Performance

Report

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| Name of service: | Performance report date: |
| St Elizabeth Home | 27 June 2022 |
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| Approved provider: | Activity date: |
| St Elizabeth Home Limited | 19 April 2022 to 22 April 2022 |

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

**This performance report**

This performance report for St Elizabeth Home (the service) has been considered by Peter Griscti, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives and others.
* the provider’s response to the assessment team’s report received 26 May 2022.

# Assessment summary

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

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

# Areas for improvement

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

### Requirement 4(3)(b)

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

* Ensure consumers are provided with supports to ensure their emotional and spiritual wellbeing, particularly where they may be recently admitted to the service.

### Requirement 4(3)(e)

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

* Demonstrate consumers are referred to relevant organisations in a timely manner and supported to engage with external providers to support wellbeing and supplement care delivery at the service.

### Requirement 6(3)(a)

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

* Ensure consumers and others feel supported to provide feedback and/or raise concerns

### 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.*

* Ensure there are sufficient staff to meet consumer needs and preferences.
* Review monitoring processes to ensure consumers are satisfied with the quality of care and services being delivered.

### Requirement 7(3)(c)

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

* Ensure effective processes are in place to ensure staff competency, including for contracted workforce personnel.

### Requirement 7(3)(e)

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

* Ensure staff performance is assessed regularly, including effective oversight of staff competency.

### 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.*

* Ensure organisational governance systems relating, but not limited to, workforce and feedback and complaints are reviewed and understood by staff, including consistent monitoring and oversight of these areas by the governing body.

# Standard 1

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

## Findings

I have found the Approved Provider compliant with Standard 1 Consumer dignity and choice as each of the 6 Requirements under this Standard have been deemed compliant.

In relation to Requirement 1(3)(a), the Assessment Team found most consumers felt they are treated with dignity and respect and overall observation of staff interaction with consumers was respectful. However, the Assessment Team observed a small number of consumer-staff interactions during the Site Audit which they considered disrespectful, in addition to noting some language used in care documentation which they felt was not demonstrative of valuing individual consumers’ identity, diversity and culture.

The Approved Provider’s response included information on actions and improvements made since the previous Site Audit during May 2021. The Approved Provider also notes their Quality Standard self-assessment tool and supporting evidence was made available to the Assessment Team while onsite which outlined actions taken regarding this Requirement.

On review of the information presented, I find the Approved Provider compliant with this Requirement. I have primarily given weight to feedback provided by consumers about how they are treated by staff, but also consider the documentation provided by the Approved Provider to demonstrate how the service understands and applies this Requirement to care and service delivery, such as use of respectful language in care planning documentation.

The Approved Provider has demonstrated it has allocated time and resources to increasing staff understanding of this Requirement, provided tools to staff to support cultural connection and understanding, and addressed documentation gaps. I have also considered where the Assessment Team have referenced findings under other Requirements (including relating to how consumers are treated when they raise concerns, language used in progress notes and depth of information in documentation), however, I do not find these examples to strongly demonstrate or correlate to a deficiency in this Requirement.

In relation to Requirement 1(3)(b), the Assessment Team found that while lifestyle staff could identify consumers from culturally diverse backgrounds, they could not describe how they support individual consumers through delivery of culturally safe care and services. The Assessment Team found minimal information is gathered regarding past trauma, cultural and spiritual needs and limited information as to how the service supports these needs.

In their response, the Approved Provider identifies there are processes in place to identify consumers who may be impacted by any form of trauma, with support provided across the entirety of care and services provided by the service. The Approved Provider notes that not all consumers have lived through prior trauma or hardship and of those that have, there are some who, through consult with their representatives, do not wish to have this listed in their care and service documentation. Examples from consumer profiles and ‘about me’ documents are provided, as is evidence of cultural diversity staff education conducted during December 2021.

I note positive feedback from consumers regarding access to Hungarian-speaking staff, however, have also considered the Approved Provider’s understanding of ‘cultural safety’ more broadly as demonstrated in examples throughout the Site Audit report and their response. For example, the provision of an onsite cultural museum and chapel, individualised strategies for consumers who are living with loss, and private arrangements (such as utilising a partner in care strategy or engagement with specific spiritual groups) for consumers who may benefit from added support. I also note the service’s opening agenda items (including an Acknowledgement of Country and prayer) in some meeting minutes provided. The care documentation examples provided demonstrate the service does capture relevant cultural information which supports provision of care in a culturally considered manner, as they align to staff feedback obtained during the Site Audit. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 1(3)(c), overall the Assessment Team found consumers were supported to make connections and maintain relationships of choice, in addition to making choices about their care and services which are respected by staff. However, some contrasting examples were provided, including relating to choosing meals, timing of care delivery and restriction on visitation timing due to administrative staff availability. Further, the Assessment Team raised discrepancy between feedback from a representative and documentation relating to decision making authority and noted that admission documents are provided in English only, limiting culturally and linguistically diverse consumers from fully understanding and participating in planning and admission.

In relation to conflicting information regarding decision making capacity, while a representative’s wishes may change over time (noting in this example, it has), I consider it reasonable that the Approved Provider has relied upon information provided and documented during a November 2021 case conference which they understood to be correct. I have also considered feedback from a clinical staff member who noted the consumer in question is independent, does things of their own accord and informs staff when they need assistance. There is no evidence that this administrative matter has caused a negative impact to the consumer. I have also considered the Approved Provider’s response to the Site Audit report and accompanying evidence, which identifies the service’s clinical documentation system as a single source of truth with regard to decision makers and includes information sent to representatives regarding decision making.

While I have considered that English-only forms or documentation may limit some consumers from independently accessing them, this is not an uncommon scenario in any Australian health or care setting. The Approved Provider reasoned why information is presented only in English and I note they provide support for consumers and representatives, as evidenced by the Assessment Team under Standard 6 Requirement 3(b), relating to provision of language and advocacy assistance. Feedback from one representative regarding restricted visitation access (affecting consumer ability to make and maintain connections) is a valid concern, however, I consider this to align more closely to staffing sufficiency and have considered it under the relevant Requirement. In any case, service management advised during the Site Audit that weekend visitation had resumed, making the complaint a historic matter which has been resolved. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 1(3)(e), the Assessment Team found that while day-to-day information is provided bilingually, key documents and form which enable decision making and choice are only available in English.

