Performance

Report

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| Name of service: | TriCare Bundaberg Aged Care Residence |
| Service address: | 12 FE Walker Street BUNDABERG QLD 4670 |
| Commission ID: | 5936 |
| Approved provider: | TriCare Bundaberg Aged Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 15 November 2022 to 17 November 2022 |
| Performance report date: | 16 December 2022 |

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

**This performance report**

This performance report for TriCare Bundaberg Aged Care Residence (**the service**) has been prepared by S Turner, 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 9 December 2022.

# Assessment summary

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

* The organisation is required to ensure that consumers are treated with dignity and respect and that staff practices reflect this.
* The service is required to ensure that consumers’ privacy is respected and that personal information remains confidential; staff practices are to reflect this.
* The organisation is required to ensure that assessment and care planning processes are completed for all consumers including those consumers who are short stay, and that consideration of risks to consumers’ health and well-being is considered.
* The organisation is required to ensure that consumers receive safe and effective clinical and personal care, including pain management, that is tailored to their needs and optimises their health and well-being.
* The organisation is required to ensure that changes in consumers’ physical function, including pain levels, is recognised and responded to in a timely manner.
* The organisation is required to ensure there are sufficient, skilled staff to deliver safe and quality care to consumers in a timely manner.

# 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. | Non-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. | Non-compliant |

Findings

Deficiencies in Standard 1 related to staff practices including the way some staff speak to consumers, manage consumers’ personal information and/or respect consumers’ privacy.

Some consumers said they did not feel respected by staff and provided examples of staff entering their room without knocking or waiting to be invited in. One consumer reported knowing about other consumers’ conditions as they hear staff when they speak loudly to each other down the corridors; another consumer said staff ‘don’t care’ that it is personal information they are sharing when they speak loudly.

The Assessment Team observed staff on a number of occasions throughout the site audit, failing to protect consumers’ privacy by talking about consumers’ conditions (including care and service needs) loudly in corridors and dining areas, and outside other consumers’ rooms. On one occasion the Assessment Team heard staff speaking loudly and inappropriately with each other discussing a named consumer who had experienced an episode of incontinence. The Assessment Team reported that one consumer was observed wearing the same set of clothing across the three days of the site audit.

Lists that included consumers’ names and details relating to their personal hygiene needs and preferences were observed on the walls of communal bathrooms.

Allied health staff were observed attending to consumers and providing services in common areas such as the dining room rather than in the privacy of the consumer’s room. One representative reported they had seen this occur many times.

The Assessment Team discussed poor staff practices with management who advised that a memorandum had been circulated to staff about consumer dignity and respect and that there had been a communication to a member of the allied health team about the requirement to complete treatments in consumers’ rooms.

The approved provider in its response to the site audit report raises concerns about the reliability of the information brought forward by the Assessment Team in relation to their observations of staff sharing consumer information in public spaces. I am satisfied staff practices were not appropriate and did not support consumers’ privacy, dignity and confidentiality as consumers provided feedback that they hear staff talking about other consumers.

The approved provider refutes information in the site audit report that one consumer wore the same set of clothing for three days. It states the consumer’s wardrobe is limited and that their clothing is similar in appearance. They submitted evidence that the consumer’s hygiene needs are attended regularly; I accept this.

The approved provider has commenced taking action to address the deficiencies brought forward in the site audit report relevant to Standard 1 and evidence to support this has been submitted. Actions include but are not limited to:

* Memoranda about expectations regarding consumers’ privacy and dignity have been issued.
* The service’s plan for continuous improvement reflects strategies to enhance consumers’ dignity and choice. Topics addressing privacy, respect and dignity have been discussed at meetings, training materials are available for staff to read and refresher training on Standard 1 is being provided.
* Information about the Code of Conduct (including the organisational Code of Conduct) has been provided and has been discussed at staff meetings.

While I acknowledge the actions the service has taken and continues to implement, I am satisfied that on occasion staff have not treated consumers with dignity and respect and that personal information has not been kept confidential.

