Performance

Report

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| Name of service: | Southern Cross Care Thornton Park |
| Service address: | 72-78 Empire Circuit PENRITH NSW 2750 |
| Commission ID: | 0495 |
| Approved provider: | Southern Cross Care (NSW & ACT) Limited |
| Activity type: | Site Audit |
| Activity date: | 11 October 2022 to 13 October 2022 |
| Performance report date: | 22 November 2022 |

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 Thornton Park (**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, 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 4 November 2022.
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: A Performance Report dated 29 April 2021 following the Site Audit conducted on 2 March to 4 March 2021.
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances determination dated: 26 September 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 | **Non-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**

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

Requirement 3(3)(d) The approved provider must demonstrate that staff monitor and record progress notes effectively and escalate any clinical deterioration or decline to management in a timely manner.

Requirement 3(3)(e)The approved provider must demonstrate that consumer’s condition needs, and preferences is consistently documented and communicated with those who are in the service and others where care responsibilities are shared and changes in a consumer’s condition is documented and communicated.

**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 Standard has been assessed as Compliant as 6 of the 6 Requirements are Compliant.

The Assessment Team found that all consumers and their representatives interviewed said they are treated with dignity and respect, with their identity, culture and diversity valued. Management and staff spoke about consumers respectfully and were observed to be interacting with consumers and their representatives in a respectful and friendly manner. The Assessment Team observed staff and management communicating respectfully with consumers when engaged in all care and lifestyle activities and staff were observed to be attentive to each consumer’s requests for assistance.

The service was previously found Non-compliant in Requirement 1(3)(b) following a Site Audit conducted on 2 March to 4 March 2021, where documentation including the service’s cultural considerations report did not clearly reflect some consumer's cultural background and provided conflicting information that was not supported in care planning documentation.

The Assessment Team have found that the service has made improvements to address the deficits in the above Requirement with the corporate lifestyle management team increasing the lifestyle staff hours in order to improve outcomes. The service has a new Lifestyle Coordinator who has helped to reshape the cultural care and services provided to the consumers under their care. Each wing of the service has a fulltime lifestyle staff member allocated to assist consumers with activities that are of interest to them. Lifestyle activities which are culturally safe extend over the 7-day week.

Most consumers residing at the service have their up-to-date cultural needs reflected in their care and activity plans. Lifestyle programs are carefully coordinated and tailored to include multicultural customary celebrations and events. Management, clinical and lifestyle staff have identified several consumers from differing cultural and linguistical backgrounds.

The service actively promotes awareness and inclusion for differing cultural backgrounds by adopting a series of regular programmed events, activities, and themed lunches, which are selected from feedback provided by consumer engagement. Lifestyle program attendance records showed culturally specific events and activities are well attended by consumers from all areas of the service and are regularly attended by most consumers residing in the memory support unit. The Chef said he works with lifestyle staff to provide themed lunches which embrace the various cultural backgrounds of consumers, enabling other consumers in the service to engage in the differing cultural customs and food flavours.

The service encourages consumers and their representatives to be involved in the decision-making processes relevant to the daily aspects of their lives and have developed a process to support the wishes of consumers to exercise choice and independence. Consumers, representatives, staff, and management provided feedback to indicate consumers are actively supported to communicate their decisions and make connections with others to maintain relationships of importance to them, including intimate relationships.

The service is supportive of consumers taking risks to enable them to live the best life they can. A documentation review undertaken by the Assessment Team demonstrated a risk assessment was undertaken where a consumer in the service choses to undertake activities deemed as a risk.

The service uses a range of mechanisms to ensure consumers are provided with current, accurate and timely information to enable them to exercise choice. Information is generally clear, easy to understand and enables consumers to exercise choice. Daily menus are available for selection via the Television (TV) located in each consumer’s room. Hard copies are available, and staff were observed assisting consumers who were unable to access the digital information and for consumers residing in the service’s memory support unit ensuring they receive their choice of meal.