I have considered the Assessment Team’s report and Approved Provider’s response and have find the Approved Provider compliant with this Requirement. As noted in Requirement (3)(c) above and observed by the Assessment Team during the Site Audit, the service makes translation and advocacy services readily available. It is also not evident that the provision of English-only forms has presented an issue for one or more consumers. Attached to their response, the Approved provider supplied supporting documentation to demonstrate how important communication translated and delivered directly to consumers.

More broadly, consumer and representative feedback shows that the service provides support for consumers in making day-to-day decisions which impact their quality of life, such as relating to meals, activities or how services are provided, and consumers were aware of information about matters which have a direct impact on them such as changes in service delivery resultant of COVID-19. The Assessment Team observed documentation showing representative satisfaction with improved communication from the service. I have also considered staff feedback regarding how they support consumer choice in meals and how the service has adapted to seeking consumer input on a daily basis, rather than weekly, and staff feedback on use of communication tools such as cue cards and electronic translation applications to support consumers better where language may be a potential barrier to providing choice.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining 2 Requirements of Quality Standard 1 Consumer dignity and choice.

The Assessment Team found the service considered and balanced safety of individual consumers with their wishes to participate in potentially risky activities which they enjoy, through undertaking risk assessments and identifying ways to mitigate risk. The service was found to have up to date and relevant risk assessments for applicable consumers.

Consumers felt that staff respected their privacy, and staff were able to describe how they ensure confidentiality of information is maintained. The Assessment Team observed staff respecting consumer privacy and dignity throughout the Site Audit. The service demonstrated a framework for information management, including relating to privacy of consumer information.

# Standard 2

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

## Findings

I have found the Approved Provider compliant with Standard 2 Ongoing assessment and planning with consumers as each of the 5 Requirements under this Standard have been deemed compliant.

In relation to Requirement 2(3)(b), the Assessment Team found a small number of examples where care needs or preferences were not included in consumer care plans. This includes verbal disturbances noted in behaviour charting but not reflected in a behaviour care plan for one consumer, and discrepancies across documentation relating to sleep for a second consumer. The Assessment Team also raise a lack of interventions related to this consumer’s swollen legs and assert that the service was slow to arrange for external review by Dementia Services Australia and a Geriatrician.

In their response, the Approved Provider supplied additional documentation and clarified the external review note was a strategy, rather than an immediate action. I have also considered it is unclear when the swelling commenced and note comments from the consumer’s representative that they are concerned about the swelling, but positive comments that ‘the service is looking after them’ (consumer). The Approved provider explained, with supporting evidence, their actions to reduce this consumer’s falls which have reduced in frequency since the Site Audit demonstrating effectiveness of implemented strategies.

I have considered that relevant charting has/is occurring for consumers in relation to behaviours and consider the Approved Provider’s explanation that to replicate this in progress notes is unnecessary with the charting being the primary source of assessment information. Similarly, it is evidenced that the service monitors consumer sleep patterns to inform care planning. While some discrepancy may be evident between charting and assessment, it has not been suggested or demonstrated that this has had a detrimental impact to the sampled consumer.

I also note that care planning documentation for other consumers sampled is up to date, including relating to end of life care and reflects consumer wishes holistically (i.e. relating to more than purely clinical needs, such as spiritual or religious preferences). I have considered staff feedback on how they approach end of life planning conversations with consumers and representatives through the admission process, which is followed up if not discussed at that time.

On balance of the information presented, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 2(3)(e), the Assessment Team found the service did not consistently demonstrate care and services were reviewed or monitored for effectiveness when changes or incidents impact individual needs.

After considering the Approved Provider’s response and accompanying documentation, I have found the provider compliant with this Requirement. The Assessment Team referenced care planning documentation for 4 consumers. In all consumer cases there is evidence that a form of assessment, update or intervention had occurred for these consumers in a relatively small time frame post incident or change in condition. For example, in relation to diet and nutrition, a consumer (with a nutrition care plan updated approximately 5 weeks prior to the Site Audit) who lost weight was referred to a dietician and reviewed under a week prior to the Site Audit. These changes had yet to be implemented at the time of the Site Audit, however, I consider it reasonable to allow for a small window of implementation time commensurate to the nature of the changes (which were relatively low risk – compared with for example, a need for a diet texture change to prevent choking). Documentation accompanying the Approved Provider’s response (progress notes) demonstrates these changes were made to the consumer’s nutrition care plan and an update provided to service catering during the Site Audit, and I note that daily monitoring continues for this consumer.

Similarly, the Assessment Team note a consumer who sustained a skin tear during March 2022 had not had an update to their skin care plan and note the wound management plan was archived at the time of the Site Audit. The Assessment Team note the wound healed prior to the Site Audit. The Approved Provider has identified that archiving wound plans is normal practice for the service once the wound has healed. The consumers’ personal hygiene care plan reflects changes to their skin are documented and strategies to mitigate risk are listed.

For a consumer who absconded from the service, the Assessment Team noted the service subsequently undertook a risk assessment, however, the Approved Provider evidenced that a risk care plan was developed within approximately one week of the incident.

I have also considered, and place weight on feedback from consumers and representatives, that care is discussed with them, that representatives are contacted when incidents occur, and there is evidence that the service undertakes care planning review both routinely and following incidents which impact care. Staff were able to discuss the process for 3-monthly care plan reviews in addition to the monthly ‘resident of the day’ process.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining 3 Requirements of Quality Standard 2 Ongoing assessment and planning with consumers.

The service demonstrated it uses a suite of assessment tools, charting and review processes to identify consumer needs on admission to the service and in an ongoing manner. Information obtained through assessment populates both a summary and extended care plan, which (for consumers viewed) appeared to accurately reflect their needs. One exception to this, however, was noted under other Requirements in relation to a consumer who has not been recognised as living with environmental restraint as they reside outside the secure wing of the facility. Accordingly, it has not been demonstrated that relevant documentation (such as capture of informed consent) has been completed and I have subsequently considered this to be an opportunity for improvement in staff recognition of restrictive practices, as it has been demonstrated that other consumers living with restrictive practices do have appropriate planning and care documentation completed. The Assessment Team also observed, through documentation, that reassessment occurs and that consumers and others are involved in care planning processes. Staff could describe individual consumer needs aligned to their care planning documentation, and the service has relevant policies and other documentation which staff can refer to, to inform practice. Staff noted they are provided with good training and tools for learning in relation to care planning and assessment.

