Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | St Basil's Kensington |
| Service address: | 95-97 Todman Avenue KENSINGTON NSW 2033 |
| Commission ID: | 2285 |
| Approved provider: | St Basil's Homes |
| Activity type: | Site Audit |
| Activity date: | 6 September 2022 to 9 September 2022 |
| Performance report date: | 14 October 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 St Basil's Kensington (**the service**) has been prepared by M Wyborn, 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 approved provider’s response to the Site Audit report dated 10 October 2022.

# Assessment summary

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

* Ensure that the consumer handbook contains information on the care planning process at the service.
* Ensure that the outcomes of consumer assessment and care planning is effectively communicated to consumers and/or representatives and that a copy of their care plan is readily available to them.

**Requirement 3(3)(a)** The service should:

* Ensure delivery of best practice care that is tailored to consumers’ needs and optimises their health and well-being, by providing education and training to staff on diabetic management and pain management.
* Ensure the service’s medication register is consistently and accurately completed when medication is administered and that the prescriber of the medication is clearly documented.

**Requirement 3(3)(b)** The service should:

* Ensure effective management of high impact or high prevalence risks, specifically in relation to wound management and pressure area care.
* Provide education and training to staff around the correct setting for the air mattresses used by consumers as a pressure relieving device.

**Requirement 3(3)(e)** The service should:

* Ensure that consumer information is consistently and accurately documented in their clinical files, including care plans, assessments, monitoring charts and progress notes. This includes a consumers’ current condition and care needs and will ensure that accurate information is available to the care staff.

**Requirement 3(3)(g)** The service should:

* Provide education and training to staff to ensure there is effective management of standard and transmission-based precautions to prevent and control infections.
* Ensure the Infection and Prevention Control Lead has their required training and has responsibility solely for the service only.
* Provide education and training to staff in relation to mask wearing, the use of sanitising wipes and changing gloves when moving between consumer bedrooms.
* Ensure appropriate processes for minimising infection related risks by ensuring appropriate antibiotic prescription.

**Requirement 4(3)(a)** The service should:

* Ensure that consumers receive effective services and supports for daily living that meet their needs goals and preferences and optimise their independence, health, wellbeing and quality of life by ensuring all consumers have their life stories completed, implementing a leisure and lifestyle calendar and providing support to consumers who are bed bound or prefer to reside in their rooms.

**Requirement 4(3)(f)** The service should:

* Provide education and training to ensure that processes are adhered to for quality consumer outcomes in relation to food and hydration and choice of meal is regularly offered to consumers.
* Ensure the dining environment reflects a pleasant dining experience and atmosphere, that consumers are offered choice and not regularly eating off trays.
* Provide education and training to staff to ensure that they are effectually engaging with consumers during meal time.

**Requirement 5(3)(b)** The service should:

* Ensure the service provides a safe, comfortable environment that supports consumers to move freely both indoors and outdoors.
* Ensure the service environment is safe for consumers and visitors and that consumer risk assessments are completed in relation to the current renovation works so that appropriate risk mitigation strategies can be implemented.
* Ensure access is easily available for all consumers and visitors including first floor access and lift access.

**Requirement 6(3)(b)** The service should:

* Ensure the service provides appropriate information to make consumers aware of relevant advocacy services or language services.

**Requirement 6(3)(c)** The service should:

* Ensure consistent, timely and appropriate action is taken in response to concerns raised by consumers and representatives about care and services.
* Provide education and training to staff regarding open disclosure.

**Requirement 7(3)(c)** The service should:

* Ensure staff have the skill and knowledge to effectively perform their roles by implementing an effective induction and orientation process, in particular for agency staff.

**Requirement 7(3)(d)** The service should:

* Provide ongoing and relevant education and training to staff in relation to assisting consumers with their personal and clinical care.
* Ensure that staff training records, whether online, face to face or via toolbox talks, are up to date.
* Ensure staff mandatory training and ongoing training requirements are up to date, including that for agency staff.
* Provide education and training to staff, including agency staff, on open disclosure and monitor staff understanding and application in the service environment.

**Requirement 8(3)(a)** The service should:

* Ensure proactive engagement with consumers in the development, delivery and evaluation of care and services.
* Provide opportunity for consumer engagement in decisions which impact on their independence, health, well-being and quality life, including meaningful involvement in the care planning process.

