Performance

Report

**1800 951 822**

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| Name: | St Charbel's Care Centre |
| Commission ID: | 0978 |
| Address: | 2 Waterloo Road, Punchbowl, New South Wales, 2196 |
| Activity type: | Review Audit |
| Activity date: | 29 August 2024 to 4 September 2024 |
| Performance report date: | 20 November 2024 |
| Service included in this assessment: | Provider: 5231 St Charbel's Care Centre Ltd  Service: 19425 St Charbel's Care Centre |

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 Charbel's Care Centre (**the service**) has been prepared by Dee Kemsley, 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 Review 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 29 September 2024
* the Assessment Contact (performance assessment) site report dated 13 August 2024 to 14 August 2024 for a site audit conducted on the same dates.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 1(3)(a) - the provider is to ensure all consumers are treated with dignity and respect, and staff are aware of and value consumer’s identity, culture and diversity, including staff engagement and interaction with consumers, and workforce monitoring and training is effective in ensuring respectful and dignified care and services for consumers.
* Requirement 1(3)(b) - the provider is to ensure all consumers receive care and services that are culturally safe, including assistance to freely engage and communicate with all staff, and where language barriers are identified these are addressed and appropriately managed.
* Requirement 1(3)(c) - the provider is to ensure each consumer is supported to exercise choice and independence regarding their care and services, including being provided with sufficient information to make informed choices and in a format that is easy to understand and in line with their cultural needs; these choices are then to be upheld by the service.
* Requirement 1(3)(d) - the provider is to ensure that where risk mitigation strategies are developed, these strategies known by staff and implemented so consumers are supported if they choose to take risks to live their best life.
* Requirement 1(3)(e) - the provider is to ensure consumers receive comprehensive, current, timely and accurate information that they can understand and enables them to make informed decisions about their care and services, including support for improved communication between staff and consumers.
* Requirement 1(3)(f) - the provider is to ensure staff practices are consistently respectful of consumers’ personal privacy, and consumers personal information is kept confidential.
* Requirement 2(3)(a) - the provider is to ensure assessment and planning considers risks to the consumer’s health and well-being and informs the delivery of safe and effective care and services; including following the development of new conditions which impact the consumers’ care needs.
* Requirement 2(3)(b) - the provider is to ensure assessment and planning consistently addresses the current needs, goals and preferences of consumers, including end of life planning, and that they are clearly documented in the consumer’s care and service plan.
* Requirement 2(3)(c) - the provider is to ensure assessment and planning is based on an ongoing partnership with consumers and representatives who the consumer wishes to involve in their care, and the provider regularly updates and communicates with representative of changes in consumers’ condition, or escalation of their care needs.
* Requirement 2(3)(d) - the provider is to ensure the outcomes of assessment and planning are effectively communicated to the consumer and representative, and they ready access to a copy of the consumer’s care plan, which is accurate and up to date, and in a format or language they can understand or are supported to understand
* Requirement 2(3)(e) – the provider is to ensure care and services are regularly reviewed for currency of information, for effectiveness following consumers’ changed care needs or deterioration in condition, or following the consumers’ discharge from hospital; clinical monitoring processes are to be consistently undertaken as directed, and then reviewed to inform appropriate care planning.
* Requirement 3(3)(a) - the provider is to ensure consumers’ clinical and personal care is best practice, tailored to their needs and optimises their health and well-being, including ensuring all staff have sufficient documented information to guide the provision of individualised care for consumers, staff practice, skills and provision of care is monitored and supported to make certain all consumers consistently receive safe and effective personal and clinical care.
* Requirement 3(3)(b) - the provider is to ensure effective systems and processes for the management of high impact high prevalence risks to consumers’ health safety and wellbeing, including individualised review of consumers care histories is undertaken to review the effectiveness of risk strategies already implemented and to ensure equipment to mitigate risk is provided in a timely way monitored effectively.
* Requirement 3(3)(c) – the provider is to ensure the needs and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.
* Requirement 3(3)(d) - the provider is to ensure deterioration or change of a consumer’s condition is recognised and responded to in a timely manner by the service; including reviews by timely reviews medical officers or medical specialists, clinical and medical monitoring or treatment directives are implemented, and escalation of care or hospitalisation is actioned as required.
* Requirement 3(3)(e) - the provider is to ensure information about the consumers care needs are documented and communicated within the service and with others where care is shared, including consumers’ care plans are to reflect consumers’ current or changed care needs, incidents are consistently recorded and reported, and monitoring charts are completed as directed and reviewed to inform the provision of effective and shared care for consumers.
* Requirement 3(3)(f) – the provider is to ensure timely and appropriate referrals to providers of other care and services occurs, including ensuring monitoring, management or alternative escalation occurs when medical reviews are delayed, and that recommendations and directives following a referral are implemented and monitored.
* Requirement 3(3)(g) – the provider is to implement an effective system to ensure staff practices adhere to appropriate standard and transmission-based precautions, plus appropriate processes are administered to minimise risk of infection transfer at the service.
* Requirement 4(3)(a) - the provider is to ensure each consumer receives safe and effective support for daily living that optimises their quality of life, including implementation of review processes to determine the effectiveness of the lifestyle program provided for each consumer.
* Requirement 4(3)(b) - the provider is to ensure services and supports promote each consumer’s emotional and psychological well-being following events that may have triggered an emotional or psychological impact for consumers and staff are educated on providing effective care and services for consumers living with dementia and/or who have experienced trauma.
* Requirement 4(3)(c) – the provider is to ensure consumers are supported to engage in their community within and outside the service’s environment and do things of interest to them, including assisting lifestyle staff on how to support consumers with community activities, and of processes to engage with external organisations to supplement activities offered to consumers.
* Requirement 4(3)(d) – the provider is to ensure information about the consumer’s current needs and preferences is communicated within the service and with others were care is shared, to enable all staff to have a shared understanding of consumers lifestyle needs and preferences.
* Requirement 4(3)(e) - the provider is to ensure timely and appropriate referrals are made to individual and other providers of care and services, including actively collaborating with others to support the diverse daily living and lifestyle needs of consumers, and staff have sufficient knowledge of referral opportunities and referral processes.
* Requirement 4(3)(f) - the provider is to ensure where meals are provided, they are varied and of suitable quality and quantity, including improve internal communication between catering and care staff and staff knowledge and understanding of consumers dietary needs, and the role of staff in supporting consumers to have a pleasant dining experience.
* Requirement 5(3)(c) – the provider is to ensure all equipment provided is safe and well maintained, including processes to identify, assess and review the effectiveness of all equipment installed and used at the service.
* Requirement 6(3)(a) – the provider is to ensure the service’s processes actively support and encourage consumers, representatives and others to provide feedback and make complaints.
* Requirement 6(3)(b) – the provider is to ensure sure consumers, representatives and staff are aware or have access to advocates and language services, and other methods of raising and resolving complaints, including review of these processes for effectiveness.
* Requirement 6(3)(c) – the provider is to ensure appropriate action and an open disclosure process is consistently used in response to complaints or incidents, including all feedback and complaints received are to be appropriately captured, responded to and addressed in consultation with the complainant, and in timely way.
* Requirement 6(3)(d) – the provider is to ensure the service captures, analyses and acts on feedback and complaints, including regular review of how they manage complaints and using feedback and complaints data to improve how they deliver quality care and services.
* Requirement 7(3)(a) – the provider is to ensure the workforce deployed enables the delivery and management of safe and quality care and services, including ensuring when agency or new staff are rostered they are provided with sufficient information and support to deliver safe and quality care, in line with consumers’ needs and preferences, that promotes continuity of care and builds relationships of trust with consumers
* Requirement 7(3)(b) – the provider must ensure workforce interactions with consumers are consistently kind, caring and respectful; and all staff, including agency staff, are supported to know consumers’ and understand their needs, to enable staff to foster relationships with consumers that are respectful and caring.
* Requirement 7(3)(c) – the provider is to ensure staff are competent and have the knowledge required to effectively perform their roles; this includes systems to monitor staff competencies are effective in ensuring staff have the required knowledge to perform their roles on an ongoing basis, and ensuring all staff have completed required competencies.
* Requirement 7(3)(d) – the provider is to ensure the workforce recruited is trained, equipped and supported to deliver outcomes required by the Standards,
* Requirement 7(3)(e) – the provider is to ensure they are able to evidence regular assessment, monitoring and review of each staff members’ performance, including during probation periods, is undertaken and this information is used to inform staff training needs as is required.
* Requirement 8(3)(a) – the provider is to ensure consumers are actively engaged and supported in the development, delivery and evaluation of care and services.
* Requirement 8(3)(b) - the provider is to ensure the governing body promotes a culture of safe, inclusive and quality care and services, including processes to ensure the Board is consistently informed of service’s operations or issues of concern identified, to enable the Board’s response and proactive management.
* Requirement 8(3)(c) – the provider is to ensure the organisation wide governance systems implemented at the service are effective, this includes in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.
* Requirement 8(3)(d) – the provider is to ensure risk management governance systems and practices monitor and effectively manage high-impact high-prevalence risks associated with consumers’ care; abuse and neglect of consumers, which include any allegations, are appropriately identified and responded to, and support is provided for consumers to live their best lives is known by all staff.
* Requirement 8(3)(e) – the provider is to ensure the organisation’s clinical governance framework is effectively communicated, understood, and appropriately practised by all staff, and regularly monitored for effectiveness, including processes for keeping the governing body appraised of these areas.

# 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. | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not 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. | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Not 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. | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as six of the six specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 1, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 1(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, while some consumers said they were treated with respect, several consumers and representatives described situations where consumers were not treated with dignity and respect. Consumers’ feedback included staff were disrespectful or they did not engage or communicate with consumers while providing care and services. One consumer spoke of being confronted by a staff member following a complaint made, and a representative said they had to repeatedly ask staff to ensure a consumer’s dignity was maintained during cares provided. The Assessment Team observed staff did not engage with consumers during mealtimes, spoke on one occasion to consumers in an inappropriate manner, transported consumers in wheelchairs inappropriately, and spoke about a consumer in front of the consumer, and in a communal area in front of other consumers. Training records reflected a large number of staff were overdue for their code of conduct training. The Assessment Team raised concerns about deficits identified regarding the lack of respect and care provided to a consumer whilst in isolation. This has been considered further under Standards 1, 2, 3 and 4 (Consumer dignity and choice, Ongoing assessment and planning with consumers, Personal care and clinical care, and Services and supports for daily living).

The approved provider, in their response to the Review Audit report, provided documentation demonstrating some staff had received training on dignity and respect. They advised staff retraining on consumer dignity, choice and cultural sensitivity was conducted in September 2024. While supporting documentation showed just over half of staff employed at the service attended this retraining, the provider has not said when the remaining staff will attend. The provider advised a staff observation audit has been developed to ensure adherence to consumers’ privacy, dignity, respect and cultural safety; however, they have not advised when the audit will be implemented nor the intended frequency of its use. The provider showed one staff member was individually counselled about discussing consumers’ care needs privately; this staff member was also referred for further training. The provider said they were committed to ensuring staff uphold the organisations code of conduct and where a breach occurred, they undertook a human resources pathway. While the provider submitted some documentation to demonstrate code of conduct education is provided and the printout reflects several staff attended over the past few months, they haven’t advised when they expect all staff to have completed this training, or monitoring processes to be implemented to ensure all training provided is effective.

Requirement 1(3)(b)

The service did not show that care and services provided were culturally safe. Consumers advised they couldn’t communicate with staff as staff don’t speak Arabic, or communication was poor for consumers who don’t understand English. Staff consistently spoke of challenges communicating with non-English speaking consumers and said they relied on the consumers’ families, families of other consumers, and staff who spoke Arabic to assist them. Apart from some language boards displayed in the lounge and dining rooms, staff could not provide examples of language aids or other translation mechanisms available to assist with communication; consumers, representatives and staff were not familiar with external language services. For one consumer, clinical assessments were documented as not completed due to the language barrier; assessment and planning has been considered further under Standard 2 (Ongoing assessment and planning for consumers). One representative said they could help translate for the consumer but the service doesn’t ask them. The Assessment Team observed staff experiencing difficulty in communicating with consumers who spoke Arabic; one staff member sought assistance from a family member visiting another consumer to interpret for them. A registered nurse thought a consumer was complaining of pain but when Arabic speaking staff translated, the consumer denied pain but expressed being emotionally distressed. While management said they assign Arabic speaking staff between the floors, staff reported there wasn’t always staff who could speak Arabic on each shift. Cultural diversity and safety training records showed that about a quarter of staff attended this training in 2023.