The Assessment Team observed, through viewing documentation, that care planning and assessment involves representatives and others aligned to individual consumer preferences. File reviews demonstrated a range of service providers and/or health specialists involved in care, and staff could describe how they include other organisations as required. Representatives confirmed they are contacted regularly to be involved in review of consumer care planning, including following incidents or other points where needs may change.

Consumers and representatives confirmed that care planning outcomes are effectively communicated to them and documented in an accessible format. Staff could describe how they access consumer care planning to inform care delivery, and how case conferences are used to discuss care matters in an ongoing manner.

# Standard 3

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

## Findings

I have found the Approved Provider compliant with Standard 3 Personal care and clinical care as each of the 7 Requirements under this Standard have been deemed compliant.

In relation to Requirement 3(3)(a), the Assessment Team found the service undertakes immediate actions following incidents to ensure the safety of the consumer, however, note limited investigation or development of preventative measures. The Assessment Team also assert the service has not delivered safe and effective care which is tailored to the needs of a new consumer who moved to the service approximately one month prior to the Site Audit, and behaviour management strategies for a separate consumer have not been evaluated to identify effectiveness.

On review of the Approved Provider’s response and accompanying evidence, I have found the provider compliant with this Requirement.

For a consumer with known skin frailty, the Assessment Team highlighted a number of minor incidents where the Assessment Team believes the service did not conduct thorough investigation. However, I have considered and are of the view that the actions taken, and preventative strategies noted, are both relevant and appropriate to the scope of each issue – particularly given they are not the result of a major incident. This consumer has a range of existing interventions for skin care, as noted by the Assessment Team. Staff discussed how they attempt to maintain this consumer’s skin integrity with actions aligned to documented strategies.

Similarly, for the newly admitted consumer (under one month), I have considered the Approved Provider’s explanation that staff continue to gather information about this consumer as they settle in at the service, including evidence that they collect information on pain, sleep and behaviours through charting/assessment to inform care. There is also evidence to show the service has been responsive in seeking Medical officer review at the consumer’s request. However, I have considered this consumer’s scenario and the service’s actions further regarding support for their emotional wellbeing under Standard 4.

With regard to a consumer’s behaviour management strategies, I note they were commenced on regular sight charting/monitoring following an incident. In their response, the Approved Provider included substantial evidence demonstrating work undertaken prior to and following the Site Audit relating to behaviour management strategies for this consumer.

I have also considered that the Assessment Team found the service to deliver safe and effective care in other areas, including relating to pain management, wound care and where chemical and environmental restrictive practices are used. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 3(3)(b), the Assessment Team discuss falls, behaviour management, diabetes management and weight management. Regarding weight management, the Assessment Team note outcome of assessments had not been transferred to consumer care plans. I have considered, however, that the most recent assessment took place less than a week prior to the Site Audit and the Approved Provider has demonstrated this has subsequently occurred. I am also of the view that the frequent review of consumers, and evidence of referral mechanisms, supports positive care outcomes.

In relation to behaviour management, the Assessment Team described several consumer incidents, however, it is unclear what deficiencies in care have occurred, with exception to the service allegedly not obtaining urinalysis on one occasion and/or minor delays in transferring assessment findings to care planning (though this is a matter relating to Standard 2 Ongoing assessment and planning with consumers). I note the service has maintained relevant and descriptive documentation in relation to this consumer demonstrating ongoing monitoring. Similarly, in relation to falls, it is evident the service undertakes appropriate post-fall monitoring and review and has relevant governance and oversight mechanisms – including a falls committee. Documentation accompanying the Approved Provider’s response demonstrates considerable follow-up occurred for one consumer identified by the Assessment Team who sustained falls. Staff were able to describe strategies to prevent falls in accordance with care planning.

The Assessment Team have also highlighted diabetes management for two consumers, with both consumers having diabetes management plans and monitoring strategies in place. Feedback in relation to this Requirement included positive comments from a representative regarding delivery of clinical care, and from staff demonstrating knowledge of high impact and high prevalence risks for individual consumers and applicable strategies to mitigate these risks.

Accordingly, based on the information presented by the Assessment Team and in Approved Provider’s response, I find the Approved Provider compliant with this Requirement.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining 5 Requirements of Quality Standard 3 Personal care and clinical care.

Staff described how they recognize and respond to the needs of consumers who are at end of life while ensuring that their goals and preferences are respected. The service has guidance material, including policies, to direct staff on processes relating to end-of-life care which focus on maximising comfort and preserving consumer dignity. Clinical staff described how consumers are monitored for deterioration, family kept informed and involved, and palliative outreach service utilised. Care staff discussed how they increased relevant care for consumers on a palliative pathway, such as more frequent repositioning and oral care.

Consumers and their representatives were overall satisfied with how the service acts upon deterioration or change in a consumer’s mental health, cognitive or physical function. Staff described how deterioration is identified, escalated to Medical officers, and representatives informed. Care documentation viewed by the Assessment Team evidenced how the service identifies and responds to changes in health status.

The service demonstrated an effective system for communicating information about consumer condition (including changes), needs and preferences, both internally and through external referrals where required. Care planning documentation identifies alternate decision makers and others involved in care, including Allied health professionals, Medical officers and other specialists. Consumers generally felt that staff were aware of their care needs, including being responsive to changes. Representatives stated they are always contacted following incidents or when care needs change, such as a change in medication. Effective systems to support information management were evident, including an electronic clinical documentation system, scheduled meetings/handovers (including associated documents), an internal messaging system and email/messaging protocols.

The service demonstrated an effective referral system to Allied health or other specialists when required. Staff were aware of services available and the Assessment Team observed use of diverse external services throughout care documentation when incidents occurred or when prompted by a change in health or condition. Consumers and representatives confirmed they are regularly reviewed by Medical officers and were satisfied with the accessibility of referred services.

The Assessment Team observed strategies and infection prevention and control (IPC) practices in place to prevent infection relate risk, reduce risk of transmission and support good antimicrobial stewardship. Clinical staff demonstrated knowledge of antimicrobial stewardship and could describe practical ways to ensure antibiotics are used appropriately. Staff discussed an IPC in place at the service, including training, an IPC manual including an outbreak management plan, screening processes for staff and visitors, presence of an IPC lead and a vaccination program.

# Standard 4

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

## Findings

I have found the Approved Provider non-compliant with Standard 4 Services and supports for daily living as 2 of the 7 Requirements under this Standard have been deemed non-compliant.