The service did demonstrate compliance with those requirements relating to cultural safety, choice, independence and decision making, including those decisions that involve an element of risk. While some consumers and representatives expressed dissatisfaction with the provision of information I have considered the information in the site audit report together with the approved provider’s response and am satisfied consumers generally receive information that enables them to exercise choice.

Consumers and representatives were dissatisfied with the information they received and provided examples of how they were not aware of activities or events occurring at the service and that they had not been informed about planned changes to the pain management program. Two consumers and one representative said they don’t receive the information they need in order to know what is happening at the service for example meeting minutes or newsletters.

Lifestyle staff reported the workload as being ‘overwhelming’ at times and said that while most consumer meetings occurred, minutes for those meetings were not always provided to consumers. They said that whilst efforts were made to provide activity schedules and information to consumers in a timely manner, this was not always achievable due to time constraints.

The Assessment Team requested from management the minutes for the consumers’ monthly meetings conducted over the previous six months; meeting minutes for July 2022 and August 2022 were provided. Management said the person responsible for typing the minutes had ceased working at the service and no additional meeting minutes were able to be located.

With respect to the pain management program, the Assessment Team were advised that physiotherapy hours had been significantly reduced impacting the delivery of massage as a non-pharmacological pain management intervention. Allied health staff advised consumers had not been advised of the changes to the program and management staff confirmed communication of the changes could have been more effective. I have considered information relating to the pain management program under Standard 3.

The approved provider acknowledges that for a two month period the monthly consumer newsletter was not released; this was attributed to a change in staffing. The monthly newsletter has recommenced and evidence of this was provided. It was noted to include information about staffing movements, lifestyle activities, COVID-19 vaccinations, hospitality and maintenance services, advocacy and feedback and complaints processes. Additionally, the response states that public announcements are made and that there is a whiteboard in a common area of the service displaying activities for the day; both of these were operating at the time of the site audit. I note too there is information in the site audit report where consumers had advised the Assessment Team that they were generally satisfied with their ability to discuss their care needs and preferences, to be involved in care planning and that they had the information they required to make choices. While there was some level of dissatisfaction with the availability of information, the service has re-established the monthly consumer newsletter. The service’s plan for continuous improvement states the monthly newsletter and consumer meeting minutes will be given to consumers and to representatives and that this will be monitored by management staff; additionally, they will be displayed on noticeboards throughout the service. Overall consumers and their representatives felt they had the information they required to make choices. I am satisfied consumers receive information that is current and timely.

There are policies, procedures and educational tools for staff that outline the service’s expectations and staff responsibilities in relation to independence, cultural diversity, inclusion and spiritually safe care.

Consumers and representatives described how staff generally provided care and services that were consistent with their cultural traditions and preferences and staff could explain how the consumer’s cultural requirements influenced care delivery.

Consumers said they generally felt supported to make decisions about their care, when others are to be involved in their care and about how their meaningful relationships are to be supported. Management said on entry to the service consumers are asked who they would like to be involved making decisions about their care and services. Case conferences are conducted with consumers and their nominated representatives as part of the consultation process and to ensure consumers are afforded the opportunity to communicate their decisions.

Staff could describe how they communicate with consumers who experience communication barriers including through the use of communications and cue cards, speaking slowly and seeking the assistance of family members.

Staff demonstrated an understanding of those areas where consumers choose to take risks. Staff explained how consumers are supported to understand the benefits and possible harm associated with their choices and said they include consumers in discussions about how to reduce risk where possible.

Care planning documentation included information about the consumers’ identity, people of importance in the consumer’s life and how the service is to support the consumer’s relationships.

# Standard 2

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

Findings

The service failed to effectively undertake assessment and care planning relating to services and supports for daily living, particularly for those consumers receiving short term care, and failed to consider risks associated with pain management following changes to the pain management program. While the Assessment Team brought forward deficiencies in relation to restrictive practices, this has been considered under Standard 3.

The Assessment Team identified that consumers had not had assessments completed to identify consumers’ pain management needs following changes in the delivery of the pain management program and this had resulted in negative outcomes for consumers.

