Performance

Report

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| Name of service: | Sunlight Residential Aged Care |
| Service address: | 43 Laurel Street WHITTLESEA VIC 3757 |
| Commission ID: | 3706 |
| Approved provider: | TLC Whittlesea Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 16 May 2023 to 19 May 2023 |
| Performance report date: | 12 July 2023 |

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 Sunlight Residential Aged Care (**the service**) has been prepared by G Hope-Simpson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 29 June 2023.
* other information and intelligence held by the Aged Care Quality and Safety Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 2 (3)(a): Ensure that consumers who self-administer their medication have current assessments in place, to manage risks associated with self-administration of medication. Ensure all aspects of consumer complex care, including oxygen therapy, are assessed and planned, and all relevant instructions in consumer care plans.
* Requirement 3 (3)(a): Ensure each consumer gets safe and effective personal care and clinical care which is in line with best practice and the consumer’s needs. Ensure that consumers who self-administer their medication receive safe and effective clinical care, in line the Guiding Principles for Medication Management in Residential Aged Care. Ensure appropriate monitoring and their ability to continue to self-administer is regularly reviewed. Ensure that use of pain medication is effectively monitored and its effectiveness for managing pain is evaluated. Ensure legal requirements for storage of controlled drugs are met. Ensure staff comply with complex care instructions set out in consumer care plans, including in relation to oxygen therapy.
* Requirement 3 (3)(b) Ensure high impact and high prevalence risks associated with the care of the consumer are managed effectively. Ensure risks associated with self-administration of medication and use of controlled drugs are managed using best practice strategies. Ensure monitoring of staff practice is effective to ensure consumers’ risks are managed effectively.
* Requirement 8(3)(d) Ensure effective risk management systems and practices, including in relation to management of high impact risks stemming from self-administration of controlled drugs. Ensure monitoring of staff and management practice is effective to ensure consumers’ risks are identified and mitigated.

# Standard 1

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

Findings

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

Consumers and representatives said staff understood consumers’ cultural backgrounds, supported their cultural needs and treated them with dignity, courtesy and respect. Care plans detailed consumers’ backgrounds, languages and communication needs. The service had documented values, policies and procedures that embedded cultural competence and required respect toward consumers. Observations of staff practice confirmed friendly, reassuring and respectful interactions and consumer rooms were decorated with items of cultural significance.

Consumers reported being able to make their own choices, takes risks to enhance their quality of life and maintain their independence in daily living. Care plans documented consumers’ important relationships and how those people were to be involved in consumers’ care. Dignity of risk assessments were mostly in place, except in relation to risks of medication self-administration, which is addressed in later Quality Standards. Otherwise, consumers confirmed clinical and personal risks were explained to them, to support their decision making. Staff understood consumers’ needs and preferences and described how the service supported consumers to maintain relationships of choice, including with spouses living at the service. Staff were observed supporting consumers to take risks they wished to take.

Consumers and representatives said that the information about consumer care and activities was clear and provided at the right time and place. Staff relied on information provided at handovers and consumers’ complete clinical and care records were accessible through the electronic care management system (ECMS). Information about daily activities, menus and well-being activities was displayed in large print at appropriate places throughout the service. Consumers and representatives said consumer confidentiality was respected and confirmed staff respected privacy during clinical and personal care. Computers were password-protected, documentation was appropriately stored, and nurses’ stations were kept locked when unattended.

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

Findings

The Assessment Team recommended the following Requirement was not met:

* 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.

To support the not met recommendation, the site audit report outlined three consumer examples demonstrating the service’s assessment and planning did not consistently ensure risks to consumers’ health and well-being informed the delivery of care and services. The site audit report contained detailed consumer, representative and staff interview evidence, as well detailed document review evidence, to show that the service did not consistently complete necessary assessment and planning to identify and manage risks relating to self-administering medication, complex care, storing drugs of dependence, pain relief and risks associated with one consumer’s mental health. As a consequence of planning and assessment failures, appropriate and effective risk management strategies were neither identified nor implemented, placing consumers at risk. Relevant (summarised) evidence brought forward in the site audit report is outlined below.