In relation to Requirement 4(3)(a), the Assessment Team raised that some consumers do not get safe and effective supports that meet their needs and optimises their wellbeing. On review of the Site Audit Report and documentation accompanying the Approved Provider’s response, I have found the Approved Provider compliant with this Requirement.

The information presented in the Site Audit report and Approved Provider’s response demonstrates the service has individualised plans for consumers, including those identified by the Assessment Team in the Site Audit report. The Approved Provider has explained that some of the repetitive or generalised statements used in care planning documentation are ‘leader statements’ and where a consumer’s preference differs, this is identified in their care planning documentation. I have considered that the consumers identified by the Assessment Team have interests and preferences documented in care planning, staff are aware of their preferences, and the service has documented their involvement in activities of interest to them. I acknowledge there are a small number of examples where consumer information could be improved to better allow for staff to understand their needs, however, on balance staff knowledge (based on examples given during the Site Audit) appears reasonable and supports delivery of quality care.

In the case of all consumers listed, it is evident the service has sought to update care planning documentation in relation to lifestyle and leisure needs, however, this is dependent on consumer ability and/or representative willingness to participate. I have also considered staff feedback in relation to this Requirement relating to how activities are planned with consumer involvement through focus groups and/or ad hoc feedback, external activities are offered (such as bus trips) and one-on-one visits are in place to support consumers who do not participate in group activities. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 4(3)(b), the Assessment Team found limited spiritual support is provided for consumers other than those of Catholic faith, or for those unable to attend onsite religious services. While staff could recollect individual faiths for several consumers, it has not been demonstrated how the service supports these consumers individually. However, the Assessment team have detailed some exceptions where consumers have well established supports to maintain spiritual or religious practices per their preferences.

For some consumers identified by the Assessment Team, I also note some discrepancy between planned lifestyle activities to support emotional or psychological wellbeing and what has been actually delivered by the service. The Approved Provider has provided some updated documentation in relation to named consumers and information on activity involvement. However, the Assessment Team highlighted the limited emotional support provided to one consumer who was documented as becoming increasingly concerned about visiting their late partner’s memorial, before subsequently absconding from the service. While I acknowledge the Approved Provider’s response which explains this consumer’s situation and the individual strategies planned, it is not evident this consumer has been provided with sufficient emotional support when required, which includes staff support to visit a memorial within the grounds of the service, which may have prevented them from leaving the service.

I also note findings relating to a consumer who is a relatively new admission to the service. Although I acknowledge the Approved Provider’s response that as a new consumer an initial assessment process was still in progress, it was not until during the Site Audit (one month since their admission) that they consumer was placed on a frequent emotional wellbeing and sight checking process. This is despite the service’s knowledge of the recent loss of their partner, depression assessment outcome (one week prior) complaints of pain (daily) and difficulty sleeping. I am of the position that emotional support strategies could have been implemented at an earlier point to better support this consumer’s transition to residential care and to improve their overall well-being.

Accordingly, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 4(3)(c), the Assessment Team note that most consumers are generally supported to participate in the community and maintain social and personal relationships. However, the Assessment Team found there are limited opportunities for consumers to engage in activities of interest other than group-based activities.

I have considered consumer feedback presented by 2 consumers who felt there was little for them to do at the service, however, it has not been identified whether their care documentation has been viewed by the Assessment Team to confirm whether the service is aware of and making efforts to deliver activities based on their interests. In relation to consumers named in the Assessment Team’s report, the Approved Provider has supplied further information to clarify the Assessment Team’s findings and how these consumers are supported to do activities of interest which include utilising arrangements such as partners in care. The service has also demonstrated how it plans activities tailored to individual needs and interests, with several consumers having highly personalised plans which note specific interests.

I have also considered information presented under this and other Requirements which notes how consumers are involved in their community and are supported to maintain personal and social relationships. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 4(3)(d), the Assessment Team found the service does not have an effective system for gathering and communicating information about consumer condition, needs and preferences in relation to this Standard. The example provided is broad and relates to communication of meals and meal feedback, however, limited evidence has been presented to corroborate this or demonstrate an impact on affected consumers. The Assessment Team have outlined the processes in place for communicating meal preferences, including an examples provided by staff which demonstrates strong familiarity with individual consumer needs and an understanding of the communication systems in place. I have considered the information presented under other Requirements and in the Approved Provider’s response and are of the view there is a reliable framework evident for communicating information about consumer needs and preferences, including the electronic documentation system and staff processes for sharing information. The Assessment Team note the service has a referral system in place to support consumers to access external providers when needed. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 4(3)(e), the Assessment Team note the service has not referred consumers for some time prior to the Site Audit to external services where consumer needs or preferences can’t be supported in house. The Assessment Team note lifestyle planning documents do not indicate where any external services have been used. I have considered that the service is seeking to recruit new volunteers to the service and have applied to an organisation to have a dog visit the service, however this has not yet occurred.

I acknowledge the Approved Provider’s response providing some examples of available external services and note that a referral system is evident, however, the examples provided align more closely to personal or clinical care needs rather than consumer to support consumer well-being more holistically. The examples provided also do not demonstrate the service has considered individualised approaches for consumers with interests or preferences which may be further supported by external organisations or individuals, such as volunteers. I note that for the consumer example provided in the Site Audit report, the Approved Provider has responded that their family are engaged in a partner in care context and visit frequently, such that there is no assessed need for referral to external services. While this might satisfy this consumer’s needs, it is not evident the service has considered exploring external options to improve this consumer’s well-being beyond leaving it to their family to meet this need, noting the consumer has an assessed preference/wish to have conversation with speakers of their native language which is difficult to be delivered in-house. I have further considered, based on consumer examples provided throughout the Site Audit report, that there are potential opportunities for care to be supplemented by external providers if available in areas such as relating to specific language needs, specific religious preferences, counselling or other support services and/or relating to niche interest groups. Accordingly, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 4(3)(f), the Assessment Team received mixed feedback on meal quality, quantity and variety. I have considered the feedback documented has highlighted negative views regarding an excess of chicken-based meals which was also identified through a dietician review of the menu, with recommendations to increase other protein options. However, overall, there is slightly more positive feedback than negative. I have also considered positive feedback regarding the culturally-specific meal options provided. No consumers raised concerns about quantity or availability of meals and positive feedback was received about the options available after hours.