**Requirement 8(3)(c)** The service should:

* Ensure staff are provided with sufficient information such as duty lists to be effective in their roles.
* Ensure policies and procedures are easily accessed by agency staff via the services intranet.
* Provide education and training to staff to ensure clinical documentation is consistent and monitoring charts are routinely completed.
* Ensure reliable communication is being provided between care staff and kitchen staff regarding the dietary needs of consumers.
* Ensure the service’s continuous improvement plan is regularly reviewed for ongoing actions and evaluated for the effectiveness of actions taken.
* Ensure the leisure and lifestyle team is appropriately financed.
* Provide agency staff with effective orientation and monitor progress of staff mandatory training requirement.
* Ensure that consumers have access to advocacy and language services to enable them to provide feedback and make complaints.

**Requirement 8(3)(d)** The service should:

* Ensure effective evaluation to reduce or remove any risks identified to consumer health, safety and well-being.
* Review the effectiveness of the organisation’s risk management framework, policies and procedures.
* Review the organisation’s policies and procedures regarding consumers with high impact or high prevalence risks, with a focus on providing individual consumer care where necessary.

**Requirement 8(3)(e)** The service should:

* Review the organisation’s clinical policies and procedures to provide more specific procedures to guide the workforce in implementing the policies.
* Provide education and training to staff on the principles of open disclosure and evaluate its application within the service environment.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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 advised they are treated with dignity and respect and their identity, culture and diversity is valued. Staff were observed throughout the site audit addressing consumers politely and respectfully.

The service has consumers with a predominantly Greek background and the service provides culturally safe care and services for Greek consumers. Information about a consumers’ life history including their cultural needs is captured as part of the care planning documentation process and this is appropriately managed by the leisure and lifestyle coordinator. Consumers advised that the service meets their cultural needs and staff demonstrated an awareness of consumers’ preferences and cultural needs.

The service demonstrates that each consumer is supported to exercise choice and independence. Consumers and representatives advised they are consulted, can make decisions when others are involved in their care and are supported to maintain relationships of choice.

Consumers are supported to take risks to enable them to live the best life they can. Some consumers are supported in their desire to be independent even though they are a little unsteady on their feet. Dignity of risk assessment documentation was completed for these consumers with risk mitigation strategies declared.

The service demonstrated appropriate processes to ensure that consumers’ privacy is respected and their personal information is kept confidential. Consumers and representatives confirmed their personal privacy is respected and were confident their personal information is only shared when necessary. Consumers advised that staff always knock on their door before entering and this was observed by the Assessment Team throughout the site audit. Both electronic and hard copy consumer files are stored confidentially.

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

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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. | Non-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 service demonstrated appropriate consideration of risk to consumer’s health and well-being is managed effectively. Dignity of risk and falls risk assessments have been actioned and completed to ensure consumers’ safety with the use of lo-lo beds.

Consumers that are on a palliative pathway have advance care planning and/or end of life planning documentation in place. These consumer plans consider risks associated with skin integrity and relevant risk assessments and pressure area care management is reported and implemented to prevent pressure injuries from occurring. Palliative care plans are reviewed every three months or when a consumer’s needs change and they are reflective of individual needs, goals and preferences.

The Assessment Team observed that consumer risk assessments are routinely completed upon admission into the service and are updated when new risks arise, or when a consumer’s circumstances change. The service demonstrated that consumer assessments and relevant plans are updated to reflect individual risk such as a diabetic management plan or a weight loss management/monitoring plan. Appropriate risk assessment tools are used by the service in line with best practice including the Abbey Pain Scale and Delirium Screening Tool.

The service demonstrated that consumer assessment and planning, including up to date consumer care plans, are reflective of the consumers’ current condition, their current needs, goals and preferences.

Consumers and representatives advised their assessment and planning is based on ongoing partnership with the consumer and/or others that the consumer wishes to involve in their care and services. This was observed by the Assessment Team through documentation review of consumer files which identified several providers involved in consumer care or services such as Dementia Support Services, physiotherapist, podiatrist, nurse practitioner, speech pathologist or a dietician. These individuals or providers then provide input towards the consumers care plans, write progress notes or update relevant consumer risk assessments.

Consumers and representatives advised they are notified when changes occur to their care plan, however, do not receive effective communication of the outcomes of assessment and planning and advised that their care plan is not readily available to them.