The site audit report brought forward an example about the first named consumer who was self-administering their medication and had a Privacy, Dignity and Choice Authorisation form completed; however the Assessment Team found the service had not documented any evaluation of the consumers’ ability to self-administer their medication. A recent care plan review did not include any review of their ability to self-administer as required by service policy.

In their written response, received 29 June 2023, the Approved Provider disagreed with the Assessment Team’s finding. Although the response included evidence to show that prior to the site audit, a Medication Self Administration Care Plan had been completed for the consumer and a medical officer was supportive of the arrangement, this document did not detail any comprehensive assessment of risks and mitigation strategies associated with self-administering medication. The Medication Self Administration Care Plan also did not contain sufficient information to guide staff on appropriate monitoring and oversight of the consumer's warfarin regime. While the response also demonstrated that a Risk Care Plan had been completed for the consumer on admission, this did not identify any risks relating to self-medication, and no documentary evidence was provided with the response to demonstrate the self-administration arrangements were reviewed every 4 months as required by the service’s Medication Management Policy and Procedure. Evidence provided with the response did not demonstrate appropriate steps have been taken to address these deficiencies, since the site audit. On balance, I am satisfied the example reflects deficiencies in assessment and planning and that the example shows non-compliance with Requirement 2(3)(a), as a result.

The site audit report also detailed that a second consumer’s family member (also a consumer) administered them an as needed controlled drug for pain, without any assessment or planning documentation to support the arrangement. Consumer, representative and staff evidence confirmed clinical staff at the service were aware of the arrangement. Staff, and the consumer’s representative, said that the consumer’s family member was administering the pain medication as it was usually required at busy times of day, and staff confirmed they did not monitor the amount of medication the family member administered. Staff also confirmed they did not monitor the consumer’s pain or the effectiveness of the medication. The service’s Medication Management Policy and Procedure did not mention requirements where a consumer manages another consumer’s medication, but requirements set out in the Pain Management Policy and Procedure were not complied with in the arrangement. The Assessment Team also found no assessment or planning documentation concerning how the administering consumer would store the controlled drug, to minimise risk to themselves and others.

The Assessment Team also identified that another aspect of the second consumer’s complex care was being managed by their family member. Staff confirmed they were not monitoring this aspect of care as per medical officer directives and contravening the service’s Complex Care Policy and Procedure. The consumer’s care planning documents contained conflicting instructions and staff reported being unable to find the information they needed to manage this aspect of the consumer’s care, demonstrating shortfalls in planning and assessment.

In their written response, the Approved Provider outlined improvements made since the site audit, noting that management of the second consumer’s pain medication had been removed from the family member. However, the Approved Provider disagreed with the ‘not met’ recommendation, based on their further conversations with the family member, since the site audit. However, I have preferred the account provided directly to the Assessment Team by the family member, their representative and staff. For this reason, I accept that staff were aware of the arrangement. The response also stated that staff regularly monitored the consumer’s pain, however documentation provided with the response did not demonstrate any recent or ongoing assessment of pain levels for the second named consumer. The response contained no evidence assessment and planning was conducted to identify risks associated with a co-consumer administering opiates and as a result, risk mitigation steps were not implemented. Risks associated with storing the controlled drug where not identified in assessment and planning processes, and control measures were not employed by the service.

In relation to the other aspect of care that was being managed by the family member, the Approved Provider stated staff monitor the therapy regimen, as per care plan directives. However, the evidence provided showed monitoring commenced during the site audit itself, indicating risks associated with this practice had not been identified and mitigated before the Assessment Team brought it to management’s attention. Additionally, while an updated care plan and other charting provided with the response showed that since the site audit, staff had been provided with clearer instructions and had commenced regular oversight of the consumer’s therapy regime, instructions in the care plan did not instruct staff to check the therapeutic equipment was turned on at regular intervals, indicating some risks remain unaddressed. For these reasons, I am satisfied the second consumer’s assessment and planning does not identify or introduce measures to mitigate risks in this aspect of their complex care. As a result, I find the example reflects non-compliance.