In their response the provider noted the service is culturally specific and caters 95% for Lebanese Arabic consumers. They advised whilst most staff are from other ethnic backgrounds, there was a basic command of fundamental words enabling staff to engage and provide care to consumers. Education on consumer dignity, choice and cultural sensitivity has been provided to staff in September 2024. However, as noted in Requirement 1(3)(a), documentation submitted showed not all staff had attended and the provider has not said when the training will be completed. The provider stated language boards are displayed prominently in consumers’ rooms and in common areas to facilitate communication. The language boards submitted by the provider displayed 10 key words only, showing the Arabic/English translation and a pictorial representation. The provider said they were investigating the most appropriate and user-friendly translation app prior to purchase; however, they did not advise on an expected completion date, or the anticipated implementation process of the app.

Requirement 1(3)(c)

The service did not demonstrate they consistently supported consumers to exercise choice and independence. While entry processes enabled consumers to decide who they wanted involved in their care, and management said they supported consumers decision making by asking consumers’ preferences; most staff weren’t able to say how they assisted consumers to make their own decisions regarding care and services provided. Several consumers said staff don’t ask their opinion or offer choices, to enable them on a daily basis to select a choice or make a decision. For 8 named consumers, their feedback or that of their representatives included there was no communication, staff did not engage with them when providing care and services, no choices were offered including for meals, no explanations were provided in Arabic, and consumers personal preferences such as for the provision of personal hygiene and general care, choice of staff, seating arrangements, and rest periods, had not been followed. Management had said consumers could point out their meal selection choices when in the servery; however, the assessment Team did not observe this occurred. A staff member said they discussed the menu with consumers to inform them of the options. However, another staff member showed that although they knew a consumer had food preferences, they had to seek assistance from Arabic speaking staff as they could not understand the consumer.

The provider in their response said, and menus submitted demonstrated, more than one meal choice was provided. However, the menus provided were in English only which does not support most consumers in understanding the meal choices offered. An example of consumers’ individualised information collected on entry was submitted, together with a named consumer’s admission summary. However, I noted that while the consumer summary recorded their personal preferences on entry in 2023, it did not reflect the consumer’s current hygiene preference, nor their changed seating and rest period preferences. While the provider showed the personal hygiene preference for one consumer was recorded, they have not addressed why this is not consistently followed by staff, or advised of processes implemented to monitor and ensure the provision of care is in line with consumers’ preferred choices. Documentation was provided to demonstrate information of consumers who speak and understand English is captured on entry, as evidenced in the list of 5 consumers. However, the provider has not advised of considerations or actions to be implemented to improve staff engagement and interaction with consumers, to better support consumers to exercise choice and independence on a daily basis. The provider has also not addressed how they are to improve support provided to consumers in communicating their decisions, other than their investigation being conducted into the most appropriate translation app.

Requirement 1(3)(d)

While the service demonstrated it supported consumers to take risks and risk mitigation strategies were developed, the service did not ensure the mitigation strategies were implemented and staff lacked awareness of the strategies. While staff had am awareness a consumer chose to smoke, they were not aware of risk mitigation strategies to be implemented including the safekeeping of the consumer’s smoking paraphernalia. Staff were also aware of a consumer preference for a diet that differed from the specialised modified diet recommended. While this consumer’s risk mitigation strategies included staff assistance and monitoring during meals, staff said the consumer was able to eat by themselves. Risk assessments had been conducted for 2 consumers, which supported them to have front door access to leave the service. While a risk mitigation strategy required these consumers to sign a specific form on exit, staff were unable to locate the form, advised another form was to be completed, and were unable demonstrate the consumers’ compliance in the forms completion. For one consumer, their dignity of risk assessment was last conducted in 2022 and management confirmed the consumer had not been reassessed.

In their response the provider submitted evidence demonstrating the consumers have signed the specified form on exiting the service in 2024. However, the provider has not advised how they will ensure all staff have a shared understanding of the required process including the correct forms to be completed or their location. The provider has not addressed or said what improvement actions are to be implemented to ensure completed dignity of risk assessments are reviewed as required, for currency of information. The provider submitted meal provision documentation and said as the consumer requiring meal assistance resides in the same room as their partner who is fed, the consumer is also supervised when they both eat in their room. However, the documentation does not reflect the consumers are both provided meals in their room at the same time, as meals are also provided in the dining room. The provider has not addressed how they will improve monitoring processes to ensure staff have a shared understanding of consumers’ documented risk mitigation strategies, and these strategies are consistently implemented to make certain the ongoing safety of consumers participating in risk taking activities.

Requirement 1(3)(e)

The service did not demonstrate information provided to consumers was communicated in way that was easy to understand. Management said approximately 95% of consumers were Arabic speaking and about half were unable to read English. However, the service provided limited information to consumers in Arabic and most consumers weren’t able to provide examples of information that was provided to them by the service. Some representatives said while information was provided by the service, it was not always sufficient to make an informed decision, or no-one talked through the information provided, such as information on advanced care planning or vaccinations. While some consumers said Lebanese speaking staff were rostered on all shifts, a high proportion said not all staff speak Arabic or they advised consumers’ only understood limited English. Consumers ask family to speak for them, to talk with management, or to translate information the service provided. As reflected in Requirement 1(3)(b) most staff expressed challenges in conversing with consumers who spoke Arabic. While lifestyle staff said they discussed activities with consumers and provided monthly information sheets, consumers were not always aware of the nature of activities being provided and said staff don’t tell them; the Assessment Team observed both activity schedules and menus displayed were in English. Consumer meeting minutes provided limited information on lifestyle activities, feedback and complaints, allied health and catering, with no documented actions or due dates.

The provider in their response stated they translate important information sent to consumers in the languages spoken by the consumers; they provided an example of a newsletter relating to an outbreak that had been translated into Arabic and Greek. Examples submitted of the service’s monthly activity sheets reflected these are made available in English, and while these also reflected a pictorial representation of the activity, the pictures do not fully explain the mature of the activity. The provider has not responded in relation to the lack of information provided in consumer meeting minutes, nor of improvements to be implemented going forward. The provider has not addressed how the service will consider ways to improve written forms of information provided to consumers, or how they will better support communication between staff and consumers, to ensure all information provided is communicated in a way that is clear, easy to understand and enables consumers to exercise choice.

Requirement 1(3)(f)

While most consumers and representatives said consumers’ privacy was respected, several consumers spoke about occasions where their privacy was not respected or maintained. The Assessment Team observed consumer’s privacy was not always respected, or their personal information was kept confidential. Consumers’ said staff enter their rooms without asking and multiple staff were observed entering consumers’ rooms without knocking, or entering open rooms without asking permission first. One consumer said they had raised their concern of staff not knocking on entering their room when they were in the bathroom; while they requested a lock be installed on their bathroom door, this hadn’t occurred. Care staff were observed talking about a consumer who was seated in front of them in the lounge room, where other consumers were also present. The personal information of 3 consumers, which included a large photo and included personal care directives, was displayed under the counter of the nurses’ station and was visible by other consumers or visitors to the service.

In their response the provider said staff education on consumer dignity, choice and cultural sensitivity was conducted in September 2024. However, as noted Requirement 1(3)(b), while not all staff attended this training the provider has not advised when the remaining staff will be scheduled to attend. The provider has also not said how they will improve monitoring processes to ensure staff practices are always respectful of consumers’ privacy. No response or further information was submitted by the provider in relation to one consumer’s personal privacy concerns, or their request for additional measures to safeguard their privacy. The provider advised the photos of consumers which were accompanied by care directives, were specifically positioned in a way to minimise the ability of others to view them; the posters have now been removed. While the provider submitted signed consent forms in relation to the use of the consumers’ photos, they have not addressed how they will make sure future staff communication displayed by the service, which may contain consumers personal care information, doesn’t compromise consumers’ privacy in any way.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to monitor, identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified, to ensure all care and services provided to consumers are culturally safe, respectful their dignity and privacy, supports consumers in their ability to make informed choice, and promotes their independence. Accordingly, I find that Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d), 1(3)(e) and 1(3)(f) are not compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not 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. | Not 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, which are involved in the care of the consumer. | Not 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as five of the five specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 2, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 2(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the Assessment Team found risks to consumers’ health and wellbeing were not always identified or used to develop strategies to manage risks, to ensure the effective delivery of care. For 9 named consumers, assessment and planning wasn’t conducted following the development of new conditions which impacted the consumers’ care needs. These included changes to skin integrity, development of pressure injuries and bruising; changes in mobility and falls, pain management needs, weight loss, development of infections, malnutrition and dehydration, bone fractures, altered sleep, and in response to significant life events resulting in changed emotional needs. Further, risks associated with distress during the provision of personal care, the use of psychotropic medication or the application of restrictive practices, or periods of required isolation had not been identified, assessed or managed appropriately. Four consumers wore soft helmets to minimise fall risks, which the service said did not constitute a restrictive practice as functional assessments had been completed to ensure consumers could remove the helmets unaided. However, The Assessment Team identified there was no information in these consumers’ functional assessments to show they could remove the helmets if they wished to do so. While representatives said concerns regarding risks to consumers health and wellbeing were raised with staff, their concerns had not been addressed, resulted in staff effectively reviewing the consumers, assessments being undertaken, and appropriate care planning being completed. Management had not agreed with the Assessment Team’s feedback regarding deficiencies identified with the service’s assessment and planning processes; management said documentation such as handover sheets and consumer nursing directives contained sufficient information on consumers’ care needs.

The approved provider, in their response to the Review Audit report, provided documentation demonstrating updated care plans or behaviour support plans have now been completed for 6 named consumers; no response was submitted in relation to 3 consumers. While consolidated consumer risk profiles, which reflected the consumer’s changed care needs and identified risks, were submitted for some of the named consumers; these risk profiles were not dated. Updated functional assessments were provided for 3 named consumers reflecting their ability to remove their helmets unaided; the provider did not submit an updated functional assessment in response for one consumer. While the provider submitted examples of handover and nursing directive documentation used to inform staff of consumers’ care needs, I noted these are mainly task orientated directives and do not reflect assessment processes or outcomes, to demonstrate management strategies are based on a comprehensive understanding of risks to the consumer, and they do not inform the overall holistic planning of the consumer’s care. The provider has not advised of improvements to be implemented to ensure comprehensive assessment, planning, implementation and evaluation of interventions are consistently undertaken by the service.

Requirement 2(3)(b)

The service did not demonstrate assessment and planning processes identified and addressed consumer’s current needs or how consumers and representatives were supported during the assessment process, including support to understand advanced care planning. The Assessment Team identified processes did not adequately inform the development of individualised palliative and end-of-life care plans, and overall consumers’ care plans did not consistently reflect their current care needs and or new conditions; this included following consumer incidents or on their discharge from hospital. In some instances staff were unable to complete assessments due to language barries, and assessments were documented as not completed as a result. Management said advanced care planning was discussed during entry, or when consumers’ condition changed; however, they noted that culturally, consumers and representatives were reluctant to discuss advanced care planning. While consumers and representatives recalled completing advanced care forms, several said there had been limited or no information provided about advanced care or end of life planning, no discussions were held, or they had not felt supported to understand the advanced care planning forms. The Assessment Team identified most advanced care plans were generic in nature and had limited individualised information about consumers’ specific care wishes. One consumer’s documentation did not evidence their advanced care and palliative care plans were updated, including pain management requirements, following their rapid deterioration. This has been considered under Requirement 2(3)(e) below.

In their response the provider submitted some consumers’ updated care plans, which have been completed to reflect their current care needs. However, the provider has not addressed how they will ensure all consumers’ care plans are reviewed for currency of documented information. The provider has not advised of process improvements to be implemented to make sure future assessment and care planning is consistently completed, reflects consumers’ current needs, and language barriers affecting assessment completion are identified and managed appropriately. Further, the provider has not said how process improvements will be reviewed for effectiveness, or will include monitoring of staff practice to ensure assessment and planning is current and completed in a timely way. While the provider submitted documentation for one consumer to evidence a family conference occurred earlier in 2024, which included a notation the consumer’s advanced care plan was signed, the documentation does not reflect what information was made available to the family about advanced care to assist in informing their decision, or that any discussion was undertaken. I noted the provider has advised they have made contact with the family to organise another care conference. However, the provider has not addressed how they will ensure all consumers and representatives are supported to understand advanced care planning, or how advanced care and end of life plans will be improved to better reflect consumers’ individualised and specific care wishes going forward.