Management staff said consumers are assessed on entry to the service with assessment and care planning occurring over the following 28 days. However, for consumers receiving short term care, assessments and care planning had not consistently occurred and the Assessment Team found that for 12 short term care consumers at the service, none had a lifestyle care plan or information documented in relation to their needs, goals and preferences relating to daily living supports. The deficiencies in the process relating to those consumers receiving short term care was acknowledged by management at the time of the site audit and an updated plan for continuous improvement was provided to the Assessment Team that included actions to address the deficits in assessment and care planning processes for these consumers.

The approved provider’s response acknowledges the organisation’s processes in relation to lifestyle assessment and care planning had not been adhered to. Actions initiated by the service and reflected in the plan for continuous improvement include:

* Policies and procedures are being revised and will include clear guidance on assessment and care planning processes for permanent consumers and for those consumers who are short stay.
* The lifestyle induction program is being reviewed in accordance with the revised policy.
* Care planning education is to be provided to identified staff.
* A plan for updating care plans is to be developed with lifestyle staff.

The response includes evidence that outstanding lifestyle care plans have been completed for consumers on short term stay. For those permanent consumers, lifestyle care plans have been reviewed.

The approved provider’s response to the site audit report includes evidence that charting and assessments were commenced for consumers following the site audit and that care plans were updated with individualised strategies to address consumer’s pain.

While I acknowledge the actions the service has taken and continues to implement to address the deficiencies identified by the Assessment Team, I am satisfied that for some consumers, assessment and care planning processes were not consistently effective and strategies to address these deficiencies are yet to be fully implemented and evaluated for effectiveness.

The service demonstrated compliance with those requirements relating to identifying consumers’ needs, goals and preferences including in relation to end of life planning. The service was able to demonstrate that assessment and planning occurred in consultation with the consumer and others that the consumer wished to be involved including other organisations and providers of care and services, and the service generally demonstrated that a care plan review process is established.

Overall, interviews with consumers and representatives and review of care planning documentation demonstrated consumers’ current needs, goals and preferences including advance care planning were identified on entry to the service. Consumers could describe what was important to them in terms of how their care is delivered and care staff were familiar with the consumers’ needs and said they referred to the registered nurse for additional guidance if required.

Staff said they access care plans through the electronic care management system. The service has a three monthly care plan and review process with registered staff in designated teams to ensure care plan reviews are conducted. Management staff said care plans are sent to representatives prior to the care plan review to facilitate areas of discussion.

Care planning documentation demonstrated input from health care professionals including medical officers, specialists, physiotherapist, podiatrist and dementia advisory services. Outcomes of assessment and care planning were documented and there was evidence of engagement with consumers and representatives when planning care and in response to an incident or change in the consumer’s well-being. Care plans generally demonstrated that a review process had occurred and for those approaching end of life, an end of life pathway had been initiated. The Assessment Team observed staff accessing the electronic care management system via mobile computers and additionally handover documentation was available to staff to support consumers’ care delivery.

# 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

Deficiencies in Standard 3 related to:

* the service’s failure to ensure that consumers’ health and well-being is optimised and that care delivery is tailored to consumers’ needs specifically in relation to pain management, and
* the service’s failure to recognise and respond to changes in consumers’ pain following a review of the service’s pain management program.

The Assessment Team were advised the physiotherapy pain management program ceased approximately four weeks prior to the site audit. The physiotherapist hours reduced from approximately 80 hours per week to 16 hours per week with approximately 60 consumers impacted. The program consisted of massage, individualised exercise programs, supervised walking and where appropriate, the use of heat packs. The revised pain management program (to replace the physiotherapist led program) was to be delivered by care staff and registered staff, with staff providing massage and supporting the walking/mobilising program previously performed by the physiotherapist. Additionally, heat packs and transcutaneous electrical nerve stimulation machines were to be used. Management staff advised that for those consumers who may be experiencing increased pain levels, that pain charting was to be conducted.