Lastly, the site audit report outlined a third consumer example of deficient assessment and planning practices in relation to self-administration of controlled pain medication. Risks to the consumer and others were not identified through risk assessments, nor were mitigation measures implemented. While some assessment documentation was completed, these did not always identify risks and some were not completed in a timely manner. The Assessment Team also found that staff failed to follow the service’s Pain Management and Medication Management policies and procedures in relation to the consumer. Times and dates the consumer self-administered the drug were not recorded, and its effectiveness in managing the consumer’s pain was not evaluated. Observations during the site audit confirmed storage requirements for the controlled drug were not in line with expected practice. The Assessment Team also found the service failed to initiate referral to relevant health professionals following an incident involving the consumer, and the incident had not been reported to the Commission via the Serious Incident Reporting Scheme (SIRS).

When the deficits relating to the consumer’s medication management were brought to management’s attention, immediate steps were taken and an improvement plan to review the arrangement was developed, with some risk mitigation measures introduced. However further observations during site audit raised concerns around drug storage.

The written response received 29 June 2023 provided additional information about the third consumer’s clinical background and details of improvement measures implemented since the site audit, including monitoring of PRN dosages, and enhanced monitoring of supply and storage of the drug. The response also provided additional context to dispute some findings in the site audit report. The response demonstrated there had been review of the consumer’s capacity to continue self-administering medication after the incident, but the response did not displace findings that prior to the site audit, staff were not properly monitoring the consumer’s intake of the drug or monitoring its’ effectiveness in managing their pain. The response disputed that referral to other health professionals was warranted following the incident, however I was not persuaded by this aspect of the response. Documentation provided with the response did not demonstrate that following the incident, the service properly monitored the consumer and another consumer involved, to determine whether escalation or additional referrals were required.

I acknowledge that since the site audit, the service has made a referral to a relevant health professional for the named consumer, has implemented measures to monitor the consumer’s PRN pain medication use and has taken steps to review and evaluate the effectiveness of the PRN arrangements. However, while the service has now taken steps to address the concerns, documentation provided indicated staff were not properly completing all checks set out in the consumer’s updated Medication Self Administration Plan, indicating risk mitigation measures are still not being properly implemented. The response also failed to assure me the service had identified any of these deficits prior to site audit.

I have carefully considered the evidence in the site audit report and the response, and I have agreed with the Assessment Team’s recommendation. I am satisfied the service failed to use consistent and timely clinical assessment and planning practices to identify risks associated with consumers self-administering their own medication, failed to accurately update care plans with recommendations in relation to complex care for one consumer and failed to properly identify new risks, or monitor and assess a consumer and others following a serious incident. Risks associated with self-administration of medication were not managed through monitoring consumers’ intakes of controlled drugs and the effectiveness of the drugs on pain levels was not evaluated in two consumers. I am satisfied there were also deficits in relation to drug storage for two consumers and I find the service had failed to act to address the inherent risks involved in one consumer administering another’s controlled pain medication. Care plans contained insufficient instructions to properly manage risks associate with self-administration of medication and the service’s quality and oversight mechanisms failed to identify the above failures in staff practice, before the site audit.

The response contained an improvement plan to address deficits around self-administration of medication, for the third consumer and education has been provided to staff on this topic. Staff have also received additional training in relation to complex care, triggered by deficits in care of the second named consumer. However, the improvement plan provided with the response was limited and did not include evaluation measures to ensure improvement actions are effective. Due to the high-risk nature of the deficits identified, and the length of time the service and organisation’s own governance structures failed to identify these, I find the service is non-compliant with Requirement 2(3)(a), at the time of writing this Performance Report. While some improvement actions have been outlined, further oversight measures are required to monitor staff practices. Time will be required to ensure the sustained implementation of those actions and ongoing monitoring by the Commission is necessary to ensure all risks are identified and addressed in a timely manner, and consumer safety is prioritised.

For these reasons, I find the service does not comply with Requirement 2(3)(a).

I am satisfied the service is compliant with the remaining four requirements of Quality Standard 2.