The service ensures each consumer’s privacy is appropriately respected and any personal information obtained while providing care is kept confidential and not disclosed outside of the consumer’s immediate care team. The Assessment Team observed clinical, care, lifestyle and domestic staff knocking on consumer’s doors prior to entering rooms to attend to call bells or individual consumer needs. Door privacy hangers were observed on consumer doors.

**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 Standard has been assessed as Compliant as 5 of the 5 Requirements are Compliant.

The service was previously found Non-compliant in Requirement 2(3)(a), as Consumer’s care planning documents did not identify specific risks or reflect evidence of comprehensive assessment and planning when risk was identified.

The service has implemented improvements to address the deficits including improvements to processes to ensure all risks are identified as soon as possible on admission to the service and are incorporated into the consumer’s care plan. The Deputy Facility Manager stated they personally review the admission documents and ensure that known risks identified on admission are communicated to the multi-disciplinary team. The Deputy Facility Manager showed examples of emails sent to the RNs in relation to identified risks to consumers. The team were also advised that a catchup with clinical staff has been implemented to provide an opportunity for staff to escalate issues and for the senior clinical team to ensure any risks identified are followed up and the necessary information is incorporated into the care plan.

The Assessment team were advised in order to catch up with the care plan reviews, there are 4 scheduled care conferences a week to ensure all care plans contain up to date information. The service has an effective assessment and care planning process to ensure staff can deliver safe and effective care and services. Risks to the consumer’s safety, health and well-being are identified and assessed with strategies to reduce the risk discussed with the consumer and detailed in the care plan.

Assessment and care planning documents were seen to identify known risks to consumers which include medical, cognitive, infection, and sensory risks, pressure area and falls risks and risks associated with equipment and environment. Strategies to inform the delivery of safe care are documented.

The service has systems and process to support consumer-centred assessment and care planning. Consumers are supported and encouraged to share their end of life and palliative care wishes with the service staff. Care plans were seen to include consumer preferences and current need, including things and people important to the consumer to maintain their well-being. Management advised discussions in relation to end of life (EOL) planning occur with the consumer and their representatives in the first weeks of admission to the service. Consumers and their representatives are supported to complete Advance Care Directives (ACD). Discussions are revisited following this and when the consumer’s condition changes.

The service demonstrated they undertake assessment and planning of care and services in partnership with the consumer and others the consumer wishes to be involved. Where appropriate other organisations and providers of care are involved in planning and assessment processes. Assessment documents, care plans, progress notes and interviews with consumers, show staff work with the consumer and/or their representatives to ensure care and service provision is in line with the consumer’s needs and preferences

The service was previously found Non-compliant in Requirement 2(3)(d) where assessment outcomes were not being effectively communicated to the consumer or documented in the care and service plan. The service has implemented the following improvements to address the deficits which include:

The Assessment Team were advised that the Deputy Facility Manager and Clinical Care Coordinator attend the daily clinical catch up and review progress notes for the previous 24 hours. They follow up the outcomes of assessments to ensure information has been communicated to consumers and their representatives and is documented into the care plan. The service demonstrated the outcomes of assessment and care planning are communicated to consumers and documented in their care plans to guide staff to deliver care and services effectively.

Most consumers and representatives interviewed stated they are satisfied the service keeps them informed of the outcome of any assessments and with any associated changes to the way care is to be delivered.

The service was previously found Non-compliant in Requirement 2(3)(e) as consumer’s care plans were not being consistently reviewed when their care or service needs change.

The service has implemented improvements to address the deficits identified with registered staff responsible for updating care plans when situations change, the Clinical Care Coordinator and Deputy Facility Manager monitor this to ensure this is being done. Management stated it is felt this process enables greater oversight and reduces the risk of care plans not being updated in line with the changing needs of consumers.

The service demonstrated processes are in place to ensure care and services plans are up-to-date and meet the consumer’s current needs including when changes are required following an adverse event or a change in the consumer’s health condition or personal preference. However, the service requires more time to fully embed the improvements.