However, consumers provided negative feedback about the way their pain is currently managed. For example:

* One consumer said they previously received massage therapy provided by the physiotherapist on a number of occasions each week and that this helped their pain management ‘enormously’. They said this had ceased approximately one month ago and while they were supposed to receive massage from care staff and/or registered staff this was not occurring and they had not received a massage for one month. They said this had impacted them significantly in a negative way and that they were now relying on increased medication to manage their pain.

Care planning documentation identified during a recent care plan review, that the consumer raised concerns about the cessation of their massage. The consumer’s medication chart identified pain relieving medication was commenced in September 2022 with additional pain relieving medication prescribed in November 2022. No pain charting was evident following cessation of the pain management program or prior to the prescribing of additional pain relieving medication.

Care staff and registered staff said they were not providing massage to the consumer.

* A second consumer described experiencing pain that was relieved by massage. The consumer said their medical officer recommended massage and pain-relieving medication as pain management strategies. However, the consumer said this is not occurring and provided an example of requesting a massage at midday on one day during the site audit and at 3.30pm this had still not occurred with staff reporting they were too busy.

The consumer’s care planning documentation reflects the medical officer’s direction to provide massage regularly throughout the day however the Assessment Team reviewed charting and identified massage was not being delivered in accordance with the medical officer’s directives. The progress notes state on one occasion in November 2022 that the consumer repeatedly approached staff and became angryafter being denied a massage. The Assessment Team found that there were multiple instances of complex/changed behaviours demonstrated by the consumer in the previous four weeks however pain charting had not commenced to determine if pain was a contributing factor.

Care staff said they provide massage to the consumer if it is requested but that they often don’t have time to do it.

The service did not demonstrate that strategies to manage consumers’ pain following the cessation of the physiotherapy led program were effective as staff were not delivering non-pharmacological pain interventions as prescribed, pain charting was not occurring, consumers’ changing pain needs were not identified and equipment to support pain management for example the transcutaneous electrical nerve stimulation machines had not been delivered.

Care and registered staff said the cessation of the physiotherapist led pain management programs had not been discussed with staff and had placed additional pressures on them.

The approved provider in its response states pain management has been reviewed across the organisation and discussed with the provider of physiotherapy services. It says that organisationally there was a move to a more individualised and personalised approach to pain management and that consumers can still be referred to physiotherapists to undergo assessment to determine suitability for physiotherapy delivered pain massage. The approved provider said the service was requested to review all consumers receiving pain massage delivered by a physiotherapist and to assess the effectiveness of this intervention. This process was to include discussions with individual consumers and a consideration of alternative interventions such as heat/cold therapy, exercise, aromatherapy and the use of transcutaneous electrical nerve stimulation. The approved provider has acknowledged that the service did not adhere to this process and in a move to realign the service with the organisational approach a site specific plan has been developed. Actions include but are not limited to:

* The approved provider has engaged in discussions with allied health providers to ensure there is an understanding of the service providers’ responsibilities in relation to consumer care.
* The December 2022 consumer and representative meeting included a discussion about new initiatives including transcutaneous electrical nerve stimulation, the use of heat/cold therapy, massage by registered nurses and care staff, and staff training in the use of pain relieving equipment/resources. Meeting minutes were submitted in the response.
* Staff training records demonstrated staff have received training in pain relieving equipment/resources.
* Thermal and skin sensation assessments are being completed for consumers who may require the use of heat/cold therapy and evidence of this was provided for some named consumers.
* Pain charting, reassessment and revision of care plans is being completed for consumers who experience pain and evidence of this was provided. Care plans submitted as an element of the response were noted to have individualised pain management interventions documented.

The Assessment Team brought forward information that processes to identify those consumers who have a restrictive practice in place were not effective. Management provided the Assessment Team with three iterations of the psychotropic register during the site audit which raised concerns about the service’s understanding of those consumers who would be considered to be subject to a chemical restrictive practice.