Requirement 2(3)(c)

Assessment and planning was not completed in ongoing partnership with consumers and representatives. Consumers overall were unable to say how they were involved in assessment or planning of their care. While some representatives said they were kept informed of consumers’ care needs and participated in care planning, most representatives said the input they provided or concerns they raised regarding consumers’ care needs, were not responded to or addressed. They said the service did not share information with them on consumers changed care needs, nor kept them informed of consumers altered conditions, including deterioration that required escalation of care and hospitalisation. Representatives feedback reflected this included changes in consumers’ general personal and clinical care needs; falls, bruising or fractures sustained, the development of infections, wounds or injuries, and general or sudden deterioration in the consumer’s health. When representatives were made aware of changes in the consumer’s condition, they advised they were not always kept informed of progress. Management said care conferences were held with consumers and representatives 6 weeks after entry, annually thereafter, or when consumers’ needs changed. However, care conference documentation showed this did not always occur in a timely way. Care conference documentation did not record discussions held around consumers’ care requirements, any relevant information provided by the service, or of actions to be taken in response to concerns raised. The Assessment Team identified language barriers, and the lack of effective communication support for consumers who don’t speak English, limited consumers’ ability to partner in assessment and planning processes. While assessment and planning demonstrated partnership with medical officers, specialists and allied health providers; outcomes of recommendations or directives following the consultation were not always recorded in consumers’ care plans.

The provider in their response submitted documentation to evidence care conferences for 2 consumers had recently been completed; the documentation generally reflected acknowledgement of pre-set discussion points, documented changes in the consumer’s care needs, and documented the discussion/provision of the consumer’s care plan. The provider further confirmed another consumer’s care conference had been scheduled. However, the provider has not addressed how they will review processes to ensure all consumers’ care conferences are up to date, completed in a timely way, and in line with policy. The provider has not advised of actions to be implemented to make sure consumers, and others the consumer chooses, are actively and consistently engaged in ongoing partnering of the assessment, planning and review of all consumers’ care and services. The provider has also not addressed how processes, including monitoring of staff, is to be improved to ensure concerns raised by representatives are appropriately responded to and addressed, and staff are guided and supported to share timely information with representatives about consumers’ care needs or changed conditions.

Requirement 2(3)(d)

The assessment Team identified the outcomes of assessment and planning were not effectively documented and communicated to consumers. Consumers and representatives regularly advised they had not seen or been provided access to a copy of consumers’ care and services plan. While management acknowledge most consumers were Arabic speaking and about half could not read English, care plans were provided in English and there were no mechanisms to enable consumers to access care plans in a format they could understand. While management said consumers’ care plans were emailed or handed to representatives following a care conference, they were unable to demonstrate this had occurred. A clinical staff member responsible for conducting case conferences was not aware a copy of the care plan was to be made available at the care conference, or emailed afterwards, and advised they had not done so.

In their response the provider submitted documentation that included 2 case conferences, which reflected the consumer’s care plan was discussed with a family member of the consumer’s next of kin, either in person or via telephone; both documents were in different formats with differing amount of detail recorded regarding information discussed. Several signed care plan consultation declarations were also submitted, which the provider said demonstrated the consumer’s next of kin had input into their care plan. This one-page document recorded that either the consumer or their next of kin had read and agreed on the details of the care plan. However, I noted in most instances the relationship of the signee to the consumer was not recorded; in one instance only the first name was recorded, and the document did not reflect whether a copy of the care plan was made available. The provider further submitted copies of emails to demonstrate that following completed care conferences, families were provided with the updated care plan; however, I noted these emails were all dated after the completion of the Review Audit. The provider has not advised of how processes are to be improved and what actions are to be taken by the service to ensure all consumers and representatives have ready access to a copy of the consumer’s care plan, which is accurate and up to date, and in a format or language they can understand or are supported to understand.

Requirement 2(3)(e)

The service did not demonstrate the effectiveness of consumers’ care and services provided was regularly reviewed, in response to changes in the consumer’s condition, or following incidents. The Assessment Team identified deficits in the service’s processes relating to the regular review of consumers’ care plans; care plans for 8 named consumers did not always reflect consumers’ current condition and care needs, and did not contain sufficient information to efficiently guide the provision of care by staff. Incident forms were not consistently completed to advise management of consumers changed care needs, injuries or allegations of staff mishandling. Where incident forms were completed, investigation of the cause of the incident, review of effectiveness of already implemented strategies, or follow up actions required to be implemented, was not always completed. Assessment and review of consumers’ care needs wasn’t always appropriately addressed following reported changes by representatives, when changes or deterioration was identified by staff, following new medical directives or changes required in treatment, or following the consumers’ discharge from hospital. Monitoring charts implemented to further observe consumers’ care needs, including to monitor for risks such as following a fall; were not always completed as directed or with appropriate information such as wound descriptions, to enable an effective review of the findings to be undertaken. For most monitoring charts, no overall review was recorded as being completed by the service to evaluate the effectiveness of care are provided, or to monitor the appropriateness of staff practice.

The provider in their response submitted documentation which evidenced some care plans have now been updated to better reflect the consumers’ current care needs. A hospital return checklist was provided for one consumer; however, while the checklist reflected listed tasks had been ticked as completed, evidence to support the required follow up was undertaken or changes implemented was not provided. The provider advised incident management processes have been reviewed; following incident report review by the clinical support specialist of clinical staff’s response, incident investigation follow up, the incident then will be reviewed by the governance manager to ensure all required actions are taken. However, the provider has not addressed how processes are to be reviewed and improvements implemented to ensure all consumers’ care plans are reviewed regularly for currency of information, reviewed for effectiveness following consumers’ changed care needs or deterioration in condition, or following the consumers’ discharge from hospital, and in a timely way. Further the provider has not advised of improvements to be implemented relating to clinical oversight, to ensure clinical monitoring processes are consistently undertaken as directed, and reviewed to inform care planning that includes the appropriate response and timely management of consumer risk.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to provide effective clinical oversight and monitoring, and to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These include ensuring all assessment and planning identifies consumers’ current and advanced care needs, considers and manages risks, is based on ongoing partnership, is documented and effectively communicated, and reviewed regularly. Accordingly, I find that Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d), and 2(3)(e) are not compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not 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. | Not 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. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as seven of the seven specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 3, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 3(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the Assessment Team found the service did not demonstrate clinical and personal care provided was always safe, effective, tailored to consumers’ needs, or optimised their health and wellbeing. While some consumers and representatives expressed their satisfaction with care provided to consumers, a high proportion of consumers and representatives were dissatisfied; with some reporting consumers’ care needs were not identified or responded to by staff, or that concerns about consumers’ care needs they raised were not followed up or addressed. Care documentation showed the service did not always ensure consumers clinical and personal care needs were documented on care plans to guide the provision of care by staff, and staff were unaware of consumers’ current or changed care needs. Clinical and medical care directives, including monitoring of consumers’ care requirements were not followed by staff and the service’s clinical oversight processes had not identified or addressed this. For 6 named consumers with conditions that presented with increased pain such as multiple falls, bruising, fractures, wounds, or infections; the Assessment Team identified their pain management needs were not always identified or effectively managed, and strategies implemented weren’t monitored appropriately and reviewed for effectiveness. For these 6 consumers their new or changed skin care needs were not effectively responded to or addressed. Skin care directives and management strategies, including for pressure injuries, wounds, bruising, cellulitis/oedema, or infections; were not always followed, documented as being provided, or monitored and reviewed for their effectiveness. For 2 of these consumers, elevated blood glucose levels were not monitored as directed. Consumers’ other care needs, changes or preferences such as sleep and rest changes; weight loss, assistance with meals or intake monitoring, and the provision of hygiene cares were not consistently provided or monitored. The service was not able to demonstrate for four consumers who were administered chemical restraint, that non-pharmacological measures were first implemented or to evidence restrictive practices were used as a last resort. Consumers and representatives expressed concern about the lack of knowledge of some clinical staff or the overall clinical oversight provided by the service; including in relation to ensuring medical reviews were actioned, escalated, or hospitalisation occurred as needed and in a timely way. Staff were not always aware of the consumer’s individual care needs they were providing care too, or of the individualised strategies to be used when providing care; staff feedback demonstrated they were not always aware of appropriate clinical monitoring processes.

The approved provider, in their response to the Review Audit report, submitted documentation to demonstrate care plans for some consumers have now been updated to better reflect the consumers’ current clinical needs and personal preferences. The provider also submitted evidence of care monitoring being charted for some consumers. For one consumer, documentation demonstrated weight loss had occurred secondary to treatment for oedema. However, overall, while some charting reflects monitoring is now being completed, for 3 consumers documentation submitted does not demonstrate charting was always completed when issues or concerns were identified and raised; charting was not demonstrated to be clinically reviewed to inform care planning changes, nor that required care provision and monitoring was consistently commenced or completed as directed. For one consumer documentation provided doesn’t demonstrate their pain was reviewed with consideration given to the consumer’s reluctance to move or altered sleep pattern. For one consumer, while meal lists were submitted, they don’t evidence staff provided assistance with the meal or sufficiency of oral intake was monitored. While documentation shows a medical officer was notified of another changed condition for this consumer, the medical review occurred 6 days later. The provider has not submitted a response in relation to concerns with the overall clinical care provided for 4 consumers, or provided evidence to support chemical restrictive practices were always administered as a last resort. While the provider submitted documentation to show staff were informed of some clinical and medical directives at staff handover, these do not demonstrate the directives were adequately followed, completed or reviewed. The provider hasn’t addressed consideration of actions to be implemented to improve clinical processes; to ensure all staff have sufficient documented information to guide the provision of individualised care for consumers, and that staff practice, skills and provision of care is monitored and supported to make certain all consumers consistently receive safe and effective personal and clinical care.

Requirement 3(3)(b)

The service did not demonstrate high-impact or high-prevalence risks associated with consumers’ care were effectively managed. Incidents were not always reported or investigated, and effective preventative or management strategies weren’t developed. Where strategies to manage risks were identified, these were not always correctly implemented or in a timely way. Management and monitoring of consumers post incident was not consistently completed in line with policy, or treatment escalated in a timely way. The Assessment Team identified for 4 consumers who experienced multiple falls, while most falls were reported as incidents, review of the consumer’s falls history was not completed to identify contributing factors and to inform preventative or management strategies. While mobility sensors linked to the call bell were implemented to prevent falls for one consumer, staff did not respond in a timely way and the call bell system was found to be faulty. The service wasn’t able to demonstrate medication prescribed to manage one consumer’s changed behaviours, was monitored or reviewed as a potential contributing factor of their falls. Post fall monitoring processes including neurological observations weren’t completed in line with policy for two consumers; escalation of treatment required for one consumers’ due to risks associated with medication administered, was not followed. Two consumers exhibited changed behaviours during care provision placing both the consumers and staff at risk. While both consumers were reviewed by behaviour specialists, their care plans weren’t updated with recommended strategies to guide the provision of care by staff, and incident and behaviour documentation showed both consumers continued to be distressed during care provision. Three consumers requiring equipment to mitigate the risk of injury, such as mobility sensor alarms or pressure relieving mattresses, either received the equipment late or it was provided at an incorrect setting; clinical monitoring had not identified this deficit.

In their response the provider submitted updated care plans and risk profiles for 2 of the 4 consumers who had experienced multiple falls. While these consumers’ falls history was also provided, evidence that a comprehensive and individualised review of the falls histories was undertaken that including the effectiveness of strategies implemented, has not been provided. A response for the other 2 consumers with increased falls was not provided, and the provider has not addressed processes to be implemented or improved, to ensure staff monitoring and management of consumers post falls was appropriately provided and effective. The provider submitted updated care plans for the 2 consumers with changed behaviours, which now reflects the specialists recommendations to guide staff practice. The provider advised the clinical support specialist and educator will work with clinical staff to ensure pressure relieving mattress are monitored and adjusted during use to ensure correct setting are applied. However, no response was provided in relation to improvements to be considered and implemented, to ensure equipment to mitigate risk is always provided in a timely way.