The Deputy Facility Manager stated care plans are reviewed monthly. There is a schedule, and the Deputy Facility Manager sends out email reminders to the registered staff of the consumer’s care plans that are due for a review and update. The Clinical Care Coordinator checks the care plans have been updated. Staff stated, and documentation showed, care plans are updated when there is a decline in health, incidents have occurred, following discharge from hospital, when there are changes in preferences.

**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. | Non-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. | Non-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 Standard has been assessed as Non-compliant as 2 of the 7 of the Requirements are Non-compliant.

The following Requirements were found to be Compliant:

* Requirement 3(3)(a)
* Requirement 3(3)(b)
* Requirement 3(3)(c)
* Requirement 3(3)(f)
* Requirement 3(3)(g)

The service was previously found Non-compliant in Requirement 3(3)(a), following a site audit between 2 March 2021 to 4 March 2021. At this Site Audit it was found that while consumers were generally satisfied with the care and services they receive, documentation and file reviews indicate consumers were not always receiving care tailored to their needs to optimise their health and wellbeing. The service has implemented several improvements to address the deficits including a new clinical management team who are working together to review daily the previous 24 hours of progress notes, attend daily clinical catch up, review outcomes of assessments and have a consistent presence on the floor in order to ensure a greater level of clinical oversight is provided.

The service demonstrated that each consumer gets safe and effective personal and clinical care that is tailored to their needs and optimises their health and well-being and in line with best practice where evidence is available. However, some consumers and representatives stated although they have seen improvements over the past few months, their confidence in the ability of the service to deliver consistent safe and effective personal care has been reduced. The Assessment Team identified 1 consumer who was not receiving effective personal and clinical care. Investigation demonstrated the service was ongoing in the process of trying to identify a care regime the consumer feels comfortable with, in order to reduce the frequency of refusals of care.

The service was previously found Non-compliant in Requirement 3(3)(b) with a systemic gap in the clinical documentation, management, and monitoring regarding consumers with identified risk. Examples of these include chemical, physical and environmental restraint, and consumers exhibiting behaviours. The service has implemented a number of actions to address the deficiencies and this visit demonstrated effective management of high impact or high prevalence risks associated with the care of consumers.

The Assessment Team interviewed staff who were able to describe the main risks for the sampled consumers and how these are managed, including the use of validated assessment tools, and appropriate identification and escalation of risks, review post incident and implementation of strategies to reduce the risk of reoccurrence.

The Assessment Team observed equipment in place to reduce harm from falls such as sensor mats, low beds and the use of air mattresses, pressure relieving cushions and heel protectors to reduce pressure injuries. The handover document observed in nurse's stations, generated from the electronic care record, included descriptions of the current risks for each consumer's ensuring staff are aware of all risks. The physiotherapist stated and documentation showed they review consumers post fall and post return from hospital.

The Assessment Team found that the service demonstrated an understanding of the needs, goals and preferences of consumers nearing the end of their life, maintaining consumers’ dignity and comfort and respecting their cultural preferences. Care plans reviewed included advance care directives (ACD) where preferences for care at EOL were documented.

Staff stated the service works closely with the local palliative care team, to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. Staff stated and documentation showed meetings are held monthly with the palliative care team to identify and discuss consumer’s plans of care.

The service demonstrated they work with consumers and their representatives to identify individuals, organisations or providers that can deliver care, services and supports to meet the consumer’s needs.

The Assessment Team identified that care planning documents reflected referrals have been made to relevant health professionals when staff identified relevant needs and the referrals are actioned in a timely manner. The referrals included Virtual Aged Care Service (VACS) and HIPPO virtual wound care review service to assist with the management of skin condition and wounds.

The service has an effective infection prevention and control program that is in line with the national guidelines. The service has identified the Facility Manager and Deputy Facility Manager as the designated infection prevention and control (IPC) leads. They are both in the process of completing the formal training and are responsible for overseeing training and monitoring of staff practice.