I note there are systems evident to identify resident dietary needs and preferences, and consumers are engaged in menu design and meal planning through a variety of forums. Consumers have provided feedback that they talk to staff about their preferences directly and several have personalised diets. Staff have been able to describe how changes are communicated among staff and the kitchen, and as noted under other Requirements there are systems to ensure referrals to dieticians are made where required.

I note the service has undertaken work to measure and track it’s performance against this Requirement, such as through food satisfaction surveys which have demonstrated a small increase in consumer approval for meals, and through food focus groups. As noted under Standard 5, the service has also aimed to improve the dining experience through establishing satellite dining rooms.

While I have considered that some negative feedback suggests further improvements remain in relation to food quality and variety, on balance of the information provided, it is evident the service provides meal options which take into consideration consumer dietary needs and preferences, including cultural. Accordingly, I find the Approved Provider compliant with this Requirement.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining Requirement of Quality Standard 4 Services and supports for daily living.

The service demonstrated that equipment provided by the service, such as relating to activities and lifestyle needs, appeared safe, suitable, clean and well maintained. The Assessment Team observed newly purchased equipment in various wings, and consumers had access to a selection of lifestyle equipment suitable for consumers of varying cognition and ability.

Standard 5

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| Organisation’s service environment | | Compliant |
| 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:  is safe, clean, well maintained and comfortable; and  enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

## Findings

I have found the Approved Provider compliant with Standard 5 Organisation’s service environment as each of the 3 Requirements under this Standard have been deemed compliant.

In relation to Requirement 5(3)(a), the Assessment Team found the service environment to be challenging for consumers to navigate/understand, with ramps and steps limiting consumer independence, interaction and function. They also noted the outdoor area to be unwelcoming and referenced findings during an earlier assessment of the service during May 2021 which had not been addressed.

The Approved Provider note that some repeat findings in this Site Audit (following the May 2021 Site Audit) require extensive work to address, such as building redesign, and require considerable planning and deliberation from the service governing body. The Approved Provider highlighted environmental improvements which had been made within the 12 months preceding the Site Audit, also observed by the Assessment Team while on site. I note some changes include relocation of the service entry and creation/refurbishment of new sitting and dining areas in two wings.

While the Assessment Team have asserted that the aspects of the environment are not welcoming nor easy to understand, I have considered, and place weight on consumer feedback that they ‘enjoyed living at the service’ including in the newly developed areas. Specific evidence demonstrating how consumers are challenged by the service environment has not been presented, nor feedback from consumers and/or representatives to suggest they feel unwelcome. I have also considered service management’s comments regarding how consumer feedback and involvement is sought relating to the service environment through avenues such as Consumer meetings and surveys. Accordingly, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 5(3)(b), the Assessment Team note that while they found the service environment overall clean and tidy, the external environment was not well maintained or safe. They received feedback that consumers were generally happy with the cleanliness of their rooms and communal areas. As with Requirement (3)(a) of this Standard, the Approved Provider notes that some matters raised by the Assessment Team were identified through a previous Site Audit. I have considered the service’s ability to address or implement outdoor improvements in the context of the COVID-19 pandemic and recent weather events and acknowledge these may have impeded action, however, would encourage the Approved Provider to continue to pursue these activities.

The Assessment Team also identified some consumer bedrooms within the secure wing are kept locked from the outside to prevent unauthorised access by other consumers, meaning consumers need to ask staff for assistance if they wish to enter their rooms from the communal area. For avoidance of doubt, it is identified that rooms are always able to be exited from the inside and at no time are consumers locked in their rooms. It is insinuated that this prevents consumers from being able to move freely within the service. As this purposeful restricted access relates to entry to personal rooms rather than communal areas, I do not consider this conflict with the intent of this Requirement prima facie, however, would expect there to be documented consent from the consumer or their decision maker, in addition to discussion of safeguards, as with any similar scenario which may constitute environmental restraint. Further, the potential issue of ensuring staff are able to assist consumers without delay must be addressed - it is noted under discussion of call bell response times that staff have been unable to locate keys at times. However, this is not noted in either the Site Audit report or the Approved Provider’s response, and there is no indication of incidents or adverse events resultant of the latter point.

While I have considered the service could improve cordoning off of outdoor areas undergoing improvement, I note that consumers can access the outdoors and were observed by the Assessment Team making use of these areas during the Site Audit. I note feedback from two consumers that the outdoor area had been made more challenging to move around in due to works, however, this is clearly temporary. While the Assessment Team also note that some outdoor areas could benefit from tidying and/or beautification, I note no consumer or representative feedback suggests a detrimental impact to consumers. I find the Approved Provider compliant with this Requirement.

In relation to Requirement 5(3)(c), the Assessment Team noted one of 2 washing machines was inoperable at the time of the Site Audit, however, was being attended by an external contractor. Similarly, staff raised that a lifter was inoperable at the time of the Site Audit, however, it appears process had not been followed as when it was raised with management, it was addressed immediately. The Assessment Team also received feedback and observed that a consumer’s bed was failing to raise or lower, however, it was not identified whether this had been brought to the service’s attention. Multiple examples have been provided that the service has demonstrated action once issues are raised.

Overall, it has been demonstrated that there are monitoring and preventative maintenance processes in place in relation to equipment and the service is responsive to issues when they arise, with the Assessment Team noting the maintenance request log demonstrated requests are attended within a few days. In their response, the Approved Provider confirmed communication had been provided to staff reiterating the process for maintenance requests. Accordingly, I find the Approved Provider compliant with this Requirement.

**Standard 6**

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

## Findings

I have found the Approved Provider non-compliant with Standard 6 Feedback and complaints as one of the 4 Requirements under this Standard have been found non-compliant.

In relation to Requirement 6(3)(a), the Assessment Team found a portion of consumers sampled did not feel encouraged nor supported to provide feedback and make complaints. This included consumers who expressed concern about raising negative feedback (both with the service or with the Assessment Team) for fear of potential retribution, I have also considered feedback from 4 staff of a similar nature.