The Assessment Team brought forward information one consumer (who was identified by the service as receiving an anti-psychotic medication as a restrictive practice) had been reviewed by a geriatrician approximately five months prior to the site audit with the specialist requesting that behavioural assessments/charting be conducted with a view to reducing or ceasing the medication. At the time of the site audit this had not occurred and management staff were not aware of the geriatrician’s recommendations relating to the possible reduction or cessation of the antipsychotic medication. The site audit report identified the consumer, while having a chemical restrictive practice in use, did not have a behaviour support plan in place. Additionally, the service could not demonstrate that an assessment was completed or informed consent provided prior to the commencement of a restrictive practice.

The approved provider in its response to the site audit report stated that the service maintains a psychotropic register to identify those medications being used as a restrictive practice; the register is reviewed monthly by senior clinical management staff and quarterly by a clinical pharmacist. The approved provider asserts the named consumer had a behavioural support plan in place and that authorisations/consents had been sought and were current; evidence of this was provided. They stated the consumer has had a medication management review completed following the site audit and behaviour charting for the consumer has commenced with the consumer currently being reviewed by their medical officer.

The service did demonstrate compliance with those requirements relating to the management of high prevalence risks, the support provided to consumers approaching end of life, the communication of consumers’ needs and preferences, referral processes and the minimisation of infection related risks.

A clinical governance framework is in place that includes policies and procedures to guide staff in relation to the management of falls, skin integrity and changed behaviours.

Consumers and representatives said staff demonstrated an understanding of consumers’ needs and preferences and that information was shared with other organisations if needed. Staff confirmed they received up to date information about consumers at handover as well as being able to access the information they required from the electronic care management system.

Overall the service had effective processes to manage risks associated with falls, chronic/complex health conditions, wound management and skin integrity. Care documentation demonstrated risks were identified and interventions implemented to manage the risk. Documentation reviewed demonstrated actions have been implemented to reduce falls, with those consumers who fall being reviewed by a registered nurse and a referral initiated to the physiotherapist where required. For consumers with complex wounds, dressings had been delivered in accordance with wound care plans, wounds were measured and photographed and clinical equipment was available to promote skin integrity.

Care plans reflected consumers’ end of life preferences and staff could describe how they support the needs, goals and preferences of consumers as they approached end of life. Management said advanced care planning is discussed on entry to the service and during the care plan review process. Care planning documentation for a deceased consumer was reviewed and demonstrated and end of life pathway had been initiated, a statement of choices had been completed, palliative medications were prescribed and a referral was made to the palliative care team.

With respect to the minimisation of infection related risks there were policies and procedures specific to infection control, anti-microbial stewardship and outbreak management including the management of a COVID-19 outbreak. There is a vaccination program for consumers and staff. The service has an infection prevention and control lead who is currently completing the required training, with additional support provided through the organisation’s head office. Staff were familiar with practices to prevent infection including hand hygiene, the use of personal protective equipment, encouraging fluids and obtaining pathology results prior to the commencement of antibiotics. Staff were observed undertaking hand hygiene, wearing personal protective equipment and participating in screening processes.

# Standard 4

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

Findings

Overall consumers and representatives felt the service’s lifestyle program was supporting their daily living and quality of life. Consumers provided feedback stating they liked playing the board games available to them and that they enjoyed the activities provided including those with children and animals.

Consumers said the service provided emotional, spiritual and psychological support when needed. One consumer advised that staff are ‘very kind’ and support them when they are feeling low. Staff described the processes for providing consumers with emotional and spiritual support. Lifestyle staff said a community visitors’ scheme is utilised when a consumer has been identified as requiring additional support. Staff said volunteers provide emotional support to consumers by conducting one on one visits especially for those consumers who choose not to participate in activities or prefer to stay in their room. Care planning documentation evidenced strategies and supports to guide staff including in relation to consumers’ emotional, spiritual and psychological well-being requirements.

Consumers and representatives said consumers are supported to participate in community activities outside the service, to visit family or to go shopping. Consumers provided examples of how the service supports them to maintain relationships with other consumers and also provides opportunities for them to do things individually. Overall, care planning documentation provided details about those people who are important to individual consumers, or who are involved in providing care or activities of interest to the consumer. Staff were familiar with those consumers who have personal relationships or who have developed a close friendship.