The Assessment Team observed staff practicing appropriate infection control processes throughout the visit. Signage was in place to identify consumers requiring contact precautions and consumers in temporary, precautionary COVID 19 isolations due to spending extended time in the community.

Clinical staff demonstrated, and documentation showed that antibiotic therapy is only prescribed if a consumer is symptomatic or has a history of infection related illness. The service has a stock of antibiotics so that treatment can commence immediately following GP initiation. Infections are monitored and a report is reviewed monthly by management to monitor of trends.

Staff stated they understand precautions required to minimise the spread of infection, they said they have access to adequate personal protective equipment including aprons, gloves, and when required masks and face shields.

The following Requirements were found to be Non-compliant.

* Requirement 3(3)(d)
* Requirement 3(3)(e)

The Assessment Team found that whilst the service demonstrated there are systems and processes in place to support the workforce to recognise and respond to consumers whose function, capacity or health condition changes or deteriorates, these processes had not been effectively implemented for one consumer.

The Assessment Team found vital observations were not recorded consistently when the consumer was observed to be unwell, resulting in staff not being able to monitor and identify further deterioration. Frequency of observations undertaken was not sufficient to identify deterioration, and the consumer’s condition was not escalated until significantly unwell.

The Assessment Team observed several staff members were involved in the care of the consumer over the days leading to the transfer to hospital. Staff were not acting in line with the organisations policies, resulting in several missed opportunities to identify and escalate deterioration. Investigation had not identified why the service’s daily clinical catch-up process and handover process had not been effective in identifying and informing the senior clinical team about ongoing concerns for the health of the consumer.

The approved provider responded to the Assessment Team’s report and advised that they have since undertaken an investigation and embedded a number of actions to strengthen their existing practices, these include education for clinical staff in relation to clinical decline and expected documented entries, emergency decision making guidelines replaced in the clinical rooms and nursing station, discussion of unwell consumers during clinical catch up and a reminder for clinical staff not to wait for GP review if this cannot be achieved in a timely manner. I have considered the providers response and acknowledge this is an isolated event, however I find that the progress note documentation and review was lacking and staff failed to escalate the deterioration of the consumer in a timely manner. I find that the approved provider is not compliant with this requirement.

The service was previously found Non-compliant in Requirement 3(3)(e) following the Assessment Team’s findings that showed care staff are not always aware of consumers’ needs and/or preferences. At times, information is not effectively documented and/or communicated.

The Assessment Team found that although the service has implemented improvements, the service was still not able to demonstrate information about a consumer’s condition, needs and preferences is consistently documented and communicated with those who are in the service and others where care responsibilities are shared.

Four consumer care files demonstrated information about the consumer’s condition had not been documented or communicated, impacting on the effective management of the consumer.

Wound Charts for sampled consumers showed no regular weekly measurements were documented or communicated, which is not in line with the organisations policy. BP monitoring was not conducted in accordance with care plan directions. This reduces the ability of staff to monitor and track healing and to identify deterioration or decline. Management initiated actions to resolve this during the site assessment.

The approved provider responded to the Assessment Team’s report advising that the lack of documentation and communication was due to an agency nurse not completing the appropriate records. I have considered the providers response; however, it was also identified that blood pressure monitoring was not documented. I believe it is Southern Cross Care’s responsibility to ensure that agency staff are inducted to follow the policies and procedures and document the information for consumers.

I find that the approved provider is not compliant with this requirement.

**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 Standard has been assessed as Compliant as 7 of the 7 Requirements are Compliant.

The Assessment Team interviewed consumers who were satisfied with the services and support provided for daily living and this was meeting their needs, goals and preferences.

Consumers receive safe and effective services that maintain their independence, wellbeing and quality of life. Staff were able to demonstrate knowledge of each consumer’s needs and preference for activities. Lifestyle planning documentation identified consumers’ choices and provided information about the services and supports consumers needed to undertake the things they want to do.