Management advised the Assessment Team that case conferences are a time where representatives receive a copy of the care plan, take it home and make changes, then return it to the service for amendment. However, this was not observed in practice. Management also advised there is a backlog in discussing care plans with consumers as the general manager prefers to spend one on one time with consumers discussing their care plans due to sensitive topics such as incontinence. Other management team members said consumers were not given copies of their care plans as they suffered from cognitive impairment. The Assessment Team interviewed consumers with no diagnosis of cognitive impairment and confirmed they did not receive effective communication about their care plan.

The consumer handbook did not contain information on the care planning process at the service therefore information is not formally provided to consumers or representatives about their involvement in the delivery of care and services. The Assessment Team provided this feedback to the clinical care managers and the general manager.

The Assessment Team observed that care planning documentation is consistently reviewed when a consumer’s care needs change or when a consumer has an incident that impacts on their care needs. Care planning documentation is also being reviewed every three months for all consumers despite circumstances changing or incidents occurring.

The service demonstrated incident forms are routinely completed. This data is used by the service to review and monitor medication or falls to determine strategies to mitigate the risk and ensure the consumers’ safety. Care plans are reviewed and updated when a consumer returns from hospital and if the consumer’s circumstances have changed when returning to the service from the hospital.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | 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. | Non-compliant |

Findings

The Assessment Team observed consumers are not receiving best practice care that is tailored to their needs or optimising their health and well-being. This includes diabetic management and pain management. A review of the service’s medication register showed that not all entries were completed as required when medication was administered. The prescriber of the medication was not documented for some consumers when their medication was dispensed.

The Assessment Team observed discrepancies in the management of high impact or high prevalence risks associated with consumer care. This was specifically in relation to wound management and pressure area care. Some care staff and one registered nurse were not aware of who is responsible to identify the correct setting for the air mattresses that some consumers use as a pressure relieving device, or the correct pressure setting for each consumer that uses an air mattress.

The Assessment Team observed that consumers who are nearing the end of their lives have appropriate documentation that reports on their care needs and preferences, their wishes and directives and consultation occurs with consumers and representatives when referral to palliative care is required, when a consumer commences the palliative pathway or when a consumer is receiving end of life care. Feedback from representatives was positive in relation to the palliative or end of life care their relative is receiving at the service.

Staff described how they ensure consumer comfort and dignity when consumers are nearing the end of their lives. The Assessment Team observed a palliative care trolley that contained oral care and other products to help maintain the consumer’s comfort and dignity.

The service demonstrated that consumers who have experienced a deterioration or change in their cognition or mental health have their needs recognised and responded to in a timely manner. In addition, the Assessment Team observed that consumer care planning documents and progress notes support that consumer deterioration or changes in their function is identified and responded to effectively.

The service did not demonstrate that there is an effective process to ensure consumer’s information is documented accurately, is reflective of a consumer’s current care needs and/or communicated effectively within the service.

Consumer information is documented in their clinical files which include care plans, assessments, monitoring charts and progress notes, however, a consumers’ current condition and care needs are not accurately documented on a consistent basis. This results in inaccurate information available to the care staff. Staff explained that the information is available in the electronic care plans, however they do not refer to these before they commence their shifts, rather they receive information on the changes to consumer needs through a staff handover discussion. The Assessment Team observed that staff who were new to the service could not provide information about the care needs for consumers in the area they worked.

The service demonstrated input of others such as allied health professionals and specialists and that referrals are made when required. The Assessment Team observed evidence of referrals to speech pathologist, dietician, wound specialist and geriatrician. The input from the specialists and allied health professionals was observed to be documented in the consumers’ clinical file.

The service demonstrated an outbreak preparedness plan and associated documents to guide their practice in the event of an outbreak. There is support for consumer and staff vaccinations and the service has adequate supplies of personal protective equipment in the event of an outbreak. However, the service did not demonstrate there is effective management of standard and transmission-based precautions to prevent and control infections.

The Infection and Prevention Control Lead (IPCL) has not completed the required training however, is working towards completion and the IPCL advised that they have responsibility to support two services at different locations. The Assessment Team observed poor practice in relation to staff mask wearing, staff were observed to be touching their masks and some staff had their masks removed while talking to other care staff in the corridors of the service.

There were no sanitising wipes available near shared equipment, including the observation machine used to record consumers blood pressure, oxygen saturation and pulse and one care staff member was observed not changing gloves when moving between consumer bedrooms.

