Performance

Report

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| Name of service: | Trentham Hostel |
| Service address: | 22-24 Victoria Street TRENTHAM VIC 3458 |
| Commission ID: | 3331 |
| Approved provider: | Central Highlands Rural Health |
| Activity type: | Site Audit |
| Activity date: | 11 April 2023 to 14 April 2023 |
| Performance report date: | 7 June 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 Trentham Hostel (**the service**) has been prepared by L Glass, 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 15 May 2023.

# 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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

* Ensure consumer behaviour support plans are tailored and contain targeted and detailed information specific to individual needs and preferences in order to inform support strategies and the plans are reviewed and evaluated for effectiveness
* Implement cohesive records management for consumer medication
* Ensure the use of restrictive practices reflect the standards and procedures recommended within the organisation and required legislation
* Ensure meals are reviewed for variety, quality and quantity and cater for consumer preferences including vegetarians
* Ensure feedback and complaints are reviewed and improvements are implemented in a timely way.

# 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

This Quality Standard is Compliant as 6 of 6 Requirements have been found Compliant.

Consumers and their representatives sampled for this requirement said consumers are treated with dignity and respect, and their identity, culture and diversity are valued as individuals. Staff were observed treating consumers with respect and demonstrating an understanding of individual choices and preferences. Consumers’ care planning documents included information about their individual preferences and people important to them. The service has policies and procedures which include consumers’ rights.

Consumers said the service provides care and services that are culturally safe. Staff were able to explain and provide examples of how they support consumers’ individual needs. Care planning documents describe consumers’ individual requirements. The Charter of Aged Care rights is displayed at the service; the service has policies and procedures to align with dignity and respect for the consumer.

Consumers and their representatives sampled said the service supported the consumers to exercise their own choice and independence and decision-making about how the care and services are delivered to meet their needs. However, two consumers provided negative feedback in relation to their mealtime choice and care documentation review for one consumer did not record whether choice was offered. Staff described how they best support the decisions of consumers. Observations made by the assessment team confirmed that staff assist consumers in maintaining relationships with their friends and families.

Consumers are satisfied that the service supported consumers to do the activities they wanted to do, including where the activities involved risk, so they could live the best life possible. Clinical staff outlined the dignity of risk and consultation process. Consumer care plans evidenced the process of consultation and decision-making, in accordance with the service’s procedures for identifying and managing risks.

Consumers and their representatives interviewed are satisfied that the information provided is current, accurate, timely and communicated in a clear and easy way to understand. Consumers and their representatives are satisfied with the communication received and timely updates about changes or incidents that have occurred. Staff described how consumers are provided with information. The organisation has documents and a process to inform and enable consumers to make choices.

Consumers and their representatives said they are confident their information is kept confidential. Care staff described how they maintain a consumer’s privacy when providing care. Staff described keeping computers locked and using passwords to access consumers’ personal information. Staff were observed knocking on bedroom doors and awaiting a response before entering and closing office doors when talking to the assessment team about consumers. Observation of staff practice shows that the privacy of consumers is respected.

# Standard 2

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

Findings

This Quality Standard is Non Compliant as 1 of 5 Requirements has been found Non Compliant.

In relation to Requirement 2(3)(e) the assessment team found consumers and representatives understood assessments and reviews post incidents such as changes in skin integrity, swallowing and nutrition and mobility. The assessment team found the service consistently documented, communicated and actioned reviews of consumers post falls. The assessment team found resident of the day (ROD) reviews were structured and occurring bi-monthly as per the service’s policy. Clinical staff and care staff could describe the types of reviews required depending on the change of circumstance or incident. However, the assessment team sampled three consumers whose behaviour support strategies were not reviewed for effectiveness post incidents. The service did not demonstrate that care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer in relation to changing behaviours. Inconsistencies in recording medication across documentation types for individual consumers was also found indicating reviews for effectiveness may not be successfully achieved.