One consumer provided feedback that they were feeling emotionally isolated and losing interest in attending to activities of daily living and was actively encouraged by staff to spend time assisting with duties in the service. This has changed the consumer’s attitude and had a positive emotional outcome.

The service has supports in place to promote each consumer’s emotional, spiritual and psychological wellbeing. Staff were able to demonstrate that they were aware of individual consumer’s needs in relation to emotional, spiritual and psychological wellbeing. The service has a dedicated chapel where all faith domination services are held. Each consumer has a Leisure and Lifestyle Abilities and Special Considerations plan completed when entering the service, where preferences for spiritual support are identified and documented. This plan is updated when consumer preferences or abilities change. The Lifestyle Coordinator said she ensures her team assist consumers to attend the religious services conducted.

The Assessment Team reviewed care plans and interviewed care staff which demonstrates consumers were referred to a psychologist when this is required. The Lifestyle Coordinator said as a team they identify, discuss and support any consumers who appear to be experiencing low mood due to social or environmental change and what may affect consumer emotional wellbeing.

The Assessment Team found that consumers felt supported to participate in activities within the service and in the outside community as they choose. The service enabled consumers to maintain social and personal connections that are important to them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer.

The Assessment Team identified processes are established to document and share information about each consumer’s needs and preferences both within the organisation and with others when required. The information is up to date and accurate and staff were able to describe ways that the service effectively manages the communication of this information in relation to services and support for daily living.

The Assessment Team interviewed staff who advised information about the consumer’s condition, needs and preferences is communicated through staff handover sheets, consumers care plans, progress notes and through face-to-face handover sessions between staff. Care plans reviewed included documentation regarding the consumers’ condition, needs and preferences, and this was consistent with the information obtained during interviews with consumers and representatives.

The service was able to demonstrate timely and appropriate referrals to individuals and providers of other care and services to enhance the lifestyle and enjoyment of consumers. The Assessment Team observed consumers attending the mobile dental clinic which was conveniently located adjacent to the main entry doors during day 1 of the Site Audit. Lifestyle staff said they make referrals to the onsite hair salon when the hairdresser attends the service on a weekly basis. The Assessment Team observed the hairdressing services to be busy with both male and female consumers attending the hair salon during the visit. Clinical staff said the service makes referrals to the NDIS, Dementia Support Australia, Older Person Advocacy Network (OPAN) and other support organisations when consumer needs are identified.

The Assessment Team interviewed consumers in relation to meals, all consumers stated they were satisfied their meals were varied and of suitable quality and quantity. Most consumers reported they enjoy their meals and have no complaints. Consumers and representatives advised that the menu has improved significantly following the commencement of the new management team and if they don’t like the dish being served, then staff will do their best to find an alternative meal which is more in keeping with their taste. Staff could describe specific dietary requirements of consumers, their likes and dislikes, as well as their preferred meal sizes.

Observations of consumers plates during the lunch service showed the majority were cleared. Service staff were observed asking if consumers had enjoyed their main course and then provided consumers with the options for dessert.

The Assessment Team interviewed consumers who said they felt safe when utilising the service’s equipment and that the equipment they needed was accessible and suitable for their needs. Consumers interviewed said they were comfortable raising their concerns if equipment required repair and understood the process when needing to report an item and said equipment was replaced when necessary.

Service equipment used for activities of daily living was observed to be safe, suitable, clean and well maintained. Mobility equipment is regularly checked to ensure safe function is maintained for consumers and items are replaced when necessary. The service provided documentation to verify the purchase of 2 replacement lifters/hoists on 6 June 2022. Care staff were observed cleaning hoist equipment prior to and following its use. The service has a maintenance schedule to ensure electrical equipment is tested annually to maintain consumer and staff safety and electrical items meet compliance.

**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 Standard has been assessed as Compliant as 3 of the 3 Requirements are Compliant.