Staff described the ways in which information about consumers is shared and how they are kept informed of the consumers’ changing care needs and preferences. Staff were aware of those consumers who are supported by external service providers and how changes in care delivery are communicated. Care planning documentation evidenced the involvement of social workers and support staff from the National Disability Insurance Scheme.

Consumers and representatives said the meals are varied and of suitable quantity and quality. Consumers are offered a range of other options if they choose not to select a meal offered on the menu. Staff described how they know consumers’ nutrition and hydration needs and preferences and said that relevant information is held on the electronic care management system. Consumers’ dietary requiremenets were reflected in care plans. Consumers provided feedback that their food allergies and preferences were accommodated and the Assessment Team confirmed that consumers’ individual requirements were reflected in care planning documentation.

The Assessment Team observed equipment available to support consumers’ lifestyle, independence and quality of life. Mobility devices such as walking aids and wheelchairs were clean, well maintained and tyres were inflated. There was a wide variety of lifestyle resources available including music, documentaries, music headphones, art and craft activities and board and table games. The hairdressing salon was clean, tidy and well equipped.

The Assessment Team brought forward deficiencies in assessment and planning relating to services and supports for daily living particularly in relation to consumers on respite, the weight of this information has been considered under Standard 2.

# 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

Consumers and representatives described how consumers find the service easy to navigate and enjoy the big spaces for social interaction; they said family and friends are always made to feel welcome. Consumers advised they can decorate their room as they choose and bring in items of their own furniture. Staff were familiar with those areas of the service where consumers liked to spend time.

Consumers and representatives were satisfied with the cleaning of their rooms and the cleanliness of the service in general. They said the furniture, fittings and equipment provided supported their independence and was kept clean and was well-maintained. Consumers said they felt staff were confident and competent in the use of equipment that supports consumers’ care and service delivery. With respect to maintenance issues, consumers said that maintenance staff react in a timely manner when maintenance is required or their items need attention.

Fire evacuation diagrams and illuminated exit signage was displayed within the service and fire fighting equipment was readily available. Maintenance staff demonstrated that fire maintenance is current and that maintenance was occurring in accordance with the schedule.

Staff said shared equipment is wiped down prior to and after use and they felt they had sufficient equipment to undertake their role and meet consumers’ needs.

The Assessment Team observed consumers, families and friends accessing all areas of the service including outdoor areas and gardens without the assistance of staff. Consumers were seen to have access to call bells when in their room. Staff were seen sanitising equipment before and after use and shared equipment was observed to be clean and in good working order. Outdoor areas were clean and furnishings were in good condition. Some external areas had shaded roofing that allowed consumers to access the area in all seasons and weather conditions.

# Standard 6

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

Findings

Consumers and representatives said they feel encouraged, safe and supported to provide feedback and make complaints. They could describe the various methods available to them including speaking directly to management or staff, attending consumer and representative meetings, through the use of feedback forms, or by contacting the service directly via email or telephone. Consumers said they had received information about complaints processes in the consumer handbook. Consumers provided examples of times when they had raised a complaint and one consumer said staff ‘sorted it out straight away’ and apologised.

Management and staff said the service captures feedback through various mechanisms including via consumer surveys that are conducted by an external agency every three months. Care staff said they assist consumers to complete feedback and complaints forms if the consumer requires help and then escalate the complaint to the registered nurse.

Staff demonstrated an understanding of the internal and external complaints mechanisms that included those advocacy and translation services available for consumers.

Feedback and complaints are logged into an electronic complaints register and are reviewed monthly by management, reported on and with opportunities for improvement added to the plan for continuous improvement.

The Assessment Team reviewed consumer meeting minutes and newsletter and noted they included information on internal and external complaints mechanisms including contact details for external advocacy agencies. The feedback and complaints register demonstrated that complaints are investigated and actioned and that the principles of open disclosure are applied appropriately. The Assessment Team observed feedback forms at reception and on notice boards throughout the service.