In response to the assessment team report the approved provider supplied clarifying information and refuted the findings in the assessment team report. The further information supplied included detailed consumer information such as consumer care profile’s, behaviour support plans, sighting charts, a progress note, a consent form, medical reviews and a geriatrician report.

In making my decision I have been influenced by both the assessment team report and the response from the approved provider. I have considered the findings in the assessment team report and the analysis and further evidence from the approved provider. I acknowledge that 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 post incidents such as changes in skin integrity, swallowing and nutrition and mobility. However, for three identified consumers in the sample, conflicting information analysis and findings are contained in the assessment team findings and the response from the provider. In weighing up the evidence I agree with the assessment team that behaviour support plans are generic and lack detailed information and guidance for example about how to specifically redirect a consumer or what particular food or beverage or comfort aid to provide. Instead, statements are high level and generic in the behaviour support plans. Evidence of evaluation of the effectiveness of any measures put in place or redirection was not demonstrated in the documentation supplied. The assessment team also noted incongruencies in the documentation about medication across the different consumer records. I find requirement 2(3)(e) Non Compliant.

I find the remaining 4 Requirements of Quality Standard 2 are Compliant.

This is because most consumers and their representatives in general expressed satisfaction with the care planning process and assessments used to identify and consider risks to the consumer’s health and well-being. The service demonstrated using a range of validated risk assessment tools to guide the staff in the delivery of care and services. Staff could describe strategies to mitigate risks and provide safe and effective care. While information was not always consistent across all care planning and handover documentation in general planning documents reflect the outcome of risk assessments in relation to falls, skin integrity, and specialised nursing care needs.

Consumers and representatives could generally confirm they were aware of assessments being ongoing and mostly reflecting current care needs. A review of consumers’ care planning documents reflected that their needs, goals, and preferences are considered during the care planning process on entry to the service. A ‘resident of the day’ (ROD) review occurs every second month and an annual care conference is held in consultation with representatives for updates or additions or changes to the care and services plan. The assessment team reviewed advanced care directives (ACD) and end-of-life plans for several consumers which were easy to find and access on the electronic health system as well as observing the representation of a heart symbol used on the handover sheet to indicate if a consumer wanted full resuscitation, or no heart symbol if a consumer was not for cardiopulmonary resuscitation (CPR). Clinical staff interviewed could describe the organisation’s process in developing end-of-life plans in discussion with the consumer and their representative.

All consumers sampled and a representative expressed satisfaction with their involvement in the care planning process. Ongoing assessment, planning and reviews of consumers’ care allow for the direct contribution of consumers and their representatives. Clinical staff described the collaboration process with the inclusion of input from other health professionals and external health services. This was supported by documentation and interviews by the assessment team.

Consumers were confident they would receive a copy of their care plan if they asked for it. Two consumer representatives were aware of a care and services plan but had not asked for a copy. Clinical staff described how they would show the screen of the electronic tablet to the consumer when or if they asked about the assessments during the two monthly review process. The service has a comprehensive checklist of assessments that clinical staff follow and discuss during the ROD review, it was provided to the assessment team and included, mobility and transfers, FRAT, lifestyle assessment, restrictive practice, nutrition and hydration, medications and clinical care.

# 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

This Quality Standard is Non Compliant as 2 of 7 Requirements have been found Non Compliant.

In relation to Requirement 3(3)(a) consumers and representatives sampled against this requirement generally expressed satisfaction with the provision of personal care the service provides. Staff demonstrated safe delivery of care in areas such as skin integrity, wound management and pain management. The organisation has a range of clinical care policies and procedures to guide staff in areas of care including restrictive practices.

However, the assessment team found the service is not always providing safe and effective care that is best practice, tailored to individual consumer’s needs and optimising their health and well-being in relation to restrictive practices. Chemical restrictive practice does not always reflect the standards, or procedures recommended within the organisation or as legislated. File review did not always demonstrate interventions, monitoring, and evaluation of chemical restraint is followed as per the service’s restrictive practice policy and procedures. The service did not demonstrate reassessment, reviews, or supports were provided for a consumer with a known history of addiction. The consumer denied the addiction and has other complex care needs.