The service does not have a schedule for cleaning slings from the lifters and only wash them once they are soiled. Management said that each consumer who requires a sling has their own.

The Assessment Team observed lifters, wheelchairs and walkers stored ordinarily in a shared bathroom.

The service did not demonstrate minimisation of infection related risks by ensuring appropriate antibiotic prescription. One registered nurse and the clinical care coordinator said that the doctor is encouraged or reminded to attend to pathology or potential infection before prescribing antibiotics, however the service did not provide an example of when this has occurred.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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. | Non-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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team observed that consumers do not receive effective services and supports for daily living that meet their needs goals and preferences and optimise their independence, health, wellbeing and quality of life. A review of documentation for leisure and lifestyle activities showed all consumers did not have comprehensive life stories completed. There is no leisure and lifestyle calendar for the dementia specific unit. The leisure and lifestyle coordinator said there is no one to one program or schedule for consumers who are bed bound or prefer to reside in their rooms. In addition, the Assessment Team observed very little interaction or engagement for consumers in the lounge room.

The service is supporting each consumer’s emotional and spiritual wellbeing and further supports are being arranged. The Assessment Team observed the Greek priest who works at the service twice a week providing prayer before the midday meal to the consumers.

The service demonstrated support for consumers to maintain social and personal relationships and to do things of interest to them. Consumers are also supported to participate outside in their community.

The service demonstrated that appropriate external referrals are occurring to support consumer clinical care. However, proactive external referrals to support consumer leisure and lifestyle activities were not observed by the Assessment Team. The service has a Greek entertainer who visits the service once a month and sings Greek songs with consumers.

The Assessment Team observed that the meals provided at the service are of suitable quality and quantity. However, processes are not being adhered to for quality outcomes for consumers in relation to food and hydration and choice of meal is not regularly offered to consumers. The dining environment lacks a pleasant dining atmosphere. The Assessment Team observed consumers to be eating off trays in their lounge room, dining room, bedroom and in the dementia specific area. All courses such as the main meal and dessert are presented to consumers on the tray all together. The Assessment Team observed that staff are not engaging with consumers during meal time and activity materials are in front or to the side of consumers while eating.

The service provides equipment to cater for the individual needs of consumers and has processes in place to ensure it is safe, suitable, clean and well-maintained. Staff said they have sufficient and appropriate equipment to meet the care needs of consumers. Consumers did not raise any concerns related to equipment.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team observed that the service environment does not have a welcoming home-like appearance or atmosphere. The service displays limited dementia enabling design and there is limited lounge furniture and many chairs have an institutionalised appearance. There is lack of personalisation in consumers’ bedrooms and colour throughout the service. There is no art work on the walls anywhere in the service apart from the dining room. The Assessment Team observed that one bathroom has a shower trolley stored there and is currently a storage area full of pressure relieving chairs due to lack of storage.

The service did not demonstrate an environment that is safe or comfortable and the Assessment Team observed that consumers are unable to move freely both indoors and outdoors.

The Assessment Team observed the commencement of renovations at the service. Specific areas were not blocked off, there were no safety fencing or signage to alert consumers or visitors and a step ladder with a bucket on top was observed in the corridor near the renovation site. Management advised the Assessment Team that risk assessments had not been completed to identify consumers who would be impacted by the noise of the renovation works, particularly cognitively impaired consumers, so that appropriate risk mitigation strategies could be implemented. Management informed the Assessment Team on the second day of the site audit the renovation would cease while the site audit was being conducted. Management said a risk assessment would be followed up for all consumers and appropriate strategies implemented before the renovation resumes.

The first floor has steep steps at the entry that consumers with mobility issues cannot access. Access is available via a lift in the garage however consumers are not able to access the lift unassisted as this is only accessed by staff with swipe cards and codes. The front door is locked and consumers cannot access the front landing without assistance. Management advised that the service is currently working on providing some consumers and representatives with swipe cards and codes. The service has two small indoor courtyards on the top level but no garden areas which consumers can access below.

The service demonstrated appropriate systems to ensure fittings and equipment are repaired and are safe for consumers. Documentation reviewed by the Assessment Team verified that maintenance is completed in a timely manner and maintenance logs are up to date. Preventative maintenance is in place at the service however, there is no hazard register at the service. Consumers, representatives and staff advised they were satisfied that they could see improvements being made.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service demonstrated support for consumers and their families to provide feedback and to make complaints. The Assessment Team observed that consumers and others have access to internal and external feedback information at the entrance to the service. This included the Aged Care Quality and Safety Commission’s complaints brochures in English and in Greek. In addition, consumers and representatives have access to the service’s internal feedback form and suggestion box near the general managers’ office.

