessment Team identified these processes were not consistently implemented. For one named consumer who lost 3.3kgs (6.5% of their body weight) between July and October 2024, weekly weights and food and fluid charting was not completed or evident in their care documentation. For a second named consumer who lost 4.3kgs (8.5% of their body weight) between August and October 2024, food and fluid charting were completed for a period of five days, but an evaluation of the charting had not occurred to identify any strategies to improve their oral intake and medical officer review had not occurred. Staff meeting minutes from 25 September 2024 records consumers experiencing unplanned weight loss needed to be reviewed immediately, with consultation and input from families regarding strategies, review of dietary profiles and review by the medical officer. Consumers’ care documentation did not support this had occurred and the number of impacted consumers was not provided. The service has had difficulty securing the services of a dietitian and has not had access to a dietitian since June 2024.

The Approved provider, in its written response, acknowledged there was a delay in addressing the unplanned weight loss for the named consumer, and a retrospective incident report for neglect was submitted to the Serious incident response scheme. A case conference was held with the named consumer’s representative, and an agreed plan to address the consumer’s unplanned weight loss was commenced. For the second named consumer with weight loss, the Approved provider submitted administration reports to evidence the provision of supplements to the consumer and food and fluid charting records were submitted from 01 September to 31 October 2024. Review of the food and fluid charting for the consumers demonstrates a lack of additional snacks recorded as per the medical officer directives. For the third named consumer with weight loss, the Approved provider included notes from the medical officer which demonstrated treatment of oedema had contributed to the weight loss. The Approved provider has cited difficulties in accessing a dietitian as compounding the lack of action taken to address the consumer’s weight loss, however it is my opinion registered staff should have the knowledge and skills to implement actions to address a consumer’s unplanned weight loss in the absence of a dietitian.

Medication administration records for consumers who require time sensitive medication evidenced insulin and antibiotics are given in a timely manner, however, medication for the treatment of Parkinson’s disease is routinely administered outside of 30 minute parameters. A review of medication charts for three named consumers receiving medication to treat Parkinson’s disease for the period from 01 to 30 September 2024 evidenced up to 47 occasions when time sensitive medication was administered outside therapeutic timeframes. Registered staff were unable to identify a cause or contributing factor to the medication not being administered as prescribed. Alerts in the electronic medication management system are only activated if medication is missed, rather than delayed or administered early.

The Approved provider, in its response, acknowledged it was unacceptable for time sensitive medication to be administered outside a 30 minute window either side of prescribed administration times and retrospective medication incident reports and notification to the Serious incident response scheme have been completed for the three consumers named in the site audit report. A revised feature has been added to the service’s electronic medication management system to prioritise time sensitive medication in dose rounds and allows for a report to be produced which identifies when time sensitive medications have not been administered within the 30 minute window. While the Approved provider evidenced improvements in staff practice relating to time sensitive medication, between 17 and 31 October 25 doses of Parkinson’s medication was not administered within the 30 minute window, this does not support the effective management of high risk for consumers requiring medication to manage their Parkinson’s disease.

The service did not demonstrate effective processes for managing high impact risk to consumers including identifying restrictive practices, managing unexpected weight loss and ensuring time sensitive medications were administered as prescribed. While the Approved provider’s response contains evidence of actions taken to address the deficiencies identified during the site audit and documented in the site audit report, the service’s own monitoring processes had not identified these deficits, and the actions will take time to be fully implemented and tested for effectiveness. Therefore, it is my decision Requirement 3(3)(b) is not compliant.

Consumers and representatives were confident the service understood consumers’ end-of-life goals, and these would be implemented. Care documentation included information for staff to assist consumers when nearing end of life and documents collaboration with the medical officer and consumers’ family. Clinical and care staff described the palliative care pathway and supports provided to consumers. Registered staff followed processes when consumers were nearing end of life which included communicating with the consumer’s family to review their goals, pain management and medical officer review.

Consumers and representatives confirmed they were satisfied with the identification and response to consumers’ deterioration. Care staff escalated any changes in a consumer’s condition to registered staff with registered staff monitoring consumers’ conditions to effectively ascertain when medical officer intervention or transfers to hospital were required. Consumers’ care documentation evidenced monitoring and escalation of a consumer’s condition when a decline or change was identified.

Consumers and representatives were satisfied consumers’ care needs and preferences were effectively communicated between staff and others who provided care. Consumers’ care documentation evidenced input from medical officers and allied health professionals to ensure appropriate care relevant to consumers’ condition and needs. Staff were informed and aware of recommendations from the medical officer, allied health professionals and other staff through the electronic care system and handovers.