In response to the assessment team report the approved provider supplied clarifying information and this included a Procedure for Restrictive Practices in Aged Care, evidence of a consumer consent form template for psychotropic use and a completed consent form for an identified consumer. The response refuted the findings in the assessment team report about the consumer with a history of addiction stating the consumer had not actively sought to satisfy the addiction since they entered the service. However, the identified consumer’s behaviour support plan, updated in March 2023 and the resident of the day report in April 2023 submitted as evidence for Requirement 3(3)(b), explicitly refers to behaviours related to the addiction and impact on another resident. A notation states the responsive behaviour should improve.

In making my decision I have considered the findings in the assessment team report and the response including further evidence and explanation from the approved provider. I have weighed up the explanation and the further evidence supplied from the approved provider about chemical restrictive practices and the conflicting evidence in the behaviour support plan and the resident of the day report for one consumer and management of addiction and behaviours. I am persuaded by the information in the evidence supplied that the consumer has ongoing issues related to addiction, that impact their behaviour and impact at least one other consumer. This has not been effectively managed by the service or tailored to the consumer’s needs. I find Requirement 3(3)(a) Non Compliant.

In relation to Requirement 3(3)(b) the service demonstrated how it identifies consumers at high risk of falls and implements falls minimisation strategies with a robust post falls procedure that is embedded within staff practice. Other high impact, high prevalence risks have effective processes implemented with policies and procedures to guide staff in risk mitigation in areas such as diabetes management, and catheter care. However, file review in relation to managing behaviours evidenced that the service did not demonstrate practice aligning with the service’s policy.

The organisation’s Behaviour Assessment and Management in Residential Aged Care procedure was last reviewed in April 2018, with changes made in January 2023. The policy’s work instructions guide staff in the procedure for behaviour assessments, documentation and charting to include the following consideration; the triggers, locations, frequency, duration, and intensity of the behaviours, people who were involved and affected, the response of others exposed to the behaviour and the circumstances to note when the behaviour is not occurring. Sampled documentation and interviews with care staff and management did not demonstrate these actions are occurring. The service did not demonstrate that high impact, high prevalence risks are effectively managed for behaviours of concern. Behaviours are not always being documented for analysis and evaluation of risk and associated management.

The response from the approved provider included clarifying information and a range of documentation for three consumers including Behaviour Support plans, care profiles, lifestyle care plan and progress notes and a medication tracker and a consent form.

In making my decision I have considered the findings in the assessment team report and the response including further evidence and explanation from the approved provider. I am persuaded by the analysis and evidence in the assessment team report that management of high risk behaviour’s is not effective and the service’s policies and procedures are not always followed. I find Requirement 3(3)(b) Non Compliant.

I find the remaining 5 Requirements under Standard 3 Compliant.

This is because consumers and representatives expressed their satisfaction with the palliative care approach provided by the service. Care documentation showed that end of life needs is met in line with consumer wishes and comfort is maintained. Staff described the end of life care pathway and resources available to them to support consumers nearing end of life. The service has organisational policies and procedures to guide the provision of palliative care.

The service had no current or recent consumers that were recognised to be deteriorating, therefore, the assessment team conducted the assessment against this requirement based on staff interviews and documentation review. The service was able to describe how staff report changes in a consumer’s health status including cognitive or physical function in a timely manner. Care staff could describe that they are required to inform clinical staff when a change or deterioration is identified. Clinical staff could discuss how they assess the changes and escalate a transfer to hospital or refer to another health provider. The medical practitioner and consumer representatives are notified of the changes and email correspondence is used to communicate changes in consumers’ care needs to staff, as well as the handover process for immediate transfer of information.

Consumers and representatives interviewed expressed satisfaction that the consumers’ care needs, and preferences are effectively communicated. Review of care plan documentation included information from external services such as pathology and/or allied health, as well as progress notes, assessments and goals of care. The service’s electronic health management system is used for recording information about the consumers and sharing alerts and other correspondence. Clinical staff and care staff described communication mechanisms including the verbal handover process and the handover sheet, duty/shower lists, whiteboard updates, progress notes and care plans to facilitate the delivery of personalised care.

