Performance

Report

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| Name of service: | Trentham Nursing Home |
| Service address: | 22-24 Victoria Street TRENTHAM VIC 3458 |
| Commission ID: | 3512 |
| 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 Nursing Home (**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 | **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 | **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.

* Ensure the use of restrictive practices reflect the standards and procedures recommended within the organisation and required legislation
* Implement clear guidelines to support staff to identify consumer deterioration and recognise and respond to escalating changes in consumer behaviour in a timely manner while respecting end of life care plan directives.
* Ensure meals are reviewed for variety, quality and quantity and cater for consumer preferences including vegetarians
* Ensure feedback and complaints are reviewed and inform improvements to be implemented in a timely way
* Ensure guidance material, procedures and information systems are effective in capturing all incidents and risks are managed and reported appropriately.

# 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 are treated with dignity and respect, and their identity, and individual culture and diversity is valued. 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 to align with dignity and respect for the consumer.

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.

Consumers and representatives said the service supported consumers to exercise their own choice and independence and decision-making about how the care and services are delivered to meet their needs. 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. Staff described how consumers are provided with information. The organisation has documentation and a process to inform and enable consumers to make choices.

Consumers and their representatives are confident consumer 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. | Compliant |

Findings

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

All consumers and their representatives generally expressed satisfaction with the care planning process and assessments used to identify and consider risks to the consumers’ 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. Care 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 on-going and assessments mostly reflect current care needs. Care planning documents reviewed by the assessment team reflect that consumer 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 consumers which were easy to find and access on the electronic health system. The assessment team observed the representation of a heart symbol used on the handover sheet to indicate 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.

Most consumers and representatives expressed satisfaction with their involvement in the care planning process. Ongoing assessment, planning and reviews of consumers’ care allow 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.

Most consumers were confident they would receive a copy of their care plan if they asked for it. Clinical staff described showing the information on 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. The checklist was provided to the assessment team and included assessment of mobility and transfers, Falls Risk Assessment Tool (FRAT), lifestyle assessment, restrictive practice, nutrition and hydration, medications and clinical care.

Consumers and representatives discussed their understanding of assessments and reviews post incidents such as when there are changes in skin integrity, swallowing and nutrition and mobility expressing satisfaction with the assessment process. The assessment team found the service consistently documented, communicated and actioned reviews of consumers post falls. The ROD reviews were structured and occurring bi-monthly as per the service’s policy. Clinical staff could describe the types of reviews required depending on the change of circumstance or incident including skin integrity and falls. For one consumer the behaviour support strategies were not reviewed for effectiveness or aligned to the use of chemical restraint and evaluation, or review did not always consistently occur. I consider the impact on the consumer under requirement 3(3)(a).

# 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. | 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. | Non-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 expressed satisfaction with the provision of personal care the service provides for the consumer. Staff demonstrated safe delivery of care in areas such as skin integrity, wound 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. The assessment team found chemical restraint practice does not reflect the standards, or procedures recommended within the organisation or as legislated. File review did not always demonstrate interventions, monitoring, and consent and evaluation of chemical restraint followed the service’s restrictive practice policy and procedures. Mechanical restraint consent was in place.

In response to the assessment team report the approved provider supplied clarifying information including a Procedure for Restrictive Practices in Aged Care, evidence of a consumer consent form template for psychotropic drug use, a completed consent form, progress notes and a behaviour support plan for an identified consumer. The response refuted the findings in the assessment team report stating chemical restraint practice does reflect the standards and procedures recommended within the organisation and as legislated. The response argues interventions and evaluation of consumers occurs prior to administering as needed medication.

I have considered the assessment team report and the response from the approved provider. In making my decision I have been influenced by both the assessment team report and the response from the approved provider. The behaviour support plan and consent form for the use of psychotropic medication including chemical restraint that was provided in the approved provider’s response is signed and dated after the assessment team report date. While I acknowledge consent is now in place, no evidence was supplied indicating either was in place at the time of the site audit. This supports the assessment team finding that chemical restraint practice does not reflect the standards, or procedures recommended within the organisation or as legislated and that file review did not always demonstrate interventions, monitoring and consent and evaluation of chemical restraint followed the service’s restrictive practice policy and procedures. I therefore find Requirement 3(3)(a) Non Compliant.

In relation to Requirement 3(3)(d) the assessment team found the service was unable to demonstrate staff consistently report all changes in a consumer’s health status, including cognitive or physical function in a timely manner. The assessment team found that for a consumer, deterioration was not considered or assessed despite displaying escalating changes in behaviour. While the consumer had an end of life care plan directing no intervention, assessment and management of the deterioration did not occur in a timely way and a subsequent transfer to hospital occurred in consultation with the consumer’s representative.

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 documentation about the end of life care plan, medical and progress notes and a hospital discharge summary. The approved provider contended the response to the consumer’s deterioration and escalating changes in behaviours, in particular, not screening for an infection was aligned to the agreed end of life care plan.

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 response including further evidence from the approved provider. I acknowledge the wishes in the consumer’s end of life care plan for no intervention, however I am persuaded by the assessment team’s findings that deterioration and escalating changes in behaviour were not recognised and responded to in a timely manner. Despite the end of life care plan directives the deterioration of the consumer resulted in the subsequent decision to transfer the consumer to hospital. While the approved provider disputes a diagnosis of an infection related to complex care needs, based on contradictory information in the discharge summary antibiotics were prescribed and the consumer recovered. The response acknowledges the confusion around the circumstances and the representative of the consumer agreeing to transfer the consumer to hospital in the particular instance despite a directive for nil intervention in the end of life care plan. In weighing up the evidence provided I find that response to deterioration was not recognised or responded to in a timely manner for this consumer impacting on the consumer’s health at the time. I find the service is Non Compliant with Requirement 3(3)(d).