Most consumers and representatives were satisfied the service facilitated referrals to other providers of care in a timely manner. Care documentation evidenced review and recommendations for consumers’ care from other health professionals. Clinical management and registered staff followed processes and pathways for identifying consumers who required referrals. Although the service made referrals to a dietitian when a change in a consumer’s condition is identified, there have been challenges in scheduling the review.

Consumers and representatives were satisfied the service was effectively managing and implementing processes to minimise the risks relating to infections and outbreaks. Staff understood their role in infection control management and antimicrobial stewardship. The service had systems in place which included screening processes on entry to the service, vaccination programs for staff and consumers, and an outbreak management plan and policies. Consumers and representatives confirmed the service provided opportunities for consumers to receive vaccinations for COVID-19 and seasonal influenza. Vaccination programs were established for consumers and the service demonstrated systems for maintaining consumer and staff vaccination records.

# Standard 4

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

Findings

Consumers and representatives were satisfied with the supports provided for consumers’ daily living which optimised their independence and quality of life. Lifestyle staff supported consumers with varying levels of independence to optimise their health and wellbeing. Care documentation recorded consumers’ needs, goals and preferences to support and optimise their daily living. Lifestyle staff engaged consumers in the development of the activities calendar influencing the inclusion of knitting clubs, game clubs and a gardening group. Consumers confirmed their participation in these groups and the opportunity to provide feedback relating to activities.

Consumers and representatives confirmed the emotional, spiritual and psychological well-being of consumers was supported. Lifestyle staff supported these areas through a volunteer program and religious activities. Consumers’ care documentation included details of their spiritual and emotional needs and the activities calendar identified daily rosary and weekly music and church services.

Consumers described the various activities they undertook in the community, the relationships they have developed or maintained and the activities which interested them. Lifestyle staff supported consumers to maintain and build relationships and they identified and supported consumers to do things of interest to them. Consumers’ care documentation recorded their interests, as well as relationships which were important to consumers.

Consumers and representatives were satisfied staff had relevant information relating to consumers’ needs and preferences. Hospitality, cleaning and care staff described how they accessed information relating to individual consumer needs including dietary preferences. Consumers’ care documentation included dietary needs and preferences, and catering and care staff said they used the dietary care plan to stay informed of consumers’ needs and preferences. The service has cleaning schedules for consumer rooms and communal areas in line with documented needs and preferences of consumers. Lifestyle staff participated in handover to ensure their knowledge of consumers’ needs was current and they could communicate any changes they have identified.

Consumers confirmed they enjoyed the meals, were always provided a choice, meals were sufficient, and they had access to food between mealtimes. The chef described how the menu was created with input and feedback from consumers and reviewed by a dietitian. Care staff demonstrated an understanding of consumers’ dietary needs and preferences and how to assist consumers to access additional food when hungry. The service held quarterly food focus meetings to gauge consumers’ satisfaction with meal choices, quantity and temperature. Staff and consumer meeting minutes from the past quarter recorded discussions relating to consumer satisfaction and feedback relating to food and opportunities for consumers to provide feedback.

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

Based on the information recorded above it is my decision this Standard is compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers were satisfied with the environment; they were able to decorate their rooms as they pleased, and the service was easy to navigate. The environment was observed to be well signed, consumers’ rooms to be personalised and the environment supported consumers’ independence and socialisation. Signs throughout the service guided consumers and visitors to wings, rooms and common areas. Wide corridors with hand railings supported consumers to mobilise and maintain their independence. Consumers were observed mobilising throughout the service with various mobility aids, with staff assistance, and independently.

While consumers and representatives were satisfied the environment was well maintained and they were satisfied with the cleaning, some consumers said they are unable to move freely both indoors and outdoors.

For two named consumers who regularly go into the community, exit codes were provided, however a code to re-enter the service had not been provided. Consumers wishing to re-enter the service are required to wait for staff assistance and feedback was provided this can take some time after hours or on the weekend. The code to exit the service was printed above the keypad, however, the service had not considered consumers with dexterity and visual impairment issues may be environmentally restrained due to their inability to access and use the keypad.

The Approved provider, in its written response to the site audit report, stated following consultation with the Commission’s Behaviour support and restrictive practices unit on 04 November 2024, the service’s restrictive practices procedure has been amended to include advice from the unit and will be released once approved. Management met with the two consumers who regularly leave the service to access the community. The Approved provider stated the named consumers were not concerned by the locked front door or long wait times for staff to open the door. Meeting minutes for a consumer and representative meeting were submitted as part of the Approved provider’s response which indicated consumers would be happy to be provided with a PIN code to enter the service. The Approved provider committed to assessing individual consumers and their ability to leave and enter the service and restrictive practice authorisations would be completed where required.