Consumers and representatives expressed satisfaction with access and referral to their medical practitioner, other health professionals and external specialist services when required. The service demonstrated the referral process both internally, with clinical staff initiating reviews with the medical, allied health and lifestyle team, and externally, when needed. File reviews reflected appropriate referrals to individuals, other organisations and specialist services.

Consumers and representatives said they were satisfied with the actions taken by the service to minimise infection related risks. Staff demonstrated standard precautions as the minimum work practice required to achieve a foundation level of infection prevention and control. Staff could describe their knowledge and understanding of infection control practices to reduce the spread of infection as well as work processes to promote antimicrobial stewardship. The service has 2 clinical staff in an Infection Prevention and Control (IPC) lead role, a regional IPC clinical nurse consultant (CNC), and an Outbreak Management Plan (OMP). The organisation has policies and procedures to provide guidance and resources to the staff.

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

Findings

This Quality Standard is Non Compliant as 1 of 7 Requirements has been found Non Compliant.

In relation to Requirement 4(3)(f) several consumers and representatives interviewed provided negative feedback in relation to the food provided at the service. Staff were knowledgeable about individual consumers’ preferences and dietary requirements. Staff were observed assisting, encouraging, and offering choices with meals during the site audit. The service has 4-weekly (monthly) rotating menu with no seasonal change. A review by the assessment team demonstrated that the menu has not had any changes or review since 2019. Whilst the assessment team requested documentation multiple times to demonstrate a dietician review of the menu, this was not provided by the service. While most consumers and representatives said consumers enjoy the meals provided, the assessment team provided feedback to management about the limited options for vegetarian meals at dinner time.

Management confirmed they were aware of concerns with the evening meal menu and provided an alternative vegetarian menu created during the site audit. Management acknowledged that they have not had a review or change of menu since 2019. Management and kitchen staff were unable to demonstrate how feedback is received for consumers in relation to meals. Environmental services management provided the template of a survey conducted in December 2022 in relation to the quality of meals and added that they are not able to find collated results of the survey. The assessment team noted the service’s improvement plan had rollover consumer feedback from 2022 in relation to consumers wanting a seasonal menu with the completion time noted as December 2023. The chef discussed that they would like to implement a seasonal menu and added that they are unable to change the menu as they did not have that authority to do so.

The approved provider’s response included clarification of the assessment team findings and further information and documentation. This included an explanation that from 2019 – 2023 priority was given to providing food during the COVID lockdowns and in 2021 introducing the International Dysphagia Standardisation Dietary Initiative (IDDSI). The response explained an external food review was commissioned and completed in December 2022. Recommendations from this review included a full menu review and seasonal menus be introduced. Management prioritised other recommendations such as equipment and infrastructure repair/replacement but had not commenced work toward a menu review.

With the appointment of new personnel in management, a Food and Nutrition Committee has been implemented and a review of the menu has commenced as evidenced in minutes provided dated May 2023. The Resident/Relative Meeting (Consumer Forum): Minutes for May 2023 note ‘Dietitian review of menu required and new seasonal menu to be developed.’

Evidence was also provided of management meeting with individuals to understand and resolve concerns about food preferences and needs and actioning feedback about meals for several consumers. Another consumer’s care plan profile identifies they are mainly vegetarian and discusses challenges in providing food options liked by the consumer. A narrative was provided demonstrating attempts to resolve the concerns about food quality and options and the approved provider disputed the proportionality of the sample size for staff interviews suggesting it was too small to provide meaningful input.

In making my decision I have considered the findings in the assessment team report and the approved provider’s response including further evidence supplied. I acknowledge the conflicting information in the assessment team report and the response from the provider refuting the findings and outlining an overview of elements of menu review since 2019. I also acknowledge the implementation of the Food and Nutrition Committee and commencement of a review of the menu and the efforts to provide the food preferences of identified consumers. However, I have taken account of the menu review gap of 4 years and while commencing, the current review is not yet finalised and outcomes not yet implemented. I therefore find Requirement 4(3)(f) Non Compliant.