The Assessment Team observed the service to be welcoming, with well-maintained facilities and gardens/courtyards. All consumers interviewed said they like living at the service and find the surroundings to be both comfortable and relaxing. Staff and management were observed to greet all consumers, visitors and staff entering the service in a friendly and welcoming manner.

The reception is located adjacent to the main entry and all visitors were observed to be greeted promptly and supported to undertake the entry requirements and to navigate the service by a member of the service’s team. The service is distributed over 2 levels and directional signage is clear and precise.

The Assessment Team found the service is safe, clean, well maintained and comfortable. There are processes in place to ensure there is regular maintenance and cleaning. Consumers and staff are encouraged to raise any maintenance or safety issues. Consumers across the three wings were observed to be able to move freely indoors and outdoors as desired.

Consumers interviewed said they found the service environment to be clean, safe and well maintained with one consumer saying that they are happy with the cleanliness of the bedroom and the common areas of the facility and there are ‘never any problems’. Consumers and their representatives said they could access the outside environment, with one consumer and representative saying the service supports them to leave the facility and visit the local coffee shop.

The Assessment Team observed consumers and their representatives freely accessing the outdoor areas, balcony gardens, and communal common areas within the service’s environment.

The service has a preventative and reactive maintenance program which covers the service requirements related to all major plant and equipment contained in the service. The service has a system to address any maintenance requests which are raised by consumers or their representatives.

**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 Standard has been assessed as Compliant as 4 of the 4 Requirements are Compliant.

The Assessment Team interviewed consumers and representatives who confirmed that they were aware of the process to provide their feedback and make complaints if necessary and staff were able to describe how they support consumers to provide their feedback and make complaints. Consumers and representatives said that they have provided feedback via surveys, at residents and residential meetings and in person to the Facility Manager and had no hesitation in doing so.

Consumers and representatives interviewed said they were aware they could seek external advice to raise and resolve complaints including the Commission, one representative was aware of the Older Person Advocacy Network (OPAN), and all consumers and representatives interviewed said they have seen brochures about the complaints process in other languages as well as information about the Commission complaints mechanism.

Consumers and representatives interviewed said they were comfortable making a complaint if necessary and would do this via the feedback form, email or directly with staff and the Facility Manager. Documentation reviewed showed actions that have been taken to obtain a resolution. The service has complaints management and open disclosure policies and a review of the complaints and feedback register showed complaints were received, actioned in a timely manner and an open disclosure process used.

Two consumers said they had noticed improvements to their care following feedback. Management described how feedback and complaints are analysed with trends identified and improvements entered and actioned via the Plan for Continuous Improvement. (PCI). Some examples of this include feedback from a family member the call bell system was not functioning well the service requested an audit of the call bell system to ensure all call bells in the rooms are working well and displaying correct timings on the system. Additionally, when feedback from consumers was received that the food was not hot the service have introduced a hot box to transport food from the kitchen to the dining rooms.

**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 Standard has been assessed as Compliant as 5 of the 5 Requirements are Compliant.

The service was previously found Non-compliant in Requirement 7(3)(a) following the Assessment Team finding staff were often not responding to call bells in a timely manner and there had been unplanned delays in employing a registered nurse to meet consumer assessment and planning needs for the service which is now at full occupancy.

The Assessment Team have found that the service has made improvements to address the deficits in the above Requirement with registered staff engaged 24/7 providing clinical care, an advanced care nurse call system has been implemented and call bells are monitored and reported on. Management reported the current average call bell response time is 6 minutes. The service has a new clinical team including a Deputy Facility Manager who was the previous Clinical Care Coordinator and a new Clinical Care Coordinator previously a senior registered nurse, to improve clinical care.

The Assessment Team interviewed consumers and representatives and found that most consumers and representative said there are enough clinical, care and therapy staff to look after their daily needs, they felt safe in the service and were well cared for.

Staff allocations reviewed, interviews with management confirmed, the service makes all attempts to fill vacant shifts, agency usage is limited, staffing levels are adapted if the occupancy numbers increase and or if the acuity of consumers changes. Staff interviewed said there were enough staff available to meet the needs of consumers, overall unfilled shifts were filled, they worked well as a team, and they were able to provide feedback to management if they had any concerns regarding staffing levels.