The service had a second storey balcony and risk assessments had not been completed or individual consumer risk assessments completed to identify if the balcony posed any risk to consumers. Consumers’ rooms on the second floor were observed to have access to a balcony from their rooms and common areas. The balconies were furnished with chairs and other accessories chosen by individual consumers such as pot plants. For one named consumer who resides on the second floor, care documentation identified they had a history of depression, anxiety, psychosis and disturbed adult behaviour. Staff identified the named consumer could become angry and depressed. An assessment had not been undertaken to assess if the balcony posed a risk to the named consumer.

The Approved provider, in its written response to the site audit report, noted the concerns raised during the site audit for consumers with access to a second floor balcony, and noted the balcony complies with all relevant building standards for height and design. The Approved provider noted at the time of the site audit all consumers had been assessed in relation to depression, resulting in seven consumers indicating their depression level mildly interfered with their regular activities. Of the seven consumers, six consumers expressed no thoughts of suicide or harm. Pharmacy reports submitted by the Approved provider indicated 53% of consumers are prescribed antidepressant medication. The remaining consumer who had previously expressed suicidal ideations on 30 September 2024 resides on the second floor of the service. The Approved provider noted a risk assessment was completed for the consumer in relation to feeding the birds on the second floor balcony on 28 September 2024. Progress notes submitted as part of the Approved provider’s response to demonstrate monitoring of the consumer who expressed suicidal ideation, evidenced a gap of almost 24 hours between the consumer expressing suicidal thoughts on 30 September 2024 and the next documented registered nurse review on 01 October 2024. Monitoring records were not provided to support the Approved provider’s assertion the consumer was monitored hourly following their expression of suicidal ideations.

In coming to a decision relating to compliance in Requirement 5(3)(b), it is my decision at the time of the site audit consumers did not have the ability to exit and re-enter the service unassisted and the service had not identified this constituted environmental restraint. Assessments had not been considered by the service to identify consumers who may be at risk of residing on the second floor of the service, to ensure their safety. Therefore, it is my decision Requirement 5(3)(b) is not compliant.

Consumers and representatives were satisfied with the furniture, fittings and equipment and demonstrated an understanding of the processes when maintenance issues were required. Cleaning and maintenance staff had processes for ensuring the furniture and equipment provided was maintained with regular cleaning. The service was observed to have a wide range of furniture and equipment which was clean and well-maintained.

# Standard 6

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

Findings

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

Consumers and representatives were encouraged to use external advocacy organisations and language services where required to assist in providing feedback and making complaints. Staff described the external services available and how they promoted and supported consumers and representatives to access these services. The consumer handbook evidenced information on complaint escalation through the organisational hierarchy, details of the Commission, advocacy services and details of translation services.

Consumers and representatives expressed confidence management would address complaints and attempt to resolve any concerns promptly. Management and staff had a shared understanding of processes to follow when a complaint was received. Staff advised they initially try to resolve any issues and report it to registered staff or management. The service evidenced policies, procedures, education material addressing feedback, complaint management, and the open disclosure process were established.

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

Based on the information recorded above it is my decision this Standard is compliant.

# Standard 7

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

Findings

Consumers and representatives stated staffing levels enabled the provision of care and services in a timely manner. Master rosters and allocation sheets demonstrated vacant shifts were filled and staff confirmed they had enough time to meet the demands of their roles and the needs of consumers. The service conducted call bell auditing monthly and any aberrant response times were investigated to identify the cause. The September 2024 call bell report evidenced; the identified average call bell time was under five minutes which was in line with the call bell policy guidelines. Staffing levels were determined by consumer acuity, care needs and regulatory requirements, to ensure a balanced approach to safety, quality care and consumer well-being.

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

Consumers and representatives felt the workforce was competent and staff had the knowledge to deliver care and services to meet the needs and preferences of consumers. Staff received support and assistance to ensure they had the skills and knowledge to undertake their roles. The service’s police check register identified all staff criminal record checks were up to date. New staff received two to three supervised shifts or more as required. Ongoing staff competency was determined through line manager feedback, performance assessments, consumer and representative feedback, surveys and reviews of clinical records and care delivery.