I find the remaining 6 Requirements under Standard 4 Compliant.

This is because consumers and their representatives described how consumers are supported to engage in the things they want to do and how individual preferences are respected. Staff described how the service supported consumers to maximise their independence, well-being and quality of life. Care planning documentation identified consumers’ choices and provided information about the services and supports needed to help them to do what they like to do.

Consumers and their representatives said the consumers’ emotional, spiritual, and psychological well-being is supported. Staff described how consumers are supported emotionally, spiritually, and psychologically. Care planning documentation includes information on consumers’ individual emotional, spiritual, and psychological needs.

Consumers and their representatives said the service offers services and supports that enable them to participate in the community, have relationships and do things of interest to them. Staff described how they support consumers to do the things of interest to them, participate within and outside the service environment and have social relationships. Care planning documents contained information on individual consumers’ interests and identified the people important to them.

Overall consumers and representatives sampled were satisfied others involved in consumer care are updated regarding any changes. A consumer expressed confidence that staff communicate appropriately with their representative and medical carers, and representatives were satisfied with the information they receive. Staff said they receive adequate information and outlined how consumer information is shared within the service. Consumer care plans contained necessary and sufficient information, and handover materials contained details regarding not only clinical needs, but also consumers risk choices.

One consumer sampled reported a referral to hearing services Australia, and another reported engagement with volunteers at the service. Staff reported making a range of referrals, and outlined organisations regularly accessed to provide additional support to consumers. Review of care plans and other documentation confirmed the involvement of external providers.

Consumers felt safe using the service's equipment and said it was easily accessible and suitable for their needs. Overall, consumers were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items are repaired or replaced when required. Overall, equipment used for activities of daily living was observed to be safe, suitable, clean, and well-maintained. However, the assessment team noted a delay in reporting of a faulty kitchen equipment.

# 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

This Quality Standard is Compliant as 3 of 3 Requirements have been found Compliant.

All consumers and representatives sampled expressed satisfaction with the service environment and how it supports independence, interaction, and function. Staff outlined aspects of the environment that assist consumers with wayfinding. The environment was observed to be welcoming and signage was observed to assist navigation. Consumers were observed utilising indoor and outdoor areas.

All consumers and representatives sampled were satisfied with the cleanliness of the service environment and said it is well-maintained. All said consumers can move freely. Staff outlined cleaning regimes and management of hazards, and a review of maintenance requests showed no outstanding issues posing a significant risk to consumers. The service was observed to be clean, and well-maintained. Outdoor areas were mostly tidy.

Overall, consumers and representatives interviewed were satisfied that furniture, fittings and equipment are clean, well maintained and suitable. Staff outlined how they ensure equipment is safe, clean and appropriate for consumers. The assessment team observed furniture and equipment to be clean and in good condition, with recent checks where indicated.

# 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. | Non-compliant |

Findings

This Quality Standard is Non Compliant as 1 of 4 Requirements has been found Non Compliant.

In relation to Requirement 6(3)(c) the assessment team found the service did not adequately demonstrate appropriate and timely actions are taken in response to feedback nor how consumers are involved in finding a solution and kept informed about the progress of action taken and/or planned. Staff demonstrated an understanding of open disclosure principles and provided examples of how they apply these in their day to day work. The organisation has a suite of policies and procedures to guide staff practice. The assessment team recommended Requirement 6(3)c was not met.

The response from the approved provider supplied clarifying information and further evidence of the service’s responses to complaints. The evidence demonstrated feedback has been provided and since the Site Audit further engagement and solutions for named consumers about resolving their complaints has been actioned. Consumers have also participated in forums involving them and creating opportunities to influence preferred outcomes to meet their needs and preferences.