Consumers and representatives confirmed they partner with the service in care planning and discussed their care needs, goals and preferences, including in relation to advance care planning and end of life care. The Assessment Team reviewed documentation for sampled consumers, which confirmed assessments were carried out to identify care needs and preferences and included a range of external specialists and health professionals. Sampled files contained end-of-life care wishes and advanced care directives and documented regular care conferences. Staff understood how assessment and planning identified and addressed consumers’ needs, goals and preferences and the role of other professionals in identifying and meeting consumer needs.

While sampled care plans mostly reflected the outcomes of assessment and planning, and consumers confirmed the service did communicate the outcomes of assessment and planning, they also said the service did not routinely offer them a copy of care plans. Care plans were available to staff at the point of service delivery and staff explained how they accessed care plans as needed. Sampled care plans contained evidence of review in response to changed needs and incidents. Policies and procedures were in place to guide staff in the review process, noting the service mandated 4 monthly routine care plan reviews, as well as ad hoc reviews in response to changes.

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

Findings

The Assessment Team recommended the following Requirements were not met:

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:
  + is best practice; and
  + is tailored to their needs; and
  + optimises their health and well-being.
* Effective management of high-impact or high-prevalence risks associated with the care of each consumer.

Requirement 3(3)(a):

The Assessment Team were satisfied that daily personal and clinical care needs, restrictive practices and skin care were well-managed by the service. However, the Team recommended ‘not met’ on the basis that the service was not providing safe and effective care that was tailored to consumer needs in relation to medication administration, evaluation, and effectiveness. Although the service had relevant policies and procedures in place to guide delivery of care, clinical and care staff were not consistently following these in relation to pain management and self-administration of medication. The Assessment Team also identified a consumer was administering medication for another consumer, without any supporting assessment, risk assessments or risk management practices in place. Deficits in the administration and management of one aspect of a consumer’s complex care were also identified. Refer to Standard 2, Requirement (3)(a), where these deficits have been outlined in detail.

In their response, received 29 June 2023, the Approved Provider disagreed with the Site Audit Report recommendations. Relevant aspects of their response have been detailed in Quality Standard 2, Requirement (3)(a), where I have also outlined my assessment of evidence in the site audit report and response. The response also stated that the service’s policies and procedures had been reviewed but no amendments were judged necessary, however staff were provided with additional education in deficit areas.

I have carefully considered evidence in the site audit report and the response, and have agreed with the Assessment Team’s recommendations. I find that staff did not adhere to the service’s policies and procedures in relation to self-administration and administration of medication for three consumers, pain assessments were not completed and evaluations of the effectiveness of PRN pain medications for two of these consumers were not being attended to prior to site audit. A consumer was administering another consumer’s pain medications, in a departure from expected practice in relation to controlled drugs. The same consumer’s complex care was not being attended to in line with policy, procedure, clinical recommendations or expected practice. I am satisfied these examples demonstrate clinical care that was not best practice and which did not consistently optimise the consumers’ physical and mental well-being. Overall, significant shortcomings in management of controlled drugs and consumers who self-administer them were present. Therefore, I find the service does not comply with Requirement 3(3)(a).

Requirement 3(3)(b):

The Assessment Team were satisfied that risks relating to falls, weight loss and skin integrity were effectively managed, however risks associated with medication management and oxygen therapy were not identified, monitored or mitigated and staff were not consistently following relevant policies in these areas. Relevant summarised evidence has been outlined previously in Quality Standard 2, Requirement (3)(a).

In their response, received 29 June 2023, the Approved Provider disagreed with findings in the site audit report and the Assessment Team’s recommendation. They provided additional context in relation to all three consumer examples. The relevant aspects of the response have been outlined previously in Requirement 2(3)(a).

I have considered evidence in the site audit report and the response and have agreed with the Assessment Team’s recommendation. While the Approved Provider’s response and evidence it included demonstrated there are policies and procedures in place to support effective management of most high impact and high prevalence risks, the systems were ineffective in relation to consumers who self-administer controlled drugs, as well as in relation to an aspect of complex care, as outlined in Requirement 2(3)(a). Due to the higher risk nature of the service’s non-compliance, improvement actions implemented since site audit do not go far enough. Further improvement actions will be required and all will require time, monitoring and thorough evaluation to ensure sustained improvements are realised and consumer safety is prioritised. For these reasons, I find the service does not comply with Requirement 3(3)(b).