Consumers and representatives advised that they are aware of how to make a complaint and have done so in the past. They said that the general manager is very approachable and addresses concerns in a timely manner.

The service did not demonstrate appropriate information to support consumer access to advocacy services or language services. One small Older Persons Advocacy Network (OPAN) poster, in English only, was observed in the foyer of the service. The service’s complaints policies and procedures promote advocacy services but no information is provided to consumers or representatives.

The service did not demonstrate consistent and/or appropriate action when consumers and representatives raise concerns about care and services. Some representatives raised concern that the action taken to resolve some complaints is not effective or timely.

Several staff were not aware of the open disclosure process and were unable to explain the requirement when asked by the Assessment Team.

The service demonstrated an effective system to capture and process complaints which feeds into the service’s continuous improvement plan to improve the quality of care and services. The service maintains a feedback register which includes complaints, concerns and compliments. The feedback register provides details of feedback provided and actions taken to resolve any issues and is monitored by the general manager who identifies trends and reports monthly to the executive team.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service demonstrated a mix of permanent and agency staff to deliver and manage care and services to consumers. Consumers and representatives advised the Assessment Team that there are sometimes not enough staff at the service or that sometimes staff are not well trained and do not know the consumer. Staff advised that they are able to complete their jobs in the time allocated and management advised that the service is currently recruiting for a registered nurse night shift and for seven permanent care staff shifts which are currently filled by agency staff.

The service demonstrated that workforce interactions with consumers is kind, caring and respectful. Consumers and representatives praised the staff for the care they provide.

The Assessment Team observed that staff do not always have the skill and knowledge to effectively perform their roles. Agency staff, including clinical staff do not have effective orientation and training to ensure they have the required knowledge and skills for their roles. Management advised the Assessment Team that the service’s induction and orientation process has been reviewed and agency staff who are booked for more than 14 days will undergo general staff orientation training. This will include competency for delivery of care and services such as a description of open disclosure, antimicrobial stewardship, serious incident response scheme (SIRS), consumer dignity and incident management. Management also advised that they are targeting training and development to support identified staff needs including training on ensuring clear and concise general documentation.

The Assessment Team observed that staff at the service are not trained to effectively assist consumers with their personal and clinical care. Staff training records indicate that not all staff have completed training and education to deliver required care and services to consumers. Management advised that staff training is provided online, face to face and through toolbox talks. Staff training is monitored online to ensure all staff are up to date with their mandatory and ongoing training requirements, however the Assessment Team observed that agency staff training is not monitored by the service. In response, management advised that the service expects that prior learning by agency staff is provided by their agency, such as elder abuse, open disclosure, privacy and dignity, SIRS, safe handling, infection control and hand hygiene hence this is not monitored. The service has no confirmation that this training has been provided. Management advised they were unaware of this and would review agency training with their employment agencies. Dementia specific training is planned to be provided by Dementia Support Australia and currently three staff have attended this training. Several staff, including agency staff, did not have an understanding of open disclosure although they have completed the training.

The service demonstrated effective systems and processes to monitor and review the performance of each member of the workforce. Management demonstrated their system for reviewing staff performance appraisals and records observed by the Assessment Team indicate that the service has an effective system for recording and monitoring staff performance and actions as a result of incidents. The service demonstrated appropriate guidelines for grievance and resolution, ending employment, counselling and discipline.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | Non-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. | Non-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. | Non-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. | Non-compliant |

Findings

The organisation did not demonstrate that it actively engages and supports consumers in the development, delivery and evaluation of care and services. Consumers are not encouraged to participate in their day to day care and do not have a broader representation in the planning of their care and services.

The service does not involve consumers in decisions which impact on their independence, health, well-being and quality life. Consumers are not supported to be involved in the care planning process. Feedback and complaints from consumers and representatives is encouraged by the service, however effective actions are not consistently taken in response.

The organisation demonstrated a good working relationship with consumers and representatives, using case conferences to focus on high care consumers. The leisure and lifestyle coordinator meets with consumers to discuss activities, food preferences and changes are communicated to the kitchen. Management encourages consumers and representatives to speak at leadership meetings to communicate their personal journeys so that staff have a better understanding of their care needs. The organisation has engaged a dementia consultant to review the service environment and discussed with consumers the change of linen colour.