# 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

Deficiencies in Standard 7 related to the failure of the service to effectively manage the workforce to deliver safe, quality care and services to consumers. Consumers and representatives expressed dissatisfaction with staffing saying consumers experienced delays in the provision of care. Consumers provided examples of how staff tell them they are ‘too busy’ with delays in staff attending to their needs resulting in negative outcomes for them, including for example episodes of incontinence, delayed pain management interventions and delays in assistance with transfers.

Staff said they don’t have sufficient time to provide care as scheduled including massages and that on occasion they sponge consumers rather than showering them due to lack of time. Staff said that at times call bells go unanswered. Lifestyle staff said that activities are delayed as staff are not consistently available to assist consumers to attend activities.

The Assessment Team observed a consumer who requested a shower and attention to their personal care needs being initially told by staff that they would ‘have to wait’ as staff did not have time to attend to them. The Assessment Team confirmed this consumer was attended to following this conversation.

Care related documentation demonstrated that non-pharmacological pain relieving strategies such as massage are not being conducted in accordance with medical directives, with staff reporting they don’t have sufficient time to undertake these duties.

Management advised that call bell response times are monitored and reviewed with wait times in excess of 10 minutes being investigated. However, the Assessment Team found call bell records for the fortnight prior to the site audit were on average greater than 10 minutes on five of the 14 days. Management advised that as a result of management changes, call bell records had not been reviewed during that period and delayed responses had not been investigated.

Management staff advised of the service’s processes for managing the roster and replacing planned and unplanned leave. The Assessment Team reviewed the service’s rostering documentation for the previous fortnight and confirmed staff absences are consistently replaced.

The approved provider in its response to the site audit report states the service utilises numerous strategies to ensure effective resourcing for the service that includes ensuring planned and unplanned leave is covered. It asserts there are sufficient staff to deliver safe, quality care and has submitted recent call bell records to demonstrate that overall response times are appropriate. The approved provider acknowledged that at times, as a result of care priorities, it has been necessary for staff and consumers to have negotiated on how hygiene needs are to be met. The approved provider asserts that staffing is sufficient to provide safe quality care but acknowledges there may be some staff who are not performing their roles in line with organisational expectations. The response includes actions that are being taken to refresh and reinforce organisational expectations. Actions include but are not limited to:

* Memoranda have been distributed to staff outlining organisational expectations in relation to staff conduct, privacy and dignity and call bell responses.
* Staff meetings have included a discussion of organisational expectations in relation to consumer dignity and respect, and call bell response times.
* Staff reminders about organisational expectations have been disseminated through the message board system.
* The plan for continuous improvement has been revised and reflects actions and initiatives to address deficiencies identified during the site audit.
* Resources and education and training has occurred in relation to the Code of Conduct.
* Senior management staff are planning to conduct staff meetings to listen to staff concerns and identify strategies to support and guide staff to manage their work time effectively.

While the approved provider asserts that there are sufficient staff to deliver quality care, I am satisfied the workforce has not been consistently delivering care and services as planned. Consumer and representative feedback confirmed this, care staff and lifestyle staff reported staffing impacted care and service delivery, there had been inconsistent monitoring of call bell response records following a change in management staff and in some instances clinical documentation demonstrated care had not been delivered in accordance with consumers’ needs.

The service did demonstrate compliance with those requirements relating to workforce interactions, staff knowledge and skills, staff training and performance review processes.

The site audit report includes information that consumers and representatives provided mixed feedback about whether or not staff were kind and caring. Negative consumer and representative feedback about staff concerned staff speaking loudly about consumers in public areas and not respecting consumers’ privacy or the confidentiality of consumer information. Additionally, the Assessment Team observed some instances of staff speaking about consumers in public areas. I have considered the weight of this information under Standard 1 and note the approved provider’s response includes actions to address the deficiencies brought forward under this Quality Standard.

The site audit report includes information that most consumers and representatives interviewed said staff treat them with dignity and respect. Consumers and representatives were able to provide examples of how staff provided care that was culturally safe and consistent with their cultural traditions. Staff were able to describe the methods they use to respect consumers’ identity and deliver care that reflects the consumers’ cultural requirements; they were observed to generally treat consumers with dignity. I am satisfied that workforce interactions with consumers were generally kind and caring.