Observations during the performance assessment showed, consumers were seen to be assisted with all activities of daily living in a calm and unrushed manner, call bells were attended to in a timely manner, there were sufficient clinical staff to cover 24/7 nursing care, there were sufficient therapy assistants available to provide group and 1:1 support, including a designated therapy staff in the Memory Support Area, there were sufficient staff to ensure quality meal service and the service was clean and well maintained.

The Assessment Team interviewed consumers and representatives who said that overall, staff were kind and caring and respectful of each consumers identity, culture and diversity. Staff knew consumers well and were able to describe their preferences in relation to care and services and unique aspects of their identity and how this impacted care. Observations of staff providing care to consumers demonstrated they were kind caring and respectful. Two consumers said the Clinical Care Coordinator is very approachable, easy to talk to and is happy to discuss any concerns they have which has resulted in improvements to their care.

The Assessment Team found that the service demonstrated the workforce is recruited, trained and equipped and supported to deliver the outcomes of these standards. Most consumers and representatives considered staff were qualified, well trained and equipped and were able to provide safe care and services. Staff advised they receive the training and education they need to provide safe and effective care.

Management advised staff complete a corporate orientation program which includes mandatory training and identify any knowledge or experience gaps which are revealed through consumer feedback, feedback from staff, direct observation, training/skills competency and staff performance appraisals, audits and incidents.

The service demonstrated the workforce is recruited, trained and equipped and supported to deliver the outcomes of these standards. Staff complete a corporate orientation program which includes mandatory training. Staff advised they receive the training and education they need to provide safe and effective care. Management identifies any knowledge or experience gaps which are revealed through consumer feedback, feedback from staff, direct observation, training/skills competency and staff performance appraisals, audits and incidents.

Overall, for the consumers sampled, consumers and representatives considered staff were qualified, well trained and equipped and were able to provide safe care and services.

The Assessment Team reviewed the training matrix for staff in various roles. Each role has specified levels of competency required and mandatory training required, and this is monitored. All staff had completed mandatory training.

The service demonstrated it regularly assesses and monitors the performance of each member of the workforce. Performance appraisals are conducted formally following the commencement of employment at three months performance review and planning occurring annually. There are systems in place to ensure performance management processes are initiated following feedback from consumers and staff, and where incidents have occurred. Management support staff to improve performance and where the need for improvement, training, monitoring is identified, this takes place.

Opportunities for assessing staff performance on an ongoing basis are identified including via feedback from consumers and representatives, audits and incidents and observations of staff practice. Performance reviews are conducted following probation, and on an annual basis. Where a staff member is not performing according to the standard expected of them, the Facility Manager has an initial informal discussion to outline areas required for performance improvement. Where further improvement, training or monitoring are required, the service seek assistance from the organisation’s human resources department.

**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 Standard has been assessed as Compliant as 5 of the 5 Requirements are Compliant.

The Assessment Team found that the Board ensures corporate governance, risk management and quality assurance systems are effective, and staff receive education and support required to meet the requirements of the Quality Standards.

A review of two recent Board meeting minutes demonstrated the Board receives information on restrictive practice, national quality indicators, dignity of risk, complaints and consumer feedback, incidents, reportable incidents, renovation and construction matters and financial matters.

The service was able to demonstrate it applies the organisation’s wide governance systems relating to information management, continuous improvement, regulatory compliance, feedback and complaints financial governance and workforce governance which assist with improving outcomes for consumers.

The organisation has a privacy policy which governs the private information collected for what purpose, where information is held, and under what circumstances it may be disclosed.

The service has an electronic care management system to document consumers care and services and to manage incidents. The electronic system is password protected and staff access the system at levels relevant to their roles. All information relating to care and services, incidents and any other changes are documented via the electronic care management system.