The Assessment Team documented that most consumers said they had no complaints and are happy at the service, and one consumer noted they would ask their representative to provide feedback if they had concerns. However, I consider this a separate matter as to whether consumers feel supported to raise concerns. I acknowledge the Approved Provider’s response and supporting documentation which outlines multiple ways in which they seek to elicit and support provision of feedback from consumers and others, namely focus groups, support from external advocates and systems to support written complaints (including anonymously), however, it is not thoroughly evidenced that consumers feel the service’s actions are supportive. In coming to a finding, I have given considerable weight to the consistent theme of feedback from consumers that they do not feel supported or comfortable to speak up with their concerns. Accordingly, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 6(3)(c), the Assessment Team found the service did not demonstrate that appropriate action was always taken in response to complaints and staff were unfamiliar with the concept of open disclosure. In their response, the Approved Provider acknowledged that action relating to complaints is an area undergoing improvement. Feedback documented throughout the Site Audit Report evidences that improvements are indeed occurring, however, I note feedback under Requirement (3)(d) of this Standard from a representative includes that it took external involvement to see change occur.

There is evidence that despite some sampled staff not being familiar with the term ‘open disclosure’, the concept has been used at the service when the service identifies an error their part. With regard to the staff who were unfamiliar with the concept, it is not identified what role(s) these staff have. While I consider it reasonable that most staff have at least a minor degree of understanding in relation to open disclosure, it would be of heightened concern if it were senior or clinical staff who are unable to describe the concept. Of note, it is evident an open disclosure approach has been used in an example relating to medication management described under Standard 3, in addition to an example accompanying the Approved Provider’s response.

The Assessment Team has included broad consumer feedback that some concerns, including relating to the environment, food and staffing had been reoccurring. However, no specific examples have been provided to demonstrate this. I have also considered service management’s acknowledgement that there has been some ongoing complaints from some consumers and representatives, however, no information regarding the nature of these complaints, nor how the service has handled them has been provided and I have been unable to rely heavily on these comments in making a finding. Accordingly, on balance of the information provided, I find the Approved Provider compliant with this Requirement.

In relation to Requirement 6(3)(d), the Assessment Team have asserted that the service does not capture all complaints and is subsequently unable to undertake effective trending, analysis and subsequent improvements. Examples have not been provided to demonstrate this, however, feedback from consumers and a representative suggests stakeholders feel a disconnect between internal complaint monitoring and service improvements – the representative notes, for example, that improvements only occurred following use of an external complaint mechanism. I am of the position that whether consumers and other stakeholders specifically link improvements to their feedback is of lesser relevance to this Requirement than evidence that the service is listening, trending and progressing – which is evidently occurring. However, it is positive to note that consumers are provided the opportunity to be involved in the governance aspect of feedback and complaints through participation on leadership and governance committees.

During the Site Audit, service management identified food as the key trend in complaints raised by consumers and outlined a program underway to make improvements in this area. I have considered feedback presented throughout the Site Audit report and are of the view that actions are occurring both in the improvement of meals and meal service and other areas. In their response, the Approved provider has also detailed governance mechanisms and oversight of feedback management, in addition to a continuous improvement plan and training plan based on Site Audit findings. Accordingly, I find the Approved Provider compliant with this Requirement.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining Requirement of Quality Standard 6 Feedback and complaints.

The Assessment Team observed information readily available to consumers and others at the service relating to obtaining support to provide feedback and/or raise concerns, including access to advocacy services, language services, and obtaining external support. Staff were aware of how to support and/or refer consumers to these services, and the service has demonstrated how it uses external services to support consumers, such as by holding onsite education/information sessions for consumers delivered by advocacy services.

**Standard 7**

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

## Findings

I have found the Approved Provider non-compliant with Standard 7 Human resources as 3 of the 5 Requirements under this Standard have been deemed non-compliant.

In relation to Requirement 7(3)(a), the Assessment Team found there were insufficient workforce numbers to deliver a consistently high level of care and services. In forming a position on compliance with this Requirement, I have considered consumer and representative feedback and the impact of staff numbers, which includes delays in call bell response and mobility assistance. However, I also note staff feedback of a consistent theme which demonstrates staff are short of time, and of concern is feedback that some consumer needs are marked as completed where they in fact go unattended due to workload pressures. However, no specific or corroborated examples have been provided and I can only consider this feedback at face value.

Management noted during the Site Audit, and in their response the Approved Provider affirmed, that the workforce model is based on increased occupancy at the service and this has not been adjusted despite the reduced current occupancy. However, this fails to demonstrate that the staffing mix and number has been properly considered based on current consumer acuity and designed to deliver safe and quality care and services. For example, it is noted that vacant lifestyle shifts are not replaced unless there are additional care staff available. I have considered that this may deny consumers contact with lifestyle services and does not demonstrate consumer needs and preferences are considered more broadly in relation to staffing mix beyond delivery of personal or clinical care.

In have also relied on both staff allocation data and call bell analysis in forming a view on compliance. I note that for a 14-day period, there were multiple shifts unfilled in differing roles. Call bell data has demonstrated a number of occasions where consumers were subject to an extended wait, however, it is not clear if the service has a policy or other expectations set with regard to response, nor the total number of call bells within the measured period to provide context. I have considered feedback in the Site Audit report that locked doors in the dementia support unit impedes timely staff response, however, no evidence has been documented to suggest this has had a detrimental impact to consumers. It is positive to note that the service undertakes analysis of call bells, however, it is not if/how this information is used to improve care delivery or outcomes for consumers, or what form of/if follow-up is undertaken following extended response times.

The Approved provider notes that a workforce demand analysis is underway. While there is reference to workforce benchmarking exercises (with the service noting higher staffing levels than other services in the industry) this does not demonstrate a thorough understanding and application of this Requirement – which seeks to ensure that staffing numbers and mix are not only sufficient, but also appropriate. I am of the position that a system for ensuring appropriate workforce numbers is clearly in development, however, at the time of the Site Audit has not been clearly demonstrated. On balance, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 7(3)(c), the Assessment Team have drawn a link between lack of specific/relevant qualifications of some personnel to their competence and performance in their role, which I do not consider as a reliable indicator of competence/incompetence without additional supporting evidence. The Approved Provider notes that both past experience and qualifications in other areas are taken into consideration alongside attitude and competency against tasks when determining suitability.

The Assessment Team have referred to staff skills in managing consumers’ changed or challenging behaviours and in incident investigation, including relating to a recent admission to the service. I accept the Approved Provider’s response justifying the processes and actions of staff, noting they are/were following service processes in relation to clinical assessment to inform care. I also acknowledge the documentation accompanying the Approved Provider’s response, however, are of the view some of this material relates strongly to staff training and education and I have accordingly considered it relation to Requirement (3)(d) of this Standard.