Requirement 3(3)(c)

The service did not adequately demonstrate the needs of a consumer nearing the end of life were recognised and addressed, or their comfort maximised. The Assessment Team identified documentation showed end of life care for one consumer was not well planned or managed, and did not evidence a compassionate approach to the needs of the consumer and their family during the palliative phase. While management said assessments and planning were revisited to ensure consumers’ palliative requirements were reviewed, this was not evidenced as being undertaken and completed. Care planning was not reflective of the consumer’s changed condition as it related to the provision of meals, their skin care needs, and pain management. Although clinical staff generally completed progress notes for cares they provided, comfort care monitoring that was initiated was inconsistently completed, and charting did not demonstrate the consumer’s individualised care needs were always closely monitored. Further, the consumer’s referral to the palliative care team for further clinical support was not documented. Representative feedback and care documentation showed while one clinical staff member and the wellbeing officer offered support, such as provision of aromatherapy, prayer and comfort to the family, this was not provided by other staff. Further, the representative expressed dissatisfaction with the palliative care provided including raisin concerns related to the lack of planning or discussions around the consumers end-of-life requirements, provision of adequate pain management, staff practice and communication as meals where provided when the consumer was no longer eating, and the family’s wishes to stay with the consumer overnight was not accommodated; only one family member was supported to do so.

The provider in their response said care provided was best practice and submitted documentation, which included confirmation the consumer had been reviewed by a palliative care team whilst in hospital. Progress notes provided reflected a follow up review of the consumer was undertaken by a geriatrician, relating to the consumers end-of-life care needs, and they had some discussions around end-of-life care with the consumer’s representatives. Progress notes by clinical staff further recorded care needs were being monitored and provided. However, while documentation submitted showed an end-of-life pathway was commenced, documentation didn’t evidence a palliative care plan was completed for the consumer to reflect their individualised and agreed palliative care needs, or the frequency care management strategies were to be implemented; this individualised information wasn’t reflected on the consumer’s end-of-life pathway to guide staff practice. The end-of-life pathway reflected some representative discussions remained pending, including cultural and spiritual needs, issues related to impending death of the consumer, and grief and loss considerations. Further, staff had not completed the pathway as frequently as required in line with policy. The provider has not provided a response regarding supporting family members to stay with consumers after-hours, during the palliative phase of their life. The provider submitted further documentation on the end-of-life care provided to 3 other consumers. However, this documentation does not relate to the information contained in the Review Audit Report, nor to the consumers interviewed and whose documentation was reviewed, and as such has not been considered further.

Requirement 3(3)(d)

Deterioration or change of consumers’ condition was not consistently recognised or responded to in a timely way. For 4 named consumers, representatives feedback and clinical documentation showed changes or deterioration in the consumers’ condition was not recognised and responded to by clinical staff without, in most instances, concerns being repeatedly raised by representatives. Clinical documentation showed gaps in identifying and monitoring of consumers’ changed conditions and the failure of the service to respond to their deterioration in a timely way. This included managing changes in consumers’ skin integrity, wound deterioration and the development of infections; provision of appropriate care during periods of required isolation with associated malnourishment, dehydration, weight loss and altered organ function. As well as monitoring and managing raised blood glucose levels, reviewing and managing altered blood pathology, identifying and responding to general decline in health, and effectively managing post fall monitoring, escalation of post fall care in line with policy or identifying post fall deterioration. Representatives expressed their dissatisfaction with communication and said on most occasions, they were not notified of the consumer’s deterioration. Representatives raised concerns regarding the lack of adequate overall clinical oversight, and they advised on occasion clinical staff would ask them whether they wanted the consumer transferred to hospital, rather than the staff making an informed clinical decision themselves.

In their response the provider submitted some documentation in relation to these consumers to demonstrate care delivered. However, documentation provided does not support the change in one consumer’s skin integrity was reviewed by the medical officer, or treatment commenced in a timely way. For one consumer who required assistance with meals, the service’s meal list documents the delivery of meals, but does not show the consumer’s intake of food and fluids was monitored consistently or reviewed. Documentation submitted does not support one consumer’s blood glucose levels were monitored at the time concerns were raised, or that an altered blood pathology report showing raised blood glucose levels and indications of dehydration, was reviewed by the medical officer in a timely way in order to escalate management of the identified deterioration. I acknowledge documentation provided shows the consumer has now been reviewed by the dietitian post hospitalisation and management strategies implemented. The provider advised moving forward, the educator is to reinforce the training on how to care for a person when in isolation. While documentation on the management of wound care for one consumer does reflect some clinical review occurred, following further deterioration subsequent referral to a foot specialist was delayed; review and treatment of the infected wound occurred 3 weeks later. I noted the consumer’s care plan has now been updated and includes their skin integrity care needs. The provider said processes to support clinical staff with wound care, assessment and referral is provided by the care manager. As part of the service’s plan for continuous improvement, a wound assessment app is to be installed to guide clinical staff with best practice assessment and the educator is to provide training on wound assessment. The provider has not responded in relation deficits identified with monitoring, management and escalation of care relating to one consumer following a fall that required hospitalisation. Nor has the provider submitted a response in relation to the non-identification or management of the general decline in health for one consumer, who had presented with fever, elevated blood glucose levels and facial droop. However, the provider advised as part of their plan for continuous improvement, the clinical support specialist will conduct a wellbeing round with the clinical staff on a daily basis to assess individual consumers for any signs of deterioration.

Requirement 3(3)(e)

The service didn’t have effective and comprehensive processes that ensured information about consumers’ condition, needs and preferences was always documented and communicated. Several representatives said they weren’t always notified of changes in the consumer’s condition, and care wasn’t always provided in line with consumers’ care needs or preferences. A high proportion of staff advised the Assessment Team they were unfamiliar with consumers’ care needs as they were agency staff, new to the service or did not yet know the consumers. Care plans were not always reflective of consumers current care needs, the risks associated with their care, changes made following hospitalisation, or following reviews undertaken by medical or allied health professionals. Staff were not aware a consumer they provided care to had a fracture following an incident, of consumers’ changed diet requirements, and of consumers’ changed conditions including new infections; staff weren’t aware of strategies to be implemented to manage these. Progress notes did not consistently document staff were identifying or reviewing consumers’ changes in condition, that management strategies were considered and commenced, or the implementation and review of new medical directives; a medical officer recorded they were not aware whether a treatment they had ordered was effective. Further, progress notes were not always completed by clinical staff to evidence appropriate care was provided to consumers following incidents, including post fall care with associated deterioration. Consumers’ incidents, including new wounds/injuries and allegations of staff mishandling, were not always recorded to inform management and not all management were consistently aware of consumers’ incidents. Appropriate or sufficiently detailed clinical monitoring was not always charted in relation to wound care, pressure area care, blood glucose monitoring, pain management, and food and fluid intake. The service was not able to demonstrate clinical and medical directives were being followed, or consumers’ care needs were effectively being managed. Clinical review of completed monitoring charts was undertaken, and these deficits in monitoring were not identified by the service.

The Provider in their response said staff are given enough information for them to care for consumers safely and for registered staff to provide clinical oversight; they submitted examples of nursing directive and handover documentation currently in use. The provider demonstrated how information on one consumer’s infection was shared with staff. The provider also showed some consumers’ care plans have now been updated, and completed risk profiles were provided for a few consumers. However, the provider has not addressed how they will ensure all consumers’ care plans are reviewed for currency of information. The provider has not advised of monitoring process and staff training improvements to be implemented to ensure consumers’ current or changed care needs are consistently documented by staff when required, incidents are consistently recorded and reported, and monitoring charts are completed as directed and reviewed to inform the provision of effective and shared care for consumers.

Requirement 3(3)(f)

The service wasn’t able to adequately demonstrate appropriate referrals were made in a timely manner, or that recommendations following a referral were documented and implemented. Some representatives expressed their dissatisfaction with the timeliness of the service’s referral processes. Consumer documentation and representative feedback showed there were delays in referrals being actioned, such as medical officer reviews following changes in consumers’ conditions; for podiatry services, for medically requested x-ray and ultrasound investigative services, and for a specialist reviews following a consumer’s deterioration. For one consumer, recommendations made following their referral to the dietitian were not implemented or followed. When a referral to a medical officer was delayed, for review of a consumer’s altered pathology report, the service didn’t ensure the consumer was clinically monitored or managed until the referral could be actioned. The Assessment Team identified the service had not ensured consumers had timely access to podiatry services; some consumers had not received podiatry services for 7 months or longer. Clinical staff were not always aware of, nor were they able to track, the progression of consumers’ referrals to completion.

In their response the provider advised of the service’s referral process whereby the clinical support specialist reviews consumers’ records daily and follows up with clinical staff to ensure referrals are actioned; this process is now to be reinforced and supported by the educator. The provider submitted documentation to demonstrate podiatry services are now up to date and current for most consumers. Information on consumers’ referral history to other services was submitted; while the provider advised this was the service’s tracking method for referrals, I noted referral recommendation or requested date is not recorded, nor the dates the referral was arranged and then completed, to monitor the timeliness of the referral process. While the provider submitted further consumer records relating to referrals being requested, these records do not show all referrals were undertaken or completed in a timely way. An explanation was provided about the delay of an x-ray being completed for one consumer; however, no response was received regarding another consumer’s delayed x-ray and ultrasound investigation. The provider has not addressed or advised of process improvements to be implemented to ensure monitoring, management or alternative escalation occurs when medical reviews are delayed, and that recommendations and directives following a referral are implemented and monitored in the future.

Requirement 3(3)(g)

Overall, consumers and representatives provided positive feedback about the service’s infection control practices. However, the Assessment Team identified staff were not familiar with standard and transmission-based infection control, or cytotoxic medication, precautions and this information was not effectively communicated to staff. Consumers with infections didn’t have treatments commenced as needed, or they weren’t adequately monitored and supported to ensure their overall wellbeing was maintained. Hospital discharge directives for 2 named consumers, for altered pathology review or the commencement of medication, was not attended to or was implemented late. Cleaning and care staff weren’t always aware of consumers’ infectious status, or of precautions needed when providing care and services; this information was not always recorded on consumers care plans. While most staff knew of personal protective equipment used for a consumer administered cytotoxic medication, they were unaware of associated risks. There was a delay in one named consumer’s infection being identified or reviewed. While in isolation, the medical officers specific infection control measures were not made available, family members were restricted from visiting, and the consumer remained in isolation 4 days longer than directed. The service didn’t have effective measures to ensure vaccination information for consumers was always made available or promoted; and in a language they were readily able to understand. Consumers and representatives said they weren’t provided with information about the benefits of being vaccinated or possible consequences of not being vaccinated. The vaccination policy provided guidance relating staff vaccination processes, but not for consumers. While documentation showed yearly influenza vaccinations were offered to consumers, COVID-19 vaccination clinics weren’t held between 2022 and June 2024. This has been considered further under Standard 8.

The provider in their response submitted documentation demonstrating the consumer receiving cytotoxic medication had this reflected on their care plan; however, I noted management strategies to guide staff practice was not recorded. While records provided show training for staff was provided on cytotoxic medication that included safety considerations and management strategies; most of this training occurred after the Review Audit and shows approximately half of all staff attended. As staff roles aren’t reflected, it is unknown if cleaning staff were included, and the provider hasn’t advised when the remaining staff will receive the training. While infection prevention training documentation and certification for a few staff was submitted, the provider hasn’t evidenced that all staff completed the training, or how the service monitors staff to ensure they have a shared understanding of infection prevention processes. The provider didn’t submit a response or on process improvements to be implemented to ensure timely follow up, review or commencement of treatment occurs for consumers’ infections on hospital discharge. Infection control measures made available to staff for the consumer requiring isolation, including visitor guidelines weren’t provided. Additional documentation was submitted on the service’s management process for a COVID-19 outbreak that included management directives for consumers in isolation; however, I noted these directives were not followed for the consumer recently in isolation. To demonstrate staff are aware and can execute infection prevention and control, the provider submitted documentation relating to the infection set up procedure for another consumer. However, this documentation does not relate to the information contained in the Review Audit Report, nor to the consumers interviewed and whose documentation was reviewed, and as such has not been considered further.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to provide effective clinical monitoring and oversight, and to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These include ensuring each consumer gets safe and effective care that optimises their health and wellbeing, effective management of risks associated with their care, the consumers’ needs and preferences nearing the end of life are addressed, deterioration or change in their condition is recognised and responded to, information on consumers’ care needs are documented and communicated, timely referrals are actioned, infection related risks are minimised and appropriately managed. Accordingly, I find that Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) are not compliant.