Staff confirmed they have access to information about consumers through the electronic care records, handover meetings, handover documents and staff meetings.

The Assessment Team found that the service maintains a corporate Plan for Continuous Improvement (PCI) and management advised opportunities for improvement are identified following incidents, audits, feedback received from consumers, representatives and staff, when changes to legislation occur and following feedback/issues identified at performance assessments.

The service was able to demonstrate there are appropriate systems and processes in place to ensure effective workforce governance. Management advised and documentation reviewed confirmed staff are employed following a recruitment process which includes application, selection aligned to position description, interview, reference and qualification checks, probationary period and contract of employment.

The organisation tracks changes to aged care law and requirements through monitoring communications from the Department of Health and other industry related organisations. The service uses meetings, training sessions and communication materials to advise staff of changes to policies and procedures, and legislative requirements. Policies and procedures have been implemented since the introduction of SIRS and legislation amendments relating to restrictive practices, including the requirement for all residential aged care providers to have Behaviour Support Plans (BSPs) in place for consumers that need them.

The Regional Manager confirmed there are financial and delegation systems in place to allow Facility Managers to make expenditures as required to support the changing needs of consumers. This can be for equipment purchases, specialist referrals and urgent staffing resources.

The service has a process and mechanisms in place for consumers, representatives and staff to provide feedback including via written feedback forms, survey, and directly to the Facility Manager and staff. The organisation and service monitor feedback and complaints and analyse trends and identify opportunities for continuous improvement.

A review of the risk management system showed the service have a system in place to assist in managing high impact high prevalence risks including clinical incident data is collected and collated via moving on audits which provides benchmarks against similar size services, a clinical indicator report an incident register and various clinical and clinical governance meetings. The service analyses and trends clinical incident data on a monthly basis and uses this information to make improvements.

The service was previously found Non-compliant in Requirement 8(3)(e) following the Assessment Team’s findings that areas within the framework were not always implemented and there has been a lack of clinical oversight for effective clinical governance. This included a lack of clinical governance and supporting information and evidence in minimising the use of restraint, assessment and planning and staff understanding and implementation of processes in these clinical areas.

The Assessment Team have found that the service has made improvements to address the deficits in the above Requirement and demonstrated that the organisation has a Clinical Governance Framework and appropriate governance structures including a Clinical Governance Committee, Clinical Quality Committee, and a Clinical Audit schedule and various meetings and reporting mechanisms. Management advised the service has been working towards implementing improvements following the previous findings of non-compliance in the areas of assessment and planning, outcomes of assessment planning are effectively communicated and documented in a care services plan, care and services are reviewed regularly, safe and effective personal and clinical care, and effective management of high impact high prevalence risks, and the internal audit findings.

The service has policies and procedures guiding staff practice on the Serious Incident Response Scheme (SIRS) including what constitutes a serious incident, reporting requirements, and staff responsibilities. A SIRS register enables management to monitor SIRS for trends and reportable incidents are escalated to service and organisational management for reporting, investigation, monitoring and identifying service improvement.

The service monitors restrictive practices via restrictive practices register and clinical meetings show evidence of discussion of consumers subject to restraint. The service identified three consumers subject to chemical restraint and the Assessment Team found medication used is used as a last resort, for the least amount of time, is monitored for side effects and effectiveness, is regularly reviewed and a behaviour support plan is in place. Informed consent has also been sought and provided.

The organisation has effective systems for preventing, managing and controlling infections and antimicrobial resistance. The organisation has an Antimicrobial Stewardship policy that aims to guide staff in reducing the use of antimicrobials. Management reported the organisation holds regular meetings where clinical staff are informed about practices that aim to make sure antimicrobials are prescribed according to best practice guidelines.

The service was able to demonstrate an open disclosure process is in place including a policy to guide staff practice and staff are trained in open disclosure principles.

Management and staff gave examples where open disclosure had been used, and complaints, incident documentation and care planning documents confirmed, the use of open disclosure, when negative events occurred.

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)