However, I have considered that there may be some compromise in the service’s ability to ensure ongoing competence by undertaking ad hoc review of staff performance when issues arise, rather than through routine performance assessment as noted under Requirement (3)(e) of this Standard. Similarly, I have observed a theme in consumer and representative feedback throughout the Site Audit Report relating to concern about agency staff performance.

As staff note, and the Approved Provider has acknowledged, use of agency staff is a necessary ongoing strategy to ensure staff coverage. Accordingly, I consider it pertinent that the service should have a strategy for continued monitoring of agency staff to ensure they are competently delivering care and services in line with expected outcomes. It is not evident that there is a framework or system to ensure this occurs. While there is some evidence that the service’s own staff are able to deliver care aligned to consumer preferences, I have placed weight on feedback that this is not always the case with agency staff and am of the view that a systems issue prevents the service from ensuring all staff, including agency, are competent and able to perform at a high standard in their roles.

I have also considered information presented under other Requirements in relation to a consumer who absconded from the service. The Assessment Team observed (through progress notes) that this consumer is restricted from leaving the service, yet relevant authorisation relating to environmental restraint was not observed. While I am of the position that this does not necessarily reflect a systemic failure in relation to restrictive practices, I have considered that staff may need to refresh their knowledge and understanding of restrictive practices to ensure it is consistently recognised in care in a holistic setting.

Accordingly, on balance of the information provided, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 7(3)(d), the Assessment Team found the service has delivered a comprehensive range of training and education to the workforce in the last 12 months, including accompanying competency assessments in areas such as hand hygiene, personal protective equipment use and medication administration. However, the Assessment Team note that despite training attendance, staff are inadequately equipped or supported to deliver the outcomes required by the Quality Standards.

The Assessment Team provided examples relating to use of open disclosure (noting a large number of staff received education on this, yet some were unable to explain the concept when interviewed by the Assessment Team), SIRS and incident management (as above) and referred to their findings in relation to staff competence (Requirement (3)(c) of this Standard).

The Approved Provider’s recruitment processes, including onboarding and/or induction processes are not discussed by the Assessment Team, however, the Approved Provider has supplied evidence of their processes in these areas in their response.

On balance of the information provided, I find the Approved Provider compliant with this Requirement. Although there are improvements to be made in ensuring knowledge through education and training is sustained and put into practice, the Approved Provider has demonstrated there is a system for ensuring staff are recruited and oriented to service processes. Similarly, there is ample evidence that staff are provided training (both mandated and discretionary) and the Approved Provider has evidenced that supports are provided to staff, including employment of a full-time educator, multiple education delivery options and an ongoing calendar of education opportunities. However, I acknowledge that while it does have some impact on this Requirement, the matters of both assessing staff competence and monitoring performance are considered under other Requirements and it is evident that these areas require attention.

In relation to Requirement 7(3)(e), the Assessment Team found the service did not have a formalized system for undertaking regular assessment and review of staff performance. The Assessment Team note this was identified at the former Site Audit and discussed with service management. In their response, the Approved Provider has acknowledged a scheduled program is under development as a continuous improvement action.

I have considered that while a formal performance framework or schedule may be lacking, it is evidenced that where performance issues arise, the service has investigated and addressed issues, including through education or competency assessment. While this is demonstrates the service is reactive when required, it limits ability to use proactive/regular performance discussions as an identification source for staff training, development and/or continuous improvement opportunities and address potential deficits before they become a larger issue. A performance framework is also crucial in monitoring staff competence and ensuring efficacy of training education provided. Accordingly, I find the Approved Provider non-compliant with this Requirement.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining Requirement of Quality Standard 7 Human resources.

Consumers and representatives consistently reported that staff are kind, caring and respectful. Multiple consumers commented on staff willingness to adapt to support their needs. The Assessment Team observed staff interacting with consumers in a kind and caring manner during the Site Audit.

**Standard 8**

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

## Findings

I have found the Approved Provider non-compliant with Standard 8 Organisational governance as one of the 5 Requirements under this Standard have been deemed non-compliant.

In relation to Requirement 8(3)(b), The Assessment Team found the governing body has not sufficiently promoted a culture of safe, inclusive or quality care and services nor demonstrated accountability for delivery of care aligned to these considerations. The reasons for this finding are underpinned by findings across all Quality Standards, but in particular observations of the service environment, workforce sufficiency and call bell response timing. The Assessment Team acknowledge that several improvements have been made since the previous Site Audit, however, are of the view the Approved Provider has not responded effectively all deficiencies which were raised at that time.

I have considered the Assessment Team’s findings and the Approved Provider’s response and on balance of the information provided, I find the Approved Provider compliant with this Requirement. The nature of several issues referred to by the Assessment Team are such that are not necessarily able to be implemented in the timeframe between the former and recent Site Audit. I consider the number of actions completed by the service to be reasonable and note the service has made progress toward others, as evidenced through continuous improvement planning documentation and other evidence accompanying the response to the Site Audit report.

Further, I note several mechanisms in place which demonstrates the Approved provider’s commitment to providing care and services are inclusive, safe and culturally appropriate. While some aspects of care and services require ongoing attention with respect to the Quality Standards, the Approved Provider has demonstrated actions which affirm the governing body’s focus on care delivery and seeking to partner with consumers to determine such needs, such as consumer involvement in Board focus groups, improving high impact and high prevalence risk reporting and utilising a new handover tool.

Further to my earlier point regarding what is reasonably achievable in a short space of time, I have also considered the environmental changes made since the previous Site Audit which support increased consumer wellbeing and privacy, including increased dining and communal areas and conversion of double rooms into single rooms. The Assessment Team notes the governing body has committed to but is yet to purchase a new call bell system, and there has been improved director understanding of the Quality Standards through Board training and engagement with independent consultants. I have also observed, through documentation accompanying the Approved Provider’s response, that there are multiple committees which oversee consumer care delivery and matters are ultimately discussed at Board level.

In relation to Requirement 8(3)(c), The Assessment Team found the service unable to demonstrate effective governance systems in a range of areas.

In relation to information management, the Assessment Team noted challenges accessing and interpreting clinical records which impedes delivery of appropriate care, however, I have considered this to be a matter of perspective as it has not been raised by service personnel as an impediment to their work. Similarly, presentation of English-only information has been flagged as an information management concern for consumers who are culturally and linguistically diverse. However, as previously noted, the service does make translation aids available and much of the information necessary to make day-to-day choices such as relating to meals, activities or raising concerns is presented bilingually. I have also considered ease of access to information for consumers and representatives. As noted, these stakeholders felt information pertaining to them, and their care, was effectively communicated and made available when requested.