The service is governed by the Board and a corporate leadership team which is responsible for overseeing the service’s strategic direction and policies to meet the Quality Standards. The Assessment Team observed that the organisation’s governing body has made improvements to strengthen corporate governance accountability at its services including more comprehensive reporting on clinical indicators, incident management and restrictive practices.

Review of the service’s operational reports indicated that the organisations’ strategic initiatives had commenced with new sub committees reporting to the Board including a leadership and governance committee. A recent report to the board identified summarised actions taken on key issues around legislative changes, serious risks/incidents, trending and analysis, clinical indicators, internal audits and operational reports.

Management advised and the Assessment Team observed that information contained in the service’s continuous improvement plan indicates that changes identified by the governing body have been developed however are at various stages of implementation and have not been evaluated for effectiveness. Ongoing improvements include clinical and environmental reviews.

The Assessment Team observed deficiencies in relation to information management, continuous improvement, workforce governance and feedback and complaints.

Information management - Staff are not provided with sufficient information such as duty lists to be effective in their roles. Policies and procedures are not easily accessed by agency staff via the services intranet. Clinical documentation is inconsistent and monitoring charts are not routinely completed. Insufficient communication is being provided between care staff and kitchen staff regarding the dietary needs of consumers. Care plans are not being provided to consumers and representatives.

Continuous improvement - The service’s continuous improvement plan generally reflects organisation wide improvements such as outcomes of concerns identified from compliance requirements, internal audits, feedback from consumers and representatives. Several items identified in the continuous improvement plan are marked as ‘incomplete’ without ongoing actions identified and the continuous improvement plan has not been evaluated for the effectiveness of actions taken despite some items being recorded as ‘closed’.

Financial governance - The leisure and lifestyle coordinator advised that they did not have a budget and has had to use their own money on leisure and lifestyle resources. Whilst the coordinator is reimbursed for these items, they said it sometimes takes a while for this to happen.

Workforce governance - Training is not always effective to equip staff to deliver the outcomes required to best support consumers. Agency staff are not always provided with effective orientation into the service for their roles. Staff training is not always effective in assisting consumers with their personal and clinical care. Information provided to staff, including agency staff, is not always provided in a manner that will support their understanding of consumers and their changing needs. Agency staff ongoing mandatory training is not monitored by the service.

Regulatory compliance - The organisation has reviewed its incident management systems and compliance reporting to ensure more robust systems and all compliance actions are completed. The service’s incident management system was observed as effective in reporting process, investigation and strategies to reduce risk of incidents reoccurring. The organisation is introducing an organisation wide clinical risk register to monitor the service’s incident management system. Management advised education will be provided to support staff in using the incident system.

Feedback and complaints - The Assessment Team observed deficiencies in relation to information provided to consumers regarding advocacy and language services to enable them to provide feedback and make complaints. It was identified that appropriate action is not always taken as a result of complaints and an open disclosure process is not well understood or used.

The organisation did not demonstrate an effective risk management system. The Assessment Team observed that identified risks to consumer health, safety and well-being are not being effectively evaluated to reduce or remove the risk in a frame that matches the level of risk and how it is affecting consumers. The organisation has a risk management framework and policies and procedures, however, these are generic and risks specific to the organisation have not been identified. Deficits in individual consumer’s care has been identified when reviewing consumers with high impact or high prevalence risks, including wound management and pressure area care. Whilst the service has recently updated policies and procedures regarding their risk management systems, they have not proven to be effective in their practice to date.

The organisation has a clinical governance framework that includes antimicrobial stewardship, minimising the use of restraint and open disclosure. The organisation has clinical policies and procedures to guide management and staff to deliver safe and quality clinical care. However, while the organisation has policies, they are largely generic and lack more specific procedures to guide the workforce in implementing these policies.

While most clinical staff had an understanding of antimicrobial stewardship, most staff did not have a reasonable knowledge of open disclosure. Open disclosure has not always been practiced in relation to the management of complaints.

The Approved Provider responded to the Site Audit report advising that they do not refute the findings and are working on fixing the non-compliant requirements identified in the report. In addition, the Approved Provider has updated their Plan for Continuous Improvement accordingly.

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

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