I am satisfied the service complies with the remaining 5 Requirements of Quality Standard 3.

Care planning documentation demonstrated the service identifies and meets the needs for consumers nearing the end of their life, maximising their comfort and preserving their dignity. Staff were familiar with processes used to assess consumers at end of life stages, and the service used a local palliative care team to provide further support, end of life care planning and management. Relevant policies and procedures were in place to guide staff practice.

Representatives interviewed said that the service recognises and responds to consumers who experience changes or deterioration. Staff nominated examples of consumers who had deteriorated and the steps they took to respond. Care planning documentation verified staff interviews and contained evidence of appropriate responses to changes in health condition, function and capacity, as well as overall deterioration. Policies and procedures in relation to the management of consumer health status deterioration were in place to guide staff practice.

Most consumers and representatives interviewed were satisfied with care delivery and how needs were communicated amongst staff. Interviewed clinical and care staff outlined how information about consumer needs is communicated at staff meetings, in progress notes and during handovers. Sampled care plans documented evidence of mostly timely and appropriate referrals to other organisations, professionals and service providers. Staff understood referral processes and outlined routine and specialist referrals made by the service.

The service demonstrated effective use of standard and transmission-based precautions to prevent and control infection. Staff reported training on infection-minimising strategies and were observed using appropriate PPE, practising hand hygiene, socially distancing and effectively sanitising equipment between uses. COVID-19 and influenza screening measures were in place. Infection rates were monitored and trended at the service and organisational level and staff understood principles of responsible antibiotic use.

# Standard 4

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

Findings

The Quality Standard is assessed as Compliant as seven of the seven specific requirements were assessed as Compliant.

Consumers who spoke to the Assessment Team said that the services, supports and activities for daily living at the service met their needs, goals and preferences and optimised their overall quality of life, independence and well-being. They said they felt at home in the service and there were plenty of activities to keep them engaged. Lifestyle and care staff demonstrated in-depth knowledge of individual consumer needs, goals, likes and dislikes, as well as ways the service optimised their independence and supported their emotional, spiritual and psychological well-being. Care plans documented strategies and preferred activities that could be used when sampled consumers required additional emotional support. However, necessary referrals and reassessments concerning one named consumer’s wellbeing were not attended to, as outlined previously in Quality Standard 2, Requirement (3)(a).

Consumers said the service supported them to maintain social and personal relationships and do things of interest to them inside and outside the service. Staff understood the supports in place to enable consumers’ participation in the service and wider communities, and what consumers needed to maintain their important relationships. Care planning documentation identified activities of interest for consumers and supports necessary for them to participate. A very wide range of diverse activities was evidenced in the service’s month activities calendar, including activities such as, but not limited to tai chi, belly dancing, carpet bowls, singalongs, church services, Zumba classes, a Men’s’ Group and a coffee club.

The service collaborated with external services and providers of lifestyle activities, including counselling services and a hairdresser, though most referrals were noted to be in relation to clinical care.

Consumers were satisfied with the meals provided at the service, and considered they were of suitable quality and provided in sufficient quantity. The service offers same day meal selection to consumers and actively seeks out consumer feedback through direct conversations, Food Forum meetings and feedback forms. Consumers commented favourably about meal presentation and alternative meal options are made available on request. A mealtime was observed, with staff seen to be assisting consumers with their meals as required.

Consumers and representatives said consumers felt safe using the provided equipment and that it is suitable for their needs. They also indicated equipment is clean, well-maintained, and suitable for use. Preventative and reactive maintenance systems were in place and documentation reviewed by the Assessment Team showed timely response to maintenance requests. Staff understood how to lodge maintenance requests using the online system and confirmed requests were actioned in a timely manner.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Quality Standard is assessed as Compliant as three of the three specific requirements were assessed as Compliant.

Consumers said that the service environment is well signposted, pleasant, clean, welcoming and encourages a sense of belonging. Observations showed large windows with lots of natural lighting and clear signage throughout. The service has lounge areas for socialising and quiet nooks scattered throughout, fitted with comfortable furnishings, books, and magazines. Consumer rooms are personalised with ornaments, pictures, bedspreads, and furnishings. Central courtyards have garden beds, shaded sitting areas, barbeque facilities, and safe pathways.