# 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. | Not Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not 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. | Not 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. | Not Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as not compliant as six of the seven specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 4, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 4(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the service did not demonstrate each consumer got safe and effective support and services for daily living. While most consumers didn’t raise concerns about the activity program offered, the Assessment Team identified consumers were provided with limited stimulation and engagement to do things of interest to them. Consumer and representative feedback and care documentation for 6 named consumers showed a lack of lifestyle activities being offered of interest to consumers, concerns raised regarding the absence of stimulation provided, and the minimal engagement by staff. Representatives expressed concerns regarding the safety of 2 named consumers due to the wandering and intrusive behaviours of other consumers. Two consumers complained about the laundry services and of missing laundry; this has been considered further under Standard 6 (Feedback and complaints). While some consumers advised they engaged in activities of their own making such as watching television, others said there was nothing to do and they were lonely or bored. Consumers’ care plans did not always reflect individualised information on activities of interest to them, or the support required they required to engage in or pursue these activities; lifestyle documentation did not always record that consumers had engaged in activities. For one consumer requiring a period of isolation, the service didn’t demonstrate the consumer was provided with activities or other stimulation during this time. Most staff, including some lifestyle staff, were unfamiliar with the daily living needs of consumers or their lifestyle preferences. During the 5 days of the Review Audit, the Assessment Team observed many consumers, some with a cognitive impairment, to be seated in communal areas and not engaged for periods of time. Consumers were either seated with their heads on tables, or in wheeled tub chairs with no individualised activities or other forms of stimulation offered; there was no engagement provided by staff.

The approved provider, in their response to the Review Audit report, submitted some documentation that included updated care and activity plans for 2 named consumers. While care plans reflected some of the consumers’ individualised interests, the separate activity plans did not reflect this information. Further, the activity plans listed set activities offered by the service and indicated whether the consumer’s wished to participate; there was no input recorded from consumers to reflect their individual or potentially different interests, nor their social pastimes other that family visits. The provider said the consumer placed in isolation did receive care, services and socialisation during this period and submitted call bell documentation to support this. However, the documentation does not show the nature of the engagement by staff, or what care was provided. The provider advised regular processes when a consumer requires isolation, is to provide snacks and activities such as colouring and puzzles; moving forward the educator will reinforce training provided on caring for consumers in isolation. A lifestyle program that recorded consumers participation in one-on-one activities, group activities, or the dementia support program was submitted. However, active participation of the named consumers in these activities was not always evidenced, nor their level of engagement was consistently monitored or documented. The provider showed while one of the 2 consumers affected by other consumers’ behaviours accepted a room change, the other consumer did not want to change rooms. However, the provider did not advise how they would ensure the ongoing safety of service’s provided for this consumer. The provider has not advised of overall improvements to be implemented to ensure each consumer receives safe and effective support for daily living that optimises their quality of life, including implementation of review processes to determine the effectiveness of the lifestyle program provided for each consumer.

Requirement 4(3)(b)

The service didn’t demonstrate each consumer’s emotional and psychological well-being was being supported. While most consumers and representatives said consumers received spiritual services, some said they would like this provided more often. Care documentation and consumer and representative feedback reflected the service did not identify periods of changes, challenges or loss experienced by 5 named consumers, which had impacted on their emotional or psychological wellbeing; appropriate and timely support had not been provided. This included a lack of internal communication and support following the loss of family members, lack of support during extended isolation where family visits were not enabled, and lack of support following incidents causing increased anxiety for the consumer. The Assessment Team identified the daily engagement needs of consumers to support their emotional wellbeing was not occurring; a number of consumers and representatives said staff either ignored consumers, or did not engage with consumers while providing care and services. The service had a dedicated wellbeing officer who visited consumers to provide emotional support; however, while one consumer’s care plan reflected they required daily emotional support, only 2 visits were documented for one month, and details about the support provided were not recorded.

In their response the provided submitted some documentation to show emotional support has been provided to consumers by the wellbeing officer, including for 3 of the named consumers. However, the documentation does not always show the reason emotional support was required, the nature of the support provided, or evidence if the frequency of support was provided in line with consumers’ care plans. Documentation to show emotional support was provided to the consumer placed in isolation, by either the wellbeing officer or other staff, was not provided. Documentation submitted reflected some emotional support was provided to one consumer immediately following incidents involving other consumers. However, while documentation showed multiple incidents occurred in a 4-week period, the overall need of the consumer for more structured or ongoing emotional or psychological support was not identified, planned for, or provided; evidence was not supplied to support the consumer was referred for any external emotional support. While the provider has submitted some consumers’ updated care plans which now include their emotional needs, they have not advised of process improvements to be implemented to ensure all staff are made aware of consumers’ changed emotional needs, and staff engage with consumers in a meaningful way that supports their emotional and psychological wellbeing.

Requirement 4(3)(c)

The Assessment Team identified the service did not have established support processes to enable consumers to participate in their community, both within and outside the service environment. Nor was the service able to evidence each consumer was supported to do things of interest to them. Some consumers expressed their satisfaction with support provided to maintain relationships, or their ability to go outdoors. However, consumers and representatives feedback for 4 named consumers revealed activities of interest to the consumers were not provided, and while the service previously offered bus outings these no longer occurred; lifestyle staff said they were looking to hire a bus driver but hadn’t been successful. Consumers and representatives said they were not aware of services or support available to them to participate in the community, outside of the service; nor were they receiving any community services. One consumer said they would like to visit a nearby church more often, but they needed to be accompanied and their family couldn’t assist. Management said previously the service had support from volunteers, and local school children visit the service weekly. However, lifestyle staff said they had no knowledge of how to support consumers to participate in community activities, or of processes for external organisations to assist in providing activities of interest for consumers.

The provider in their response submitted recent correspondence to demonstrate they use community volunteer services. However, the correspondence shows that as all recommended participants speak or understand very little English, the volunteer who attended could not continue and alternative arrangements were to be considered. The provider has not submitted a response in relation to bus outings resuming. The provider has not advised of process and service improvements to be implemented to ensure consumers are supported to engage in community activities on regular and ongoing basis. Nor have they addressed how they will assist and train lifestyle staff on how to support consumers with community activities, and of processes to engage with external organisations to supplement activities offered to consumers.

Requirement 4(3)(d)

Most consumers and representatives advised there were staff who were not aware of consumers’ conditions, needs and preferences. A high proportion of staff weren’t able to demonstrate they were familiar with consumers or their lifestyle preferences, including their dietary needs. Care plans did not always reflect consumers’ individualised information or management strategies to be implemented, to guide staff with supporting consumers with their daily living requirements. Consumer and representative feedback, observations and care documentation for 5 named consumers didn’t reflect consumers’ current or changed care and lifestyle requirements were documented or communicated in a timely way. Where care needs were documented, management strategies to support consumers weren’t always recorded, or the support provided wasn’t documented in line with care plan directives. Strategies to support the emotional needs one consumers included provision of meals in the dining room; however, they were provided meals in their room. For another consumer, changes to their emotional needs were documented 6 days after the event and not all staff were aware. One consumer’s dietary dislike and allergy wasn’t reflected on their care plan, catering staff were not aware and the food items continued to be served. Records for one consumer requiring twice weekly therapeutic treatment by allied health showed treatment was provided only 3 times in one month. The Assessment Team identified electronic records of allied health scheduled treatments could not be accessed by staff for the past 3 months; management had acknowledged this and said the issue would be resolved. One consumer who was not able to use the call bell system did not have this reflected on their care plan, and two consumer’s care plans did not contain information on how they could be supported to pursue activities of interest to them.

In their response the provider submitted some documentation including updated care plans for 3 consumers to better reflect their emotional needs and activity preferences; for one consumer their inability to use the call bell is now reflected on assessment with alternative management strategies provided. Documentation further evidenced the more recently appointed wellbeing officer is providing emotional support to some consumers. However, the provider hasn’t submitted a response regarding the consumer whose meals are provided in their room rather than the dining room as directed. While the provider evidenced dietary requirements for one consumers were recorded on entry, the entry date is approximately 16 months ago and documentation provided doesn’t demonstrate the consumer’s dietary requirements have been revisited; I noted the dietary assessment doesn’t ask consumers about food allergies. Although the provider showed one consumer was offered exercises which were occasionally refused, confirmation therapeutic treatment was given in line with their care plan was not provided; the provider submitted no follow up regarding difficulties experienced by staff in accessing electronic allied health documentation. The provider included examples of documentation demonstrating information is handed over to staff when new consumers enter the service. However, the provider has not advised of improved processes to be implemented and monitored for effectiveness to ensure consumers’ information is current, is effectively communicated in a timely way, and all staff have a shared understanding of consumers lifestyle needs and preferences.

Requirement 4(3)(e)

Most consumers and representatives said they were not aware of, or they have not required, referral opportunities to individuals or other organisations for support to be provided relating to consumers’ daily living and lifestyle needs. One representative said the service had implemented recommendations following the consumer’s referral to a dementia specialist, which included providing support to the consumer during telephone interactions. However, one consumer advised they had not received support from external organisations, including volunteers or community groups, to accompany and support them to attend church services outside the service. Management wasn’t able to provide processes for referrals or examples of when consumers had been referred to others for support with consumers’ daily living or lifestyle requirements. The lifestyle officer said they were not made aware of the referral policy and they had not made any referrals to supplement lifestyle services for consumers.

The provider in their response submitted documentation to demonstrate an external provider of mental health services has attended the service, and to show the facility uses the services of a community visitors scheme. However, this documentation reflects the external provider of mental health support had discontinued providing services earlier in the year and would not be able to resume services in the near future. While a volunteer recently attended the facility to review providing community visitor’s scheme services, they had advised due to language barries they could not continue and alternative arrangements were to be considered. The provider has not advised of improvements to be considered or implemented to demonstrate how the service actively and effectively collaborates with other individuals or organisations to support the diverse daily living and lifestyle needs of consumers. Also, to ensure referral opportunities are identified and implemented in a timely way, and staff have sufficient knowledge of referral opportunities and referral processes.

Requirement 4(3)(f)

While some consumers expressed satisfaction with meals at the service and some improvements were noted following the engagement of a new chef, most consumers expressed their dissatisfaction with the food and meal service provided. For 9 named consumers, care and complaint documentation, and consumer and representative feedback included concerns raised about the quality and nutritional value of the food, the way meals were prepared, only one menu choice was provided, and foreign objects found in meals which were unpalatable or could have caused the consumer to choke. Two consumers said they were served food they disliked or were allergic to, one consumer said staff haven’t asked why they don’t like the food, and one representative said they bring in meals for the consumer as food prepared by the service was not to the consumer’s preference. Staff feedback and observations made by the Assessment Team did not demonstrate staff were knowledgeable of consumers’ nutrition and hydration needs, and staff did not always contribute positively to the overall dining experience of consumers. Some consumers weren’t assisted with their meals as required. Several staff stood when assisting consumers; they did not engage with the consumer during the meal, and they did not always know what made up the puree meal they were providing to consumers. When one consumer didn’t eat their meal, staff removed their plate without any enquiry or communication. Two consumers were served meals not of a texture required in line with their care plans; however, for one consumer a staff member considered the meal provided was correct. Catering and care staff did not have a shared understanding of who was responsible the provision of consumers’ thickened fluids, and training records showed fluid thickening education was last provided in October 2023 with a recorded attendance of about a quarter of staff.

In their response the provider submitted examples of the service’s menu which does demonstrate a choice of meals is offered, as well as alternative options if the meal choices are not to the consumers liking. However, I noted menus are provided in English. Documentation provided show the service’s caterer obtains consumer feedback on the meals served, and actions taken to address any requests or concerns raised. However, I noted a number of items raised were not recorded as closed. In relation to complaints raised regarding foreign objects found in 2 consumers meals, the provider submitted documentation to evidence apologies were extended, investigations were completed, actions taken to prevent any recurrences, and education was provided to catering staff. Documentation was submitted by the provider to show 2 consumers wished to consume food not of a texture recommended, or as reflected in their care plans. While one consumer had a signed risk assessment reflecting possible risks associated with their choice and management strategies, the provider said although one representative supported the consumer’s choice they had declined sign the risk assessment. However, the provider has not advised of actions to be taken to revisit this with the representative as I noted their initial refusal occurred in 2023. The provider has not addressed what process improvements are to be taken to improve consumers’ overall satisfaction with the meal service provided, including to improve internal communication between catering and care staff, to improve staff knowledge and understanding of consumers dietary needs, and the role of staff in supporting consumers to have a pleasant dining experience.