The assessment team recommended Requirement 6(3)(c) was not met. I have come to a different view. I have considered the assessment team report and the response from the approved provider. I am satisfied that appropriate action is taken and consumers complaints are responded to, including involving the consumer in solutions that meet their needs and that an open disclosure process is used when things go wrong. I find Requirement 6(3)(c) is Compliant.

In relation to Requirement 6(3)(d) the assessment team found the service did not adequately demonstrate feedback was effectively recorded, monitored, and analysed to improve the quality of care and services. The service collects feedback in various ways for example a consumer engagement survey (applied bi-monthly) and annual survey. While the results are collated the service did not demonstrate how results are analysed, shared, discussed, or used to inform improvements. While consumers shared how they have provided feedback to the service, the service’s feedback register (for the last 6 months) did not reflect any feedback/complaints from consumers residing at the service (Hostel).

The service acknowledged to the assessment team that feedback had not been recorded on the electronic system (VHIMS feedback module) therefore was not captured on the service’s feedback register. In response the service advised all feedback (verbal, from meetings, feedback forms and emails etc.) will now be recorded as described above in alignment with the organisation’s consumer feedback procedure.

The assessment team report found the Service Improvement Plan (SIP) for 2023 covers both the co located Hostel and Nursing Home and reflects 18 of 25 items have been rolled over from 2022. While the response actions were reported to be in various stages of progress the service did not demonstrate the status of the improvements had been communicated to consumers. The SIP did not reflect a consumer’s feedback in relation to the availability of vegetarian options/choices.

The response from the approved provider included an outline of a survey undertaken bimonthly as part of the ROD with a consumer and/or their representative. The response noted follow up actions required are documented in individual resident progress notes and followed up for that resident as part of ROD processes, responses are documented using a templated audit tool and an overall aggregate summarised and reviewed by management to ascertain whether there is a themed area of concern. Management can also ensure residents who have responded in the negative to the survey have had appropriate actions taken and documented. As outlined the response stated actions for individual resident responses are documented in resident progress notes, not on the audit tool.

In making my decision I have considered the assessment team report and the response from the approved provider. I acknowledge that feedback and complaints are documented in different formats. However, I am not satisfied the overall summaries and aggregated feedback and complaints has been used to improve the quality of care and services. Some improvements have been made since the site audit such as recommencing resident and representative meetings and a food and nutrition group, however I note the SIP did not reflect a consumer’s feedback in relation to the availability of preferred foods despite a long term issue being evident about this theme. I find Requirement 6(3)(d) Non Compliant.

I find the remaining 2 Requirements under Standard 6 Compliant.

This is because while consumers and representatives interviewed did not always demonstrate an awareness of all the ways the service encourages feedback, all said they felt comfortable to verbally raise feedback and/or use the service’s feedback form. Staff interviewed described various ways they support consumers to provide feedback and make complaints and demonstrated knowledge of the services feedback mechanisms. The service has a variety of ways to encourage and support stakeholders to provide feedback and make complaints. While ‘resident meetings’ have not been consistently held in the last 12 months they have recommenced. Consumers/representatives are provided with information about Aged Care Charter of Rights and feedback and complaints when moving into the service through their residential agreement.

Aged Care Quality and Safety Commission complaints information was displayed and available, however, information about other services (language, advocacy and hearing) to support raising feedback and complaints was not initially displayed nor readily available within the current ‘residential aged care handbook.’ A revised and approved version of the ‘residential aged care handbook’ (not yet in circulation) included the Charter of Aged Care Rights and the New Code of Conduct and a revised version of the ‘residential aged care handbook’ contained the contact details of an advocacy service. While the handbook included information about hearing and language services, contact details to support consumers to access these services in confidence or independently was not included at the time of the Site Audit.

# 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

This Quality Standard is Compliant as 5 of 5 Requirements have been found Compliant.

The service has a procedure to monitor planned and actual staffing which informs recruitment needs. The service has procedures to cover unplanned leave including affiliations with several staffing agencies. Overall consumers and representatives expressed in various ways there were sufficient staff to meet their care and service needs. Staff expressed while they can be busy from time to time, they are able to meet consumer needs as per consumers preferences.