Cleaning schedules were in place of each unit and communal areas, guiding staff on cleaning processes and frequencies for detailed and touch point cleaning. Outdoor areas were observed to be safe, clean and easily accessible to consumers. While consumers in the Memory Support Unit were subject to environmental restraint, the unit had a large outdoor area that was freely accessible to those residing within, and all requirements for restrictive practices were met. Documented policies were in place to guide staff practice in relation to equipment maintenance, stock management and cleaning services.

Consumers and representatives were satisfied that furniture and equipment at the service was safe, clean and well maintained. The Assessment Team observed that furniture and equipment appeared to be modern, of solid construction, clean and well maintained throughout the service. Staff said they had sufficient equipment to do their jobs and that the equipment was of good quality. Hoists had been recently serviced and were subject to routine scheduled maintenance. Assistance equipment was noted in consumer rooms, and staff confirmed they were cleaned after each use, which was observed during the site audit.

# Standard 6

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

Findings

The Quality Standard is assessed as Compliant as four of the four specific requirements were assessed as Compliant.

The service encouraged consumers and representatives to provide feedback and make complaints, including through feedback forms and consumer meetings. Consumers were all aware of how to provide feedback and were aware of external avenues for making complaints such as through advocacy services or the Commission. Staff understood how to access language and advocacy services, understood the feedback and complaints processes and described how they supported consumers and representatives to give feedback. Feedback and complaints were encouraged through use of signage and information about the feedback process; feedback boxes were located throughout the service. Multilingual information about advocacy services and information about the Commission were displayed in the service.

A Feedback Policy and Procedure was in place and documentation review demonstrated staff adhered to its requirements when handling feedback and complaints. Consumers confirmed the service responded appropriately to feedback and practices open disclosure. Staff gave examples of actions taken in response to complaints and clearly understood their role in ensuring that feedback and concerns were addressed, and actions were taken to prevent the concern arising again.

Staff understood how feedback and complaints contributed to continuous improvement efforts. A Continuous Improvement Policy and Procedure was in place and was understood by staff. Examples of feedback that lead to service level improvements included a sports bar implemented at the service and establishment of a ‘people’s shed’ due to open in later 2023. Consumers felt that their concerns were treated seriously and would contribute to an overall improvement in services.

# Standard 7

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

Findings

The Quality Standard is assessed as Compliant as five of the five specific requirements were assessed as Compliant.

Consumers and representatives provided mixed feedback about staffing levels at the service, with half raising concerns regarding longer than acceptable call bell response times in the recent past. Consumers mentioned, and call bell data confirmed, some excessive call bell waits experienced between February to April of 2023. Staff, management and interview evidence demonstrated these were the result of technical problems with the call bell system which were rectified in April 2023, resulting in improvements to call bell response times since then. Interviewed consumers who raised concerns about excessive wait times confirmed that response times had recently improved, and while those consumers expressed frustration and agitation about the wait times earlier in the year, significant detrimental impact to those consumers was not identified. However, as outlined in Quality Standard 2, Requirement 3(a), one consumer expressed the concern that they were taking on responsibility for aspects of care that staff were too busy to attend to in a timely manner. Another consumer was self-administering pain medication to avoid waiting for pain relief. This information has contributed to findings of non-compliance in Requirements 2(3)(a), 3(3)(a), 3(3)(b) and 8(3)d), where it is most relevant. As documentation review, review of average call bell response times and consideration of ongoing recruitment efforts indicated the service has usually deployed sufficient number and mix of staff, and given recent improvements in call bell response times, the Assessment Team were satisfied that Requirement 7(3)(a) was met.

Consumers and representatives said staff were kind, caring and gentle in delivering care and services and were respectful of their diversity and preferences. Observations during the audit confirmed this. Consumers and representatives sampled were confident that staff were skilled and had the knowledge they need to provide quality care. Management outlined processes used to ensure staff had the qualifications and knowledge necessary to effectively perform their roles.