Requirement 4(3)(g)

The Assessment Team observed equipment provided to support consumers’ daily living and lifestyle requirements was overall safe, suitable, clean and well maintained. Most consumers and representatives didn’t raise any concerns in relation to equipment provided, although a few consumers’ advised the service had not assisted with the cleaning of their equipment such as mobility aids. Lifestyle staff said there was sufficient equipment to support the activities provided and the service had recently purchased additional equipment that included soft toys, board games and puzzles. However, the Assessment Team observed several consumer’s living with a cognitive impairment, who were seated in communal areas for extended periods and who were not provided with activity equipment to promote their stimulation or engagement; this has been considered further under Requirement 4(3)(a). Care staff said there was enough equipment to provide care and services, and said a recent request for more equipment was raised and supported by management. The service had preventative maintenance contracts for all equipment and the maintenance officer checked equipment under supervision provided the governing body.

Conclusion

The service demonstrated where equipment is provided to support consumers’ daily living and lifestyle requirements, overall it was suitable, safe, clean and well maintained. Accordingly, I find Requirement 4(3)(g) is compliant. While I acknowledge the service has commenced implementing some corrective actions in relation to the other Requirements, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These includes ensuring each consumer gets effective services and supports for daily living, which promotes their emotional and spiritual wellbeing, and assists them to participate in their community. Further, information about the consumers’ needs and preferences is communicated, referrals to other providers are made and in a timely way, and meals are provided of a suitable quality and in accordance with consumers’ preferences. Accordingly, I find that Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), and 4(3)(f) are not compliant.

# Standard 5

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

Findings

The Quality Standard is assessed as not compliant as one of the three specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 5, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 5(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the Assessment Team observed the service to have a welcoming environment; consumers were accommodated in single or twin share rooms with ensuite facilities. Consumers were able to move freely through both indoor and outdoor areas of the service; consumers, family members and visitors were observed interacting with each other in communal lounge rooms and outdoor areas provided. Representatives said consumers’ preferred living arrangements were accommodated, including for consumers who were married. Consumers’ were supported to decorate their rooms with personal items, such as family photos, pictures, ornaments, and furniture to provide a sense of belonging. Dining rooms were observed to bright and spacious, and enabled consumers with mobility aids to move comfortably. For one consumer whose window faced a wall, the service had painted large landscape murals to make the view more enjoyable.

Requirement 5(3)(b)

The Assessment Team identified that overall, the service environment was safe, clean and well maintained. The layout of the service environment promoted the free movement of consumers both indoors and outdoors; consumers residing on the first floor required lift access to go outdoors. The courtyard and garden areas were observed to be well maintained. Most consumers and representatives were satisfied with the maintenance and cleanliness of environment, and said they can go outdoors when they wanted to. However, one consumer advised they used to enjoy living at the service but they are now scared following incidents with another consumer; this has been considered further under Standard 4 (Services and Supports for daily living). Staff were knowledgeable of processes to report maintenance issues and said these were addressed promptly. The service conducted regular room audits with repairs being undertaken as needed. While the preventative maintenance schedule for external providers was up to date and completed, the schedule for works to be completed by the service’s maintenance officer was not. The chairman said the scheduled works had been completed, acknowledged this hadn’t been documented, and arranged for follow up to occur. Maintenance related documents including for emergency procedures, fire and electrical safety, and pest control reports were in order.

Requirement 5(3)(c)

The service was not able to demonstrate all equipment was well maintained, or always provided to consumers in a timely way. The delayed provision of equipment has been considered further under Standard 3 (Personal and clinical care). While consumers and representatives didn’t raise concerns in relation to furniture and fittings provided, a high proportion provided negative comments about the service’s call bell system and the delayed response by staff. Some consumers’ said they don’t use the call bell as staff take a long time to respond, while others said they use the call bell but have to wait. Some representatives expressed concern regarding mobility sensor alerts, linked to the call bell system, not being answered; the Assessment Team observed activated sensors not being responded to by staff in a timely way. Call bell and sensor reports showed wait times were up to many hours. Management said the call bell system wasn’t suitable for the service’s current high care setting, alerts for high-risk consumers weren’t reliable, and faulty issues had been reported in February 2024; a new call bell system was to be installed in the next few weeks. Taking into consideration the immediate safety of consumers, management arranged for additional staff to be rostered on each floor and for each shift, until the new system was installed.

The approved provider, in their response to the Review Audit report, submitted documentation which included project plan details relating to the installation of a new nurse call system. A revised project scope and plan for this installation reflected the nurse call upgrade had been completed for some consumers’ rooms; these rooms were used to train and educate staff, including the educator, on the use and functionality of the new system. The proposed completion of consumer room upgrades on level 1, was scheduled for early October 2024; once all consumers’ rooms were completed, nurse call upgrades will proceed in the service’s common areas, staff stations and with the services phone system. However, the provider has not advised how they are to communicate and advise consumers and representatives of the installation of this new call bell system.

Conclusion

Overall, the service demonstrated the service environment was welcoming, clean, well maintained and enabled consumers to move freely throughout the service environment. Accordingly, I find that Requirements 5(3)(a) and 5(3)(b) are compliant. While I acknowledge the service has commenced implementing corrective actions in relation to the call bell system, I consider the installation of the new call bell system will still take time to be fully completed, for all staff to be educated in its correct use, and for the service to review and evaluate the effectiveness of this improvement. I further encourage the provider to communicate the installation of improved call bell system with consumers and representatives, and to consider the implementation of revised processes to monitor and ensure staff respond to consumers’ call bells in a timely way. Accordingly, I find that Requirement 5(3)(c) is not compliant.

# 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. | Not 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. | Not Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as four of the four specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 6, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 6(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the Assessment Team identified while most consumers and representatives said they were able to provide feedback or make complaints, deficiencies in the service’s processes for resolving complaints discouraged them from using the complaint system. A few consumers said they felt comfortable to make complaints, but they had not needed to. However, 5 named consumers and representatives provided negative feedback; while some said they had raised many concerns about care and services provided, their complaints had not been acknowledged or responded to and so they felt there was no point in complaining. One spoke of being confronted by a staff member about a complaint they had made to the service, while another said they didn’t know who to complain to and staff were unable to assist them. The service’s complaints register reflected one representative gave feedback in June 2024 about not knowing how to make a formal complaint. Staff training records on feedback and complaints show only 15 staff members completed the training in 2023, and 7 staff members completed the training in 2024. The organisation’s complaints procedure did not fully reflect the service’s complaints process; the service’s feedback form was not included. While external complaint information was displayed on posters in English, Arabic and Greek; complaint feedback forms were only available English. Catering feedback forms available in both English and Arabic and located in dining rooms, were missing the first page.

The approved provider, in their response to the Review Audit report, submitted some documentation to show acknowledgement and updates were provided to one of the named complainants, and to show another complainant does know how to use the service’s complaint system. However, the documentation doesn’t demonstrate the service fully addressed the concerns raised, or responded in a timely way and to the satisfaction of the complainant; one representative wrote in their complaint that while they had provided the same feedback 2 weeks prior, they had received no response. The provider has not addressed whether further training is to be scheduled to ensure all staff have attended education on feedback and complaints, and whether review measures are to be implemented to make certain the organisation’s complaints procedures provides consumers with current and accurate information. Also, whether other actions to be applied to ensure consumers have access to feedback mechanisms that take into consideration the language needs and preferences of consumers. The provider has not advised of overall improvements to be considered and actioned to make sure the service’s processes actively support and encourage consumers, representatives and others to provide feedback and make complaints.

Requirement 6(3)(b)

The service did not ensure consumers were made aware of, and had access to advocates, language services and other methods of raising and resolving complaints. The Assessment Team observed notices and brochures displayed in the service’s environment promoting advocacy, language and external complaint handling services; information about these services were also in the consumer handbook. However, consumers and representatives said they were not aware of advocacy or languages services they could access. One consumer advised several staff were unable to assist them when they requested to speak to the Assessment Team during the Review Audit. The Assessment Team identified staff weren’t aware of advocacy services or of any advocacy organisations. Staff advised of language barriers resulting in communication challenges they experienced when engaging with consumers; however, staff were not familiar with external language services available and relied on other staff or consumers’ family members for translation. While management said Arabic speaking staff were assigned between the floors of the service, a staff member said Arabic speaking staff were not always on their shift. Management said advocacy information was shared with consumers and representatives, such as in consumer meetings; however, information to demonstrate this was not provided.

In their response the provider submitted consumer and representative meeting minutes for September 2024, to demonstrate advocacy services, translation services and updates on changes to the service are communicated. However, I noted this meeting occurred after the Review Audit and minutes of previous consumer and representative meetings held were not provided. The provider has not advised of overall process improvements to be implemented to make sure staff, as well as consumers and representatives are aware or have access to advocates and language services, and other methods of raising and resolving complaints; and how these processes will be reviewed for effectiveness.

Requirement 6(3)(c)

The service did not demonstrate appropriate action was taken in response to complaints. Consumers and representatives expressed their dissatisfaction with the service’s complaints processes. Feedback provided regarding complaints made in relation to 11 consumers included, complaints submitted verbally, via email or in writing were not responded to; complainants didn’t feel heard, they never or seldom received an apology, responses provided were not communicated in a timely way, and they were not satisfied with the outcome of the response. Where improvements actions had been implemented by the service, these were often not sustained and the complainants had to deal with the same issue on an ongoing basis. The Assessment Team identified many complaints raised by consumers and representatives weren’t recorded in the services complaints register; this was acknowledged by management. The register recorded some complaints were addressed, open disclosure practiced, and reflected consumers’ satisfaction; however, this was inconsistent with feedback received from complainants. The complaints registered did not record details of actions taken or the effectiveness of the actions, and feedback forms for most complaints addressed by the service showed sections were incomplete; this included suggestions, proposed solution, action completed, and feedback discussed in quality indicator meetings. While the service had an open disclosure policy, staff were unaware of the concept of open disclosure. The Assessment Team identified following consumer incidents, and subsequent complaints raised; the service was unable to demonstrate the incidents were thoroughly investigated and reviewed, deficiencies in staff practice were appropriately identified and addressed, and open disclosure was undertaken.

The provider in their response submitted some complaint documentation, together with the service’s complaint register for a one-month period, which they advised was requested by the Assessment Team during the Review Audit, but not provided; this included complaint documentation relating to complaints for two named representative. However, I noted this documentation does not demonstrate the service fully addressed or rectified the concerns raised, addressed the issues to the satisfaction of the complainant, or always addressed the complaints in a timely way. Documentation for a more recent complaint received and addressed by the service was submitted to demonstrate open disclosure is provided relevant to the complaint; however, I noted the management of this complaint and the service’s response occurred after the Review Audit. The provider has not advised of process improvements to be implemented to ensure all feedback and complaints received are appropriately captured, responded to and addressed in consultation with the complainant, and in timely way. Further, the provider has not said how they will make sure corrective actions implemented are monitored and reviewed for their effectiveness, the complainant is satisfied with the outcome, and open disclosure is practised and demonstrated.

Requirement 6(3)(d)

The service was unable to demonstrate consumer and representative feedback and complaints were reviewed and used to improve the quality of care and services provided. A consumer feedback survey conducted earlier in 2024 identified consumers suggested improvements in a number of areas. While management had advised of a couple of improvements commenced, they didn’t provide further information on implementing the remaining suggested improvements. The Assessment Team found previously identified issues of concern recorded in the service’s plan for continuous improvement, continued to exist based on consumer and representative feedback and observations; these included cultural safety as staff weren’t familiar with consumers’ backgrounds, missing laundry items, and dissatisfaction with meals. Apart from meals, neither the survey results nor feedback and complaints were used to drive continuous improvement. While consumer and representative meeting minutes demonstrated discussion topics included the care provision, lifestyle, allied health, meals and feedback and complaints, there was limited or no record of actions to be taken or due dates.