In relation to continuous improvement, I have considered the service has a continuous improvement plan in place and has made some progress in rectifying deficiencies raised at a previous Site Audit. The Assessment Team have found that some areas have had limited improvement, including relating to environmental or infrastructure changes. However, I have considered the broad scope of proposed improvements against what has been completed in a relatively short space of time and note the Approved Provider’s commitment to pursue further improvements.

In relation to feedback and complaints, I have considered that the service has demonstrated a system to ensure action is taken in response to complaints and to ensure culturally and linguistically diverse consumers are supported. I also note there are systems to engage consumers in the complaints management process and involve them in feedback processes, such as through both specific (e.g. relating to food) focus groups and broad forums (such as the leadership and governance meeting). In their response, the Approved Provider has supplied further evidence to demonstrate mechanisms demonstrating consumer engagement in feedback and complaint systems. However, the organisation has not identified that some consumers feel unsupported to raise concerns as found by the Assessment Team. I note the service has a recently implemented complaints framework including templates and a policy, however, it has not been fully integrated with staff education running behind schedule as a result of a recent COVID-19 outbreak. The Assessment Team have also noted that some recurring complaints have not been documented.

In relation to financial governance, the service has demonstrated a system for seeking or approving expenditure where required to meet changing consumer care needs – such as in the case of discretionary spend for consumer equipment.

In relation to workforce governance, I note the service has commenced an external review of workforce planning and strengthened its staff education capability through creation of a new learning and development role. However, I am of the position that issues remain including lack of a system for ensuring staff performance is monitored and assurance of staff competence.

In relation to regulatory compliance, specifically in tracking changes to legislative requirements, the service has demonstrated it uses external bodies and subscription services to remain abreast and aware of change. The service demonstrated actions following introduction of SIRS and new IMS requirements, including implementation of behaviour support plans.

On balance of the information presented, I find the Approved Provider has been able to demonstrate an effective governance system in relation to information management, financial oversight and regulatory compliance, however, it not been demonstrated that systems relating to workforce and feedback and complaints and are fully effective at this time. Accordingly, I find the Approved Provider non-compliant with this Requirement.

In relation to Requirement 8(3)(d), the Assessment Team assert that the service does not have effective risk management systems and practices, as they service does not routinely undertake thorough analysis of incidents to inform development of effective prevention measures. However, the Assessment Team note the service has documented frameworks for managing risk, identifying and responding to abuse and neglect, supporting consumer wellbeing and managing and preventing incidents.

On review of the information presented, I find the Approved Provider compliant with this Requirement. In coming to a finding, I have considered that both the Assessment Team and the Approved Provider have presented evidence to showing that the organisation has a risk management framework and overall undertakes practices to support effective management of risk. The service has an incident reporting system and staff could describe the incident reporting process, and the care evaluation process supports the identification of risks during care.

I note the service responded promptly to the incidents referred to by the Assessment Team under this Requirement, however, the Assessment Team assert that the system is ineffective due to investigation of those incidents lacking sufficient depth or thoroughness. Based on coverage of incidents noted throughout this Site Report, I have considered that this does not strongly reflect a deficiency in the organisation’s systems as related to this Requirement, rather, it relates to staff actions and processes following individual incidents. I am of the view that for the incidents described, the service response and investigation has been proportionate and reasonable with respect to the nature of those incidents. It is evident that the service considers the circumstances relating to individual incidents, undertakes a root cause analysis, and utilises tools to help determine whether incidents are potentially reportable through the serious incident reporting scheme. I am of the view that the Assessment Team’s findings have highlighted a number of opportunities for improvement, particularly where processes and/or paperwork may be incomplete following incidents, however, this also in part reflects the service’s failure to monitor staff competence and performance as noted under the respective Requirements of Standard 7.

With regard to supporting consumers to live their life in accordance with their preferences, it is evident the service has a framework which supports capture of consumer wishes, supports staff understanding and awareness of how to deliver care and has defined opportunities to engage consumers throughout this process.

In relation to Requirement 8(3)(e), the Assessment Team found the service has a clinical governance framework which addresses antimicrobial stewardship, minimising restraint and open disclosure. However, the Assessment Team found that governance systems have been ineffective in ensuring consumers receive safe and effective care which considers relevant risks to their health and wellbeing, and the service has failed to demonstrate open disclosure is consistently used where applicable.

On review of the information presented, I find the Approved Provider compliant with this Requirement. In coming to this finding, I have considered that the Assessment Team found the service has a documented clinical governance framework and note related improvements have been made in oversight of clinical care. This includes delivery of staff training, development of processes and procedures, clinical indicator monitoring and implementation of an auditing program to monitor, trend and benchmark clinical data. Regular clinical governance meetings occur and this is also reflected in the Approved Provider’s response and accompanying documentation.

The Assessment Team highlight that the service has not recognised (assessed) one consumer as being subject to environmental restraint, however, this does not necessarily demonstrate a governance system failure and I have considered the core deficiency as being likely related to staff competence. There is evidence to demonstrate the service has provided restrictive practices training, however, the service has not demonstrated a robust system to ensure staff are competent. On balance, the service has demonstrated there is a system for ensuring restrictive practices (both broadly and specific to chemical restraint) in use are regularly reviewed and minimised where possible and in other examples, consumers do appear to have relevant assessment, planning and authorisation documentation in place.

While the Assessment Team found some staff were unfamiliar with the term ‘open disclosure’, I have found there is a framework which supports open disclosure and it is evident is has been used in relation to at least some clinical incidents. I acknowledge there may be additional opportunities to practice open disclosure. The service has demonstrated it has appropriate and effective systems to promote good antimicrobial stewardship through delivery of care and services.

Accordingly, I find the Approved Provider compliant with this Requirement.

I am satisfied that the Approved Provider has demonstrated compliance with the remaining Requirement of Quality Standard 8 Organisational governance.

The service has a framework for supporting consumer engagement in the development, delivery and evaluation of care and services through organisational policies and procedures and facilitates involvement in a variety of ways including relating to food, activities and overall operations of the service. Documentation showed that the service involves consumers in Leadership and governance meetings and various focus groups. Information presented throughout the Site Audit report evidences that consumers are engaged and provide input into how their care and services are planned and delivered.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)