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

The service had established systems to effectively monitor and evaluate the performance and capabilities of the workforce. Additionally, the service ensured ongoing support and professional development opportunities were provided to each staff member to foster continuous growth and improvement. An electronic management system was used for monitoring compliance with performance appraisals, which were contemporaneous and reviewed by regional management. Staff performance was monitored through observations, analysis of clinical data and consumer and representative feedback. Any issues in performance identified through these monitoring mechanisms were addressed immediately and triggered a performance review.

Based on the information recorded above it is my decision this Standard is compliant.

# Standard 8

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

Findings

The service supported consumers’ and representatives’ involvement in the development, delivery and evaluation of care and services. Consumers voiced their opinion in how care and services were delivered. Consumers were supported to be engaged in the development, delivery and evaluation of care and services, including monthly consumer and representative, food focus meetings, consultative forums, consumer and representative surveys and through feedback forms. The service had a quality care advisory body which was represented by two consumer representatives. The service incorporated consumer feedback and suggestions in different ways to implement changes in care and services locally and at an organisational level.

The service’s governing body promoted a culture of safe, inclusive, and quality care and services. The governing body monitored the service’s compliance with the Quality Standards, and ensured it was accountable for the delivery of care and services across the organisation.

The organisation’s governance framework had a leadership structure with the Board retaining overall accountability for quality and safety in the organisation. Organisational framework documents evidence roles and responsibilities of the executive leadership team, governance committees, and service management had been established. The quality audit schedule and reports evidence the service conducted monthly quality audits against the Quality Standards and used this information in conjunction with clinical data to identify deficiencies in care, policies, or procedures. It is noted however, the deficits identified in Standards 3 and 5 were not identified through the service’s quality audits.

The service had effective governance systems in place relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Information was readily accessible within the organisation’s information management system to support staff to undertake their roles. Policies, procedures and training modules were available for staff in their dedicated electronic management system. Clinical staff provided a handover to registered and care staff verbally at the beginning of each shift and handover notes were available for staff to refer to throughout the shift. Consumers and representatives were satisfied with the way information about care and services was managed and how the information was provided to them. Opportunities for improvement were identified through a range of sources including, but not limited to, consumer and representative feedback, survey results, clinical indicator trends and critical incident data. The service’s plan for continuous improvement identified planned and completed improvement actions in relation to numerous areas of care and service delivery. The service’s annual budget was generated by the organisation’s finance managers in consultation with the regional manager and facility manager and considered rosters, capital expenditure, occupancy, and Australian National Aged Care Classification funding compliance. The service had a workforce governance framework in place to ensure the provision of an appropriate number of staff who were skilled and qualified and received ongoing training and support relevant to their roles. Legislative changes, industry standards and guidelines were monitored by the organisation through subscriptions to various legislative services and peak bodies including the Commission and state health department. The service’s incident documentation demonstrated the service reported incidents requiring notification to the Serious incident response scheme as per required timeframes. It is noted however, incidents whereby consumers received time sensitive medication outside therapeutic timeframes had not been identified independently by the service and had not been considered as potentially meeting the threshold for serious incidents. Systems were in place to encourage the provision of consumer feedback and complaints and ensure appropriate and proportionate action is taken. Meeting minutes evidenced, complaints and feedback were agenda items in monthly quality governance meetings.

The organisation had policies describing how to manage high impact and high prevalence risks; respond to abuse and neglect; support consumer choice and decision-making; and report and manage incidents. The organisation had documented procedures and clinical care pathway guidance for managing high impact and high prevalence risks. The service had an electronic information management system in place where incidents were recorded by the responsible staff member. The service completed dignity of risk forms for consumers who elected to take risks to support them to live their best lives. While not all incidents (including time sensitive medication administration) had been recorded or analysed, and not all consumers who may be at risk had risk assessments completed, it is my decision these deficiencies are better suited and addressed in Standards 3 and 5, and the overall risk management systems at the organisational level were effective.

The service had a clinical governance framework to help guide staff on provision of safe care including outlining core elements of antimicrobial stewardship, restrictive practices, and open disclosure. The service had policies, procedures, and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control, and the management of infectious outbreaks. Clinical management and staff demonstrated an understanding of acquiring pathology results prior to the administration of antibiotics. Staff understood how they practiced open disclosure, including being open, transparent, and apologising when things went wrong. Staff minimised the use of restrictive practices by employing non-pharmacological strategies. While not all consumers who may have been subject to restrictive practices were identified by the service, the organisation demonstrated a commitment minimising the use of restraint.

While there has been deficits and non-compliance identified in other Standards, it is my decision the organisation was accountable for the delivery of safe and quality care and services, and this was evidenced by the response received from the Approved provider and actions taken to address deficits identified at the site audit. Therefore, it is my decision this Standard is compliant.

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