In their response the provider said, and documentation submitted evidenced, the consumer feedback survey has now been evaluated and actions are to be assigned to the relative team members. However, the provider has not advised of process improvements to be applied to ensure the service captures, analyses and acts on feedback and complaints, to improve how they deliver quality care and services, or how they will regularly review and improve how they manage complaints.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These include ensuring consumers, representatives and others are encouraged and supported to provide feedback and make complaints; consumers are made aware of advocacy and language services, and external avenues for resolving complaints, appropriate action is taken and open disclosure is practised, and feedback and complaints are reviewed and used to improve the quality of care and services. Accordingly, I find that Requirements 6(3)(a), 6(3)(b), 6(3)(c), and 6(3)(d) are not compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not 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. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as five of five specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 7, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 7(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the service was unable to demonstrate their workforce was planned to enable the delivery and management of safe and effective care and services. While some consumers and representatives said there were enough staff, a high proportion provided feedback related to workforce insufficiency, which negatively impacted the safety and delivery of care provided to consumers. Feedback included there was not enough staff and especially on weekends, and staff were late in providing assistance or rushed when providing care. Feedback further feedback identified agency staff didn’t know consumers or their care needs, staff didn’t provide hygiene care as needed or did not provide personal care in line with consumers’ preferences. Representatives expressed concern consumers’ mobility sensor alerts, implemented to prevent falls, were not answered in a timely way. Some staff said there wasn’t enough rostered staff even though vacant shifts were replaced with agency staff; staff expressed concern they were unable to complete documentation when agency staff were used as they required additional support. Overall, agency staff weren’t able to provide information about consumers they were caring for, and an agency registered nurse said they weren’t provided with handover information, or information on consumers’ risks, complex care or other care matters; agency staff orientation checklists weren’t always completed or signed off by management. Management advised of ongoing recruitment to reduce agency usage. Call bell and sensor reports showed lengthy wait times for consumers, and up to many hours. Management said the call bell system wasn’t suitable for the service’s current high care setting, alerts weren’t reliable, and this was a long-standing issue; a new call bell system was to be installed in the next few weeks. In the interim, management arranged for additional staff to be rostered on each floor and for each shift, until the new system was installed.

The approved provider, in their response to the Review Audit report, submitted some documentation which included data showing a reduction in agency registered nurse usage over the past few months; however, it does reflect increased agency care staff usage. The provider said they recently hired several new employees to reduce reliance on agency staff and create a casual pool of staff to draw from; however, documentation to support this was not included. Records reflected staff attendance at meetings where staff were informed of safeguarding measures insitu until the new nurse call bell system is fully implemented; the service’s new call bell system has been considered further under Standard 5 (Organisation’s service environment). While the provider submitted a duty statement for care staff undertaking rounding duties that included answering call bells, they have not advised of improvements to monitoring process to be implemented, to ensure activated call bells and sensor alerts are responded to in a timely way. The provider reiterated staff retraining on consumer dignity, respect, choice and cultural sensitivity was conducted in September 2024; this has been considered further under Standard 1 (Consumer dignity and choice). However, the provider has not addressed how they will make sure when agency or new staff are rostered, they are provided with sufficient information and support to deliver safe and quality care and services, in line with consumers’ needs and preferences, which promotes continuity of care and builds relationships of trust with consumers.

Requirement 7(3)(b)

While some consumers and representatives said staff were kind, caring and respectful, care documentation and feedback from other consumers and representatives showed staff did not consistently demonstrate kindness or respect towards consumers. Consumers’ feedback reflected staff were disrespectful or they did not engage or communicate with consumers while providing care and services; this has been considered further under Standard One (Consumer dignity and choice). Representative feedback for one consumer who liked to spend time in their room and didn’t use their call bell, reflected staff don’t enter the consumer’s room to spend time with them. A representative of a consumer who changed rooms, said they needed to wait an extended period for staff to provide assistance and equipment, and when the equipment was provided it was dirty. Another representative said agency staff don’t know consumers and don’t show an interest; while photos displayed in the room guide staff on correct positioning of the consumer in bed, they regularly see the consumer slumped over when they visit. The Assessment Team identified feedback or documentation for 3 consumers, raised allegations of staff mishandling the consumers during care provision; this has been considered under Standard 8 (Organisation governance).

In their response the provider reiterated staff retraining on consumer dignity, respect, choice and cultural sensitivity was conducted in September 2024. While supporting documentation showed just over half of staff employed attended this retraining, the provider has not said when the remaining staff will attend. The provider said a staff observation audit has been developed to ensure adherence to consumers’ privacy, dignity, respect and cultural safety; however, they have not advised when the audit will be implemented nor the intended frequency of its use. The provider has not advised of considerations or actions to be implemented to improve the overall engagement and interaction of staff with consumers. Nor of process improvements to ensure all staff, including agency staff, are supported to know consumers’ and understand their needs, and to enable staff to foster relationships with consumers that are respectful and caring.

Requirement 7(3)(c)

The service did not adequately demonstrate effective processes were implemented to ensure staff had the necessary knowledge and were competent in undertaking their roles. Consumer and representative feedback was mixed regarding staff knowledge. However, for 7 consumers; consumer, representative and staff feedback, observations made by the Assessment Team, and care documentation showed staff didn’t demonstrate they were competent in some aspects of their roles. This included care staff not attending to eye toilets correctly, not providing appropriate mobility or meal assistance in line with care plan directives, and not completing clinical monitoring charts appropriately. Care staff did not have a shared understanding of correct thickened fluids preparation, and advised they didn’t know how to reposition a consumer whilst the consumer was seated in a chair. Registered staff didn’t always demonstrate they had sufficient clinical knowledge or showed they provided effective clinical oversight. This included administrating crushed medication incorrectly, not managing consumers complex care needs appropriately, not reviewing monitoring charts to oversee staff practice and to inform effective care planning and management, not following up or actioning changes in consumers’ care needs, and not initiating or managing consumers’ escalation of care when needed or in a timely way. The service identified gaps in staff competency mid-2024 and said they were establishing a train the trainer program; experienced staff were to lead a staff competency assessment team. While management said the clinical support specialist provided guidance and support to registered staff, the clinical support specialist had resigned during the Review Audit. A dementia support program was established July 2024; however, documentation for the newly appointed dementia support worker, previously a lifestyle officer, did not demonstrate they had dementia related training.

The provider in their response advised as the lifestyle officer had previous experience working in a memory support unit of another aged care facility, they were asked to step into the dementia support worker role; documentation submitted showed a position description and duty statement for the role has been developed. However, the provider has not advised further on the progress of the establishment of the service’s train the trainer program; or whether the clinical support specialist’s role has been replaced and of other ways clinical support is provided to staff in the interim. The provider has not advised of monitoring and process improvements to be implemented, to ensure the workforce is competent overall and staff have sufficient knowledge to effectively perform their roles; and how these processes will be reviewed for effectiveness.

Requirement 7(3)(d)

The service was unable to demonstrate the workforce was adequately trained, equipped, and supported to deliver safe and quality care and services to consumers. While most staff said there was enough education provided, the Assessment Team identified staff had not completed all mandatory training to support them in effectively performing their roles; the effectiveness of training provided was not shown to be reviewed by the service. Some staff were inexperienced and lacked overall knowledge regarding providing safe and effective care for consumers, or of their role responsibilities in accordance with the Quality Standards. While management said staff meetings were used to update staff on changes in aged care legislation, documentation to demonstrate this was not provided. Quality meeting minutes for July 2024 identified staff knowledge of regulatory compliance was poor; regulatory compliance related topics were included in online training and supplemented with toolbox talks. However, management was unable to provide supporting evidence these sessions were conducted. Training records showed some staff were overdue for fire safety, restrictive practices, and code of conduct education, and these records didn’t reflect training for the lifestyle team, including the wellbeing officer. While training records were requested for the lifestyle team, they weren’t provided. A new registered nurse commenced employment in August 2023; however, their induction documentation was only completed in May 2024. Management said this occurred as the nurse was always on the floor. Induction and buddy programs for care staff showed pre-employment, induction day, and buddy shift checklists were unfinished and not marked off as completed by the manager.

In their response the provider submitted documentation to demonstrate some of the education that has been provided to staff. However, this documentation only records the title of the training session and does not detail the content of the education provided. Further, it does not reflect the role of staff or that all staff attended the training sessions relevant to their roles. With the exception of manual handling training, most training sessions recorded attendance of 20 or fewer staff. The provider has not submitted staff meeting minutes to show where changes in aged care legislation have been discussed. While the provider has submitted some records of staff attendance related to code of conduct education provided between July and September 2024, they haven’t provided records to show staff who were overdue for fire safety and restrictive practices training, have now completed this education. The provider has not made available education records for the lifestyle team, nor have they responded to the deficiencies identified in their induction documentation. The provider has not advised of processes improvements to be implemented to ensure that overall the workforce is trained, equipped and supported to deliver outcomes required by the Quality Standards.

Requirement 7(3)(e)

The service was unable to demonstrate regular assessment, monitoring and review of each staff member’s performance was undertaken. Most staff said they had not been provided with regular assessment of their performance; either they had not had a performance review or could not recall when their last review occurred. New staff were unaware of their probation periods and were unable to provide details of completed probation reviews. While the service’s electronic staff performance review schedule had a due date of 14 September 2024, only 9 out of 97 staff had reviews completed. Management said previous reviews were completed manually and would be retrieved; however, this data was not provided to the Assessment Team. Management acknowledged staff appraisals were behind schedule, but said regular assessment and monitoring was conducted during day-to-day observations. Induction documentation for staff showed 3 or 6 monthly probation performance reviews hadn’t always been conducted. The 3-month probation record for one registered nurse reflected numerous gaps had been identified in their clinical practice. While records a couple of weeks later detailed they had made ongoing errors, even though training had been provided, no further information or actions were documented. Management said they weren’t able to use consumer feedback to inform staff training needs, as feedback didn’t identify staff to enable management to take action against the particular staff member. Management advised one medication competent care staff was under performance management; however, they were unable to provide the Assessment Team with the staff member’s performance improvement plan.

The provider in their response submitted some documentation samples to demonstrate staff are competency assessed on safe medication administration prior their assignment of a medication competent role. Also, the service’s checklists completed for the induction and buddy program and buddy shifts were provided, to demonstrate onboarding and induction processes of new staff. While the provider said there were established processes for performance management when staff performance issues are identified, this information was not submitted. However, the provider hasn’t advised of actions to be taken to ensure outstanding performance and probation reviews are conducted for each staff member, or completion timeframes. The provider hasn’t advised of further actions taken following the additional concerns identified during the probation period of one registered nurse, or submitted the performance improvement plan for the medication competent care staff under performance management. The provider has not advised of overall process improvements to be implemented to ensure they are able to evidence regular assessment, monitoring and review of each staff members’ performance, including during probation periods, is undertaken and this information is used to inform staff training needs.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These include ensuring the workforce is planned to enable the delivery and management of safe and quality care and services, workforce interactions with consumers is kind, caring and respectful; the workforce is competent, have qualifications and knowledge and are trained and supported to deliver outcomes required by the Standards, and each staff members performance is regularly assessed, monitored and reviewed. Accordingly, I find that Requirements 7(3)(a), 7(3)(b), 7(3)(c), 7(3)(d), and 7(3)(e) are not compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not 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. | Not 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. | Not 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. | Not 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. | Not Compliant |

Findings

The Quality Standard is assessed as not compliant as five of five specific Requirements have been assessed as not compliant.

At an Assessment Contact site audit dated 13 August 2024 to 14 August 2024 the Assessment Team identified areas of deficiencies related to Standard 8, which they have referred to or included in the Review Audit report. This information has also been reflected and considered below.

Requirement 8(3)(a)

At the Review Audit conducted 29 August 2024 to 4 September 2024, the Assessment Team identified while some consumers and representatives considered the service was well run, others disagreed and said they were not involved in the development, delivery and evaluation of care and services. Consumers and representatives said they weren’t asked to provide feedback or make suggestions, and concerns raised hadn’t been responded to or effectively managed; documentation showed complaints and concerns verbalised weren’t always used to drive improvements at the service. Consumers and others the consumer chose, weren’t always engaged in partnering during assessment, planning and review processes of the consumer’s care; care conferences weren’t always conducted and language barriers further limited their patterning ability; this has been considered further under Standard 2 (Ongoing assessment and planning with consumers). Bimonthly consumer meetings were held; however, meeting minutes showed management presented information to consumers did not evidence discussions on service operations, or that concerns raised were addressed. While consumer advisory committee was established, processes to support consumers in nominating and participating in the committee weren’t demonstrated. Management said consumers and representatives were approached based on their involvement in the service and their ability to engage without bias; consumers and representatives were not asked to nominate. Further, participation support wasn’t given to the selected consumers, and no information on discussion points were given so members could prepare for the meeting. Two consumers management said were committee members were not aware of the committee or any associated meetings; one consumer said as they spoke very limited English they wouldn’t be able to participate.