Consumers praised staff and could not identify any further training they required. Staff said they were well supported with a range of useful training packages, and confirmed they completed mandatory ‘buddy’ shifts on commencement of employment. Staff were also required to complete mandatory training and competencies through online and face-to-face platforms. Mandatory training completion was monitored by management and the service updated professional and probity checks annually. Training relevant to these Quality Standards included training on the Serious Incident Reporting Scheme (SIRS), restrictive practices, elder abuse, infection control and medication management. Mandatory training modules had a completion rate of 97% on the day of the Site Audit.

The service regularly monitored, assessed and reviewed the performance of staff. Clinical staff had annual performance appraisals and care staff completed monthly competencies, for ongoing regular appraisal. Staff files contained evidence of performance appraisals and showed that the service attended to performance management as required, using best practice principles.

# Standard 8

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

Findings

The Assessment Team recommended the following Requirement was not met:

* Effective risk management systems and practices, including but not limited to the following:
* managing high impact or high prevalence risks associated with the care of consumers;
* identifying and responding to abuse and neglect of consumers;
* supporting consumers to live the best life they can
* managing and preventing incidents, including the use of an incident management system.

Relevant (summarised) evidence brought forward in the site audit report is outlined below.

The Assessment Team found the service had mostly effective risk management systems to monitor and assess high impact or high prevalence risks associated with the care of consumers, including in relation to pressure injuries, falls, restrictive practices and infections. The service had a procedure in which risks are reported, escalated, and reviewed by management at the service level and the organisation’s executive management, including the governing body. Staff interviewed were able to explain risk management processes, including key areas of risk that had been identified and were being mitigated. However, as outlined previously in Quality Standard 2 Requirement 3(a), the service was unable to demonstrate how risks associated with self-medication are identified, escalated, actioned, mitigated and monitored. Deficits in management of the second named consumer’s complex care were also identified.

In their response, received 29 June 2023, the Approved Provider disagreed with the site audit report ‘not met’ recommendation and brought forward additional information and contextual evidence to dispute the three named consumer examples outlined in Requirement 2(3)(a). All relevant aspects of the response were outlined in Requirement 2(3)(a). Additionally, in relation to the third named consumer, the response outlined several steps taken since the site audit to manage risks associated with their self-administration of PRN pain medication. However, the response did not demonstrate an effective organisational process for identifying and assessing risks to consumer safety when consumers self-administer and store controlled drugs. The response did not demonstrate a well-established system for monitoring those consumers or for maintaining oversight of staff practice, to ensure organisational policies and procedures are followed. Similarly, the response did not assure me that complex clinical care risks related to the second consumer were being effectively managed prior to site audit, and an updated care plan developed did not address all risks identified in the site audit report. The response did not assure me the service has identified appropriate and sustainable governance and oversight improvements to monitor care and service delivery in these areas moving forward. For these reasons, I find the service does not comply with Requirement 8(3)(d).

I am satisfied service complies with the remaining 4 Requirements of Quality Standard 8.

Consumers were engaged in the development, delivery and evaluation of care and services, through monthly Resident Support Group meetings, food forum meetings, twice annual CEO visits and consumer experience surveys. Feedback from consumer meetings informed the service’s continuous improvement plan, with examples of service-level improvement as result of this feedback identified during the site audit.

Consumers and representatives interviewed said the organisation promotes a culture of safe, inclusive, and quality care and is accountable for its delivery. The organisation’s policies and procedures outlined how the governing body maintains oversight of service operations through regular quality meetings held monthly, which supports the reporting function to the governing body. The organisation’s CEO regularly attends the service to meet consumers and receive feedback directly. Review of governing body meeting minutes confirmed it regularly reviews the service’s incident reports, feedback trends, improvement data and monthly clinical indicators.

Documentation review and information from staff and management interviews, demonstrated effective organisation-wide governance systems in relation information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The service has policies and procedures that detail processes around each governance system, to guide staff practice.

The service had a documented clinical governance framework implemented at the service, and staff applied it in their practice. Included within the framework were policies on infection control and management, antimicrobial stewardship, minimising restrictive practices and open disclosure.

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