Consumers and representatives expressed in various ways staff know them and are kind, caring and respectful. Staff interviewed demonstrated knowledge and respect for consumers sampled. Observations of staff interactions with consumers were kind and respectful. The organisation has a suite of documents and process which communicate expected staff behaviours.

The service has a range of policies and procedures to ensure staff have qualifications, knowledge, and competence to perform their roles. In the last year the organisation has implemented a new online training platform for mandatory and required training and education and most recently enrolled all staff in Commission based learning platform (ALIS). The service was aware and acknowledged staff mandatory training was yet to meet organisational expected target rates. Staff interviewed demonstrated knowledge of open disclosure, restrictive practice, antimicrobial stewardship, and incident management. However, the service did not demonstrate recent training in these areas.

The service has a range of systems and processes to ensure staff are recruited, trained, equipped, and supported. Documentation sampled demonstrated application of the services processes. Recently employed staff confirmed these processes were effective form them.

The service applies an annual appraisal process, a performance management process, and a probationary period for new employees to assess, monitor and review the performance of their employees.

# Standard 8

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

Findings

This Quality Standard is Compliant as 5 of 5 Requirements have been found Compliant.

In relation to Standard 8, Requirement 8(3)(a) the assessment team found the organisation has a range of ways to involve consumers and the broader community in the development, delivery and evaluation of care and services. These include a Board consumer advisory committee and a consumer engagement survey which is applied bi-monthly as part of resident of the day process. While consumer lifestyle meetings were reinstated in February 2023, ‘resident meetings’ have not been held with any regularity in the last 12 months. The service did not adequately demonstrate consumer feedback and results of surveys are used in the development, delivery and evaluation of care and services. Consumer feedback specifically in relation to meals and dining experience captured on the SIP has not been actioned in a timely manner. Consumers interviewed provided mixed feedback in relation to being involved in the development, delivery and evaluation of care and services. The assessment team recommended the Requirement was not met.

The response from the approved provider included clarifying information and further evidence including a calendar of meetings for 2023, minutes of the most recent resident and representative meeting, and the Trentham Food Focus Group Meeting Minutes. This evidence demonstrated that since the site audit consumers are engaged in and supported to participate in the development and evaluation of their care and services.

In making my decision I have considered the findings in the assessment team report and the approved provider’s response including further evidence supplied. I have come to a different view to the assessment team. This is because I am satisfied the further information supplied includes planned actions and actions taken as documented in the minutes and calendar, confirming consumers are engaged in the development, delivery and evaluation of care and services and are supported in their engagement. This includes for example, lifestyle activities and the commencement of a menu review process. I therefore find Requirement 8(3)a, Compliant.

The organisation has a range of committees and systems which feed into and inform the Board of management. A member of the Board described how information is reviewed and discussed at the Board level and used to promote a culture of safe quality care and services. Members of the Board were noted to have a broad range of experience across multiple sectors. The organisation also has a senior leadership team and a documented committee structure with information from a number of sub committees feeding up into the above advisory committees and the Board.

The organisation has a range of governance systems which are generally effective. However, information management, continuous improvement and regulatory systems have not always been effectively applied nor deficits in these processes identified through the service’s monitoring systems. Senior management onsite during the site audit acknowledged current monitoring systems had not always identified deficits identified by the assessment team. Senior management advised they were already considering ways they could improve monitoring processes. This is considered in Requirement 6(3)(d)

The organisation has a range of risk management systems and practices. Staff confirmed they have access to the service’s electronic incident reporting system, procedures, and have been provided training. Senior management talked to the various systems and practices and actions being implemented to mitigate/minimise risks.

The organisation has a clinical governance framework including but not limited to antimicrobial stewardship, restrictive practices, and open disclosure. Staff interviewed demonstrated and understanding of the organisation’s systems and practices and provided examples of how these inform their day to day work.

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)