The approved provider, in their response to the Review Audit report, submitted documentation to show how some complaints were acknowledged, responded to, and captured on the service’s plan for continuous improvement to inform broader service improvements. However, these examples don’t show the complaints were fully addressed, concerns rectified and in a timely way, or to the satisfaction of the complainants. Some complaints, such as laundry and meal services, were recorded and addressed on the improvement plan in 2023; however, I noted feedback from consumers and representatives reflected current concerns in these areas. Complaint trend data was submitted; the provider said once complaint interventions were implemented the data shows a reduction in number of complaints. However, I noted the Review Audit report reflects many complaints made hadn’t been captured the service’s complaint register in the first instance. While a care conference example was provided to demonstrate a good outcome for the consumer, this doesn’t relate to information in the Review Audit Report, nor to consumers interviewed or whose documentation was reviewed, and it has not been considered further. Example of a letter addressed to an individual inviting them to participate in the service’s consumer advisory committee was provided. However, the provider has not addressed how all consumers and representatives were offered in writing the opportunity to establish a consumer advisory body, how they were actively engaged, or how they could be part of the committee. Consumer meeting minutes for September 2024 were provided to show services provided and updates on changes are communicated; however, I noted this meeting occurred after the Review Audit and previous meeting minutes held weren’t provided. Overall, the provider has not advised of process improvements to be implemented to ensure consumers are consistently supported to be engaged in the development, delivery and evaluation of care and services.

Requirement 8(3)(b)

The governing body did not make certain effective mechanisms were implemented to ensure the Board was kept informed, and enabled to identify and take proactive action as needed, to ensure a culture of safe, inclusive and quality care and services was delivered. While deficiencies were identified across all 8 Quality Standards, these deficiencies weren’t identified by the governing body’s systems. Management provided a written report to the Board and the chairman attended the service daily. However, there were no other reported mechanisms used by the governing body to satisfy itself Quality Standards were being met; the Assessment Team identified that some environmental audits and an infection control checklist were completed in July 2024. Management said the organisation had recently subscribed to an external quality monitoring whereby audits and clinical indicators were completed, but this had not yet been implemented. A recent completed consumer survey highlighted a range of issues; however, there was no demonstration improvements of the issues were undertake. There were limited initiatives for promoting or monitoring vaccination rates made by the Board until prompted by communications from the Department of Health and the Commission. While the Assessment Contact report 13-14 August 2024 reflected serious concerns about the provision of clinical care, which was raised with management, this was not conveyed to the Board in the service’s management report. The organisation identified the call bell system faulty and consumers’ requests for assistance or sensor alerts weren’t reliable; management advised a new call bell system was to be installed. However, risks associated system failure itself wasn’t identified and measures ensuring the immediate safety of consumers hadn’t been considered by the governing body until raised by the Assessment Team. Following discussions regarding the extent of the deficits identified during the Review Audit, the governing body appointed consultants to review the care and services provided.

In their response the provider submitted revised quality indicator data showing inclusion of vaccination rates and advised this data is now provided to the Board for their guidance and direction. Documentation was also submitted to demonstrate quality indicator reports with benchmarking data had been obtained from the external provider for June and July 2024. However, the provider has not advised of overall process improvements to be implemented to ensure the governing body promotes a culture of safe, inclusive and quality care and services; nor of mechanisms to be employed to ensure the Board is consistently informed of service’s operations or issues of concern identified, to enable the governing body’s response and proactive management.

Requirement 8(3)(c)

While the organisation has effective systems in relation to financial governance, the organisation could not demonstrate effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

Information management: care plans weren’t reflective of consumers’ clinical and lifestyle needs resulting in risks not being managed; care monitoring gaps and lack of review didn’t inform effective care planning or monitoring of staff practice. Lack of incident documentation resulted in service management being uninformed and insufficient details recorded such as causative factors. Staff weren’t familiar with consumers, their care needs or associated risks. Information about feedback and complaint trending hadn’t been effectively captured to inform continuous improvement. Workforce induction, orientation and probation documentation wasn’t completed or reviewed to inform effective monitoring of staff performance. Overall effective monitoring hadn’t occurred related to care and services such as audits, surveys and other feedback avenues. While the organisation had externally sourced policies and procedures, these hadn’t been tailored to the organisation’s specific needs; the organisation did not have policies or procedures regarding vaccination and anti-viral medications, or on updating consumers’ vaccination status. Further, staff did not have a shared understanding where the service’s policies and procedures were located.

Continuous improvement: Management said avenues for identifying opportunities for continuous improvement included feedback, meetings, audits, and observations. However, the Assessment Team identified deficiencies evident in feedback and complaint systems, information management, incident management, and clinical care management; together with a lack of audits and effective monitoring systems, this reduced the organisation’s ability to undertake comprehensive and effective continuous improvement activities. Further, the organisation’s continuous improvement systems hadn’t been effective in identifying the deficits found in all 8 Quality Standards during the Review Audit.

Workforce governance: The organisation’s systems and processes hadn’t ensured there were sufficient rostered staff, who were competent and knowledgeable in their roles and adequately trained and supported to the deliver safe and quality care and services. Staff didn’t always know consumers or their individual needs, did not always interact with consumers in a kind and caring way, and consumers frequently waited long periods for staff to respond to their requests for assistance.

Feedback and complaints: The governing body hadn’t ensured the feedback and complaint system was robust, effectively captured and addressed consumers concerns, and facilitated open disclosure. Access to advocacy and language services wasn’t supported for consumers and complaints weren’t thoroughly investigated and used to drive improvements.

Regulatory compliance: The organisation wasn’t able to demonstrate its systems were adequate to ensure compliance with regulatory obligations. Responsibilities relating to Serious Incident Response Scheme (SIRS) reporting weren’t fully understood by staff. Although investigations generally were initiated following incidents, including allegations of unreasonable use of force, management hadn’t always fully documented these investigations or implemented support measures for affected consumers to ensure their ongoing safety. Key information for some incidents weren’t always reported including where there had been staff failure in monitoring consumers post incident. In relation to allegations of neglect for one consumer, management didn’t consider key information and was of the opinion there had been no neglect; management said the allegation did not meet SIRS reporting requirements as no person had been identified as being neglectful. The organisation hadn’t ensured legislative requirements for minimising the use of restrictive practices were always followed; nor had they ensured the service complied with the Quality Standards, as deficiencies were identified across all 8 Quality Standards.

Financial governance: The organisation demonstrated there were effective systems for financial governance. Management had an allocated spending delegation; the governing body was always available to approve purchases and services exceeding the delegated amount. Recent approvals had been for the new call bell system and to purchase of wider beds.

The provider in their response submitted documentation to show current consumer and organisational information provided to staff; they said sufficient information was provided for staff to care consumers safely. However, deficits in information management and sharing has been considered in detail under the Quality Standards in this report, and the negative impact this had had on consumers ongoing health, wellbeing and safety. The provider said the service’s plan for continuous improvement contains identified improvements on assessment, planning, care conferences and individualisation of same. However, I noted not all service improvements identified in the Review Audit report have been captured on the service’s plan, and improvements that are reflected are still in progress. Various documentation was submitted related to the workforce; the provider said the organisation recognised the high use of agency staff and the instability of the lifestyle team had been difficult to manage, The organisation are concentrating on recruiting and retaining their own staff; the Board had been aware of call bell issues and a new call bell is being implemented. While I acknowledge these improvements planned to support the workforce, these will take time to be fully implemented and then reviewed for their effectiveness. The provider offered examples of documentation relating to consumer feedback, surveys and meetings to demonstrate avenues for consumers to provide feedback. However, as detailed in Standard 6 the organisation has not demonstrated feedback was always captured, responded to or to the satisfaction of the complainant. The provider submitted some documentation to show their incident investigation process, together with their consideration of what constitutes SIRS reporting requirements and reporting timeframes; together with their compliance with the use of chemical restraint for one consumer. However, the organisation has not demonstrated all consumer incidents, including allegations of mishandling or neglect, were documented as incidents in the first place; investigations of the complaint or incident were fully undertaken and documented, reported to SIRS, and the outcome of the incident and investigation was appropriately communicated to consumers and representatives; to demonstrate the service is fulfilling their legislative responsibilities.

Requirement 8(3)(d)

While the organisation has policies and procedures in relation to managing risks, the organisation’s processes hadn’t ensured consumers’ risks were always effectively identified and managed. Key components of a robust incident management system were not evident including documenting and reporting all incidents, thorough investigation and analysis to identify contributing factors, review of existing prevention strategies, and further consideration of measures to prevent future incidents weren’t always completed. This has been considered under Standard 3 (Personal and clinical care). While management said the service had a high-impact or high-prevalence risk register, this was not provided. Long standing call bell system deficiencies had presented further high-level risk for consumers; however, this hadn’t been considered in any incidents involving falls and the organisation had only recently commenced a call bell system replacement and measures to ensure the immediate safety of consumers.

While the organisation has processes to enable consumers to take risks to live the best life they can, the organisation haven’t effectively monitored the processes to ensure that prevention strategies to mitigate the risks are implemented. This has been considered under Standard 2 (Ongoing assessment and planning with consumers).

The governing body hasn’t ensured there were effective systems to make sure they are made aware of situations which may constitute abuse or neglect. For 6 named consumers, management did not demonstrate they completed or documented comprehensive analysis of reported incidents, or in relation to information they had been made aware of including complaints, to enable them to identify allegations of unreasonable use of force or of instances that may be considered neglect. Reports of ineffective clinical monitoring and care provision for consumers relating to wound and skin care, following falls, and during a period of isolation were not appropriately investigated, responded to or reported as is required. These have been considered under Standard 2 and Standard 3 (Ongoing assessment and planning with consumers and Personal and clinical care).

In their response the provider has now submitted the service’s risk register for consumers. However, I noted this register is undated and the provider has not advised how it is used or communicated with staff. The provider submitted documentation related to the installation and progress of the new call bell system. However, the provider has not advised of how the new system will be monitored for effectiveness going forward. The provider submitted updated care plans for most of the named consumers, which now better reflect their current care needs. However, overall, the provider has not advised of process improvements to be implemented to ensure risk management governance systems and practices always monitor and effectively manage high-impact high-prevalence risks associated with consumers’ care; that abuse and neglect of consumers, which include any allegations, are appropriately identified and responded to, and support is provided for consumers to live their best lives is known by all staff; and how they will keep the governing body appraised of these areas.

Requirement 8(3)(e)

The organisation had a clinical governance framework with policies and procedures to support the provision of clinical care. However, the governing body had not ensured components of the clinical governance system were consistently and effectively implemented and monitored. While the organisation collected clinical indicator data, they didn’t evidence other processes to monitor the overall performance of the clinical systems were undertaken, including clinical audits. Deficits in clinical care were identified that included lack of assessment and care planning; failure to effectively monitor and manage each consumer’s care needs, to make timely referrals, or to identify and respond changes or deterioration in consumers’ conditions. The service’s clinical oversight processes hadn’t identified these deficiencies. The organisation had policies and procedures related to infection control, minimising use of restraint, and open disclosure; However, the governing body hadn’t ensured that these are always implemented. This has been considered in Standards 3 (Personal care and clinical care) and elsewhere in Standard 8. Management didn’t demonstrate open disclosure was practised when concerns about care provision was raised by representatives in relation to 4 consumers; these concerns related to poor staff practice and included lack of documentation to show appropriate monitoring and care was provided.

The provider in their response submitted documentation to demonstrate quality indicator reports with benchmarking data is now being obtained from an external provider. Documentation was submitted in relation clinical care provided, which the provider stated evidenced that timely identification, interventions, referrals and monitoring have been undertaken for consumers. Some further documentation regarding infection control, minimising the use of restraint and open disclosure was also submitted, including training and process guides; these submissions have been considered in Standards 3 and 6 (Personal care and clinical care and Feedback and complaints) and elsewhere in Standard 8. However, the provider has not advised of overall process improvements to be implemented to ensure the organisation’s clinical governance framework is effectively communicated, understood, and appropriately practised by all staff, and regularly monitored for effectiveness; including processes to keep the governing body appraised of this areas.

Conclusion

While I acknowledge the service has commenced implementing some corrective actions, I was not provided with sufficient evidence in the approved provider’s response to satisfy me the service has understood and addressed the deficiencies identified by the Assessment Team in relation this Standard, as reflected above. This includes having systems and process to identify and address deficits in staff knowledge, understanding, and practice; and then to evaluate these for effectiveness. The approved provider has commenced some improvements, and I encourage them to extend these improvements to address all the deficits identified. These include ensuring consumers are engaged in the development, delivery and evaluation of care and services, the governing body effectively promotes a culture of safe, inclusive and quality care, there are effective organisation governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints, effective risk management systems and practices, and an effective clinical governance framework. Accordingly, I find that Requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d), and 8(3)(e) are not compliant.

1. The preparation of the performance report is in accordance with section 76A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)