I find the remaining 5 Requirements under Standard 3 Compliant.

This is because 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 to manage these risks with policies and procedures to guide staff in risk mitigation in areas such as diabetes management, and catheter care. The service keeps a register that documents consumers’ clinical directives, such as the catheter care information and interventions for consumers. The assessment team found the service consistently documented, communicated and actioned reviews of consumers post falls.

Consumers and representatives sampled expressed their satisfaction with the palliative care approach provided by the service. Care documentation showed that end of life needs are 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.

Most consumers and representatives sampled 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.

All consumers and representatives sampled 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 have 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. 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. Management acknowledged that they have not had a review or change of menu 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. Management and kitchen staff were unable to demonstrate how feedback is received for consumers in relation to meals. Staff were knowledgeable about individual consumers’ preferences and dietary requirements. Staff were observed assisting, encouraging, and offering choices with meals during the site audit. 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 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. Dietician reviews of food allergies, intolerances, preferences and needs were also provided for several identified consumers. The response refutes the assessment team’s finding that vegetarians are not catered for stating there are no vegetarians at the service.

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 review is not yet finalised and outcomes implemented. I therefore find Requirement 4(3)(f) Non Compliant.

I find the remaining 6 Requirements under Standard 4 Compliant.

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.

Consumers and representatives sampled were satisfied others involved in consumer care are updated regarding any changes. A representative expressed that they 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.

Consumers and representatives reported satisfaction with the referral process, and engagement of 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 the reporting of 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 way finding. 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 around 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)(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.

All feedback had not been recorded on their electronic system (VHIMS feedback module) therefore was not captured on the feedback register. In response the assessment team was 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 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.

The response from the approved provider noted a summary of overall responses is reviewed by management to ascertain whether there is a themed area of concern, and management can also ensure residents who have responded in the negative to the survey have had appropriate actions taken and documented. The response stated actions for individual resident responses are documented in resident progress notes, not on the audit tool. Assessors may not have been aware outcomes and actions in relation to responses are documented in individual resident progress notes, not on the audit tool.

In making my decision I have considered the findings in the assessment team report and the approved provider’s response including further evidence supplied. While I accept that the approved provider has policies and procedures to guide staff practice, these have not always been followed. For example, feedback and complaints have not always been recorded in the electronic system. I acknowledge progress notes are used to record, monitor and follow up actions for individuals and that overall summaries of collated survey results are monitored by management for follow up. However, I consider the evidence of review and using complaints and feedback to improve quality and care of services is not demonstrated and items for improvement from last year are still outstanding. I find Requirement 6(3) d Non Compliant.

I find the remaining 3 Requirements under Standard 6 Compliant.

This is because the service has a variety of ways to encourage and support stakeholders to provide feedback and make complaints including forms, surveys, and meetings. While ‘resident meetings’ have not been consistently held in the last 12 months they have recommenced. The response from the approved provider demonstrated resident meetings have recommenced. Consumers sampled expressed in various ways they feel comfortable to raise things as needed. Staff interviewed described various ways they support consumers to provide feedback and make complaints and demonstrated knowledge of the services feedback mechanisms.

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 displayed nor readily available within the current ‘residential aged care handbook’.

The service demonstrated in general, appropriate and timely actions are taken in response to complaints. 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.

# 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 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 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 processes 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 the Aged Care Quality and Safety 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 service’s processes. Recently employed staff confirmed these processes were effective for 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. | 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

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

In relation to 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 the ROD process. However, 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. 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.

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 confirm 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 food and nutrition requests and the commencement of a menu review process. I therefore find Requirement 8(3)(a), Compliant.

In relation to Requirement 8(3)(d) the assessment team found 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. However, the service did not demonstrate effective management of an incident which impacted on consumers. The service’s monitoring systems were not effective at identifying this deficit. The documentation to guide management of behavioural incidents (verbal and physical) was last reviewed in 2018 and referred to rescinded Aged Care and Quality Standards. The organisation’s clinical incident management procedure was last reviewed in 2021 and provides guidance on the reporting and management of clinical incidents including reportable incidents.

In response to the assessment team report the approved provider supplied clarifying information and further evidence. This included Information Management Systems training session and attendance records and an Induction presentation relating to incident management and open disclosure. The response also refuted the findings of the assessment team in relation to an incident between consumers and whether or not it should be reported and challenged the assessment team’s findings about specific incidents and reporting them in the Incident Management System.

In making my decision I have considered the findings in the assessment team report and the approved provider’s response including further evidence supplied. While I acknowledge the Incident Management System is used at the service and the training is in place for a large number of staff the service has also acknowledged it uses progress notes to capture incidents. A sample of consumers identified an incident between consumers resulting in the impacted consumer being relocated to the co located service. This was not identified as a reportable incident. Guidance and procedure information was also not current. I am persuaded by the findings of the assessment team that effective management systems and practices have not been demonstrated. I therefore find Requirement 8(3)(d) Non Compliant.

I find the remaining 3 Requirements under Standard 8 Compliant.

This is because the organisation has a range of committees and systems which feed into and inform the Board of management. A member of the Board of management described how information is reviewed and discussed at the Board level and used to promote a culture of safe quality care and services.

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) and 8(3)(d).

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 organisations 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)