Consumers were satisfied with staff knowledge and skills. Members of the workforce had the qualifications and knowledge to effectively and competently perform their roles. There are position descriptions for each role and a register is maintained to ensure criminal record checks are current. Management described recruitment processes and said that competency is determined through skills assessments and is then monitored through performance review processes, consumer feedback, audits and surveys. Staff said they had completed regular performance reviews that involved feedback from supervisors on their performance and an opportunity to identify areas for further improvement and training.

Staff could describe the training, support and professional development they receive. Management said new staff complete an orientation program including training in mandatory topics and a number of shifts where they work with and shadow an existing staff member. Staff training records are maintained and demonstrated high levels of attendance. Topics included in the education program included manual handling, abuse, unexplained absences serious incident response scheme and infection prevention and control.

# 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

The service demonstrated that consumers are engaged in the development, delivery and evaluation of care and services through consumer meetings, quarterly surveys, feedback forms and other feedback mechanisms. Examples were provided where consumer input had resulted in the development of new services including for example the introduction of a shopping program and the development of a gardening area. Consumers said they considered the service is well run and that they can provide feedback to management.

There is a leadership structure with the governing body holding overall accountability for quality and safety. Quality and clinical governance frameworks are established and promote a person-centred care experience. The frameworks emphasize an expectation that services are to be safe, integrated and effective and that this is to be achieved through partnerships with consumers and the employment of skilled and experienced staff. A monthly board of directors’ meeting occurs and addresses compliance matters, and clinical and operational risk.

There are generally effective governance mechanisms that address areas including information management, continuous improvement, financial management, regulatory compliance, workforce governance and feedback and complaints. While the site audit report includes information about delays in staff responses to consumers’ requests for assistance, overall, I am satisfied that there are processes to manage workforce governance and that these are being improved following the site audit. The site audit report includes evidence that there are high levels of compliance with attendance at mandatory training, that there are mechanisms to monitor staff performance and that performance review processes are up to date.

Management advised legislative changes are monitored through subscriptions to various legislative services and peak bodies. Changes and updates are distributed to staff via email alerts, the service’s intranet and staff meetings.

The site audit report included deficiencies under risk management systems and practices that primarily related to changes that had occurred to the service’s pain management program. The site audit report included information that consumers had not received information about the planned changes and that consumers’ changed pain management needs had not been promptly identified and addressed following this change. I note the service has taken action to address the deficiencies brought forward by the Assessment Team that relate to the pain management program and I have considered the weight of this information under Standard 3.

There are policies and procedures relating to incident reporting, responding to abuse and neglect and the reporting and management of incidents. Management described systems that are in place to identify, manage and monitor high-impact and high-prevalence risks associated with the care of consumers including falls, skin integrity, pressure injuries, medication errors and incident management. Incidents are captured within the electronic care management system and are reviewed by management. The requirements associated with the Serious Incident Response Scheme had been met where appropriate. Monthly reporting includes clinical indicators, incidents and risks; data is analysed to identify themes and trends and inform continuous improvement activities. I am satisfied that overall, effective risk management systems and practices are in place.

The site audit report included deficiencies relating to clinical governance specifically the use of chemical restrictive practices. The approved provider’s response to the site audit report states that there are mechanisms to capture the use of chemical restrictive practice; a register is reviewed by clinical management staff and a clinical pharmacist on a regular basis and was found to be accurate when reviewed December 2022. Evidence of restrictive practice assessments, authorisations and behaviour support plans were submitted as an element of the response.

There is information in the site audit report that the service has a documented clinical governance framework and policies relating to anti-microbial stewardship, restrictive practices and open disclosure. Overall management and staff demonstrated knowledge of the clinical governance framework that includes reporting processes, monitoring systems, the analysis of clinical indicator data and staff training. The site audit report states there are high levels of compliance with mandatory training. A clinical governance report is tabled monthly at board meetings. I am satisfied that overall clinical governance supports the delivery of safe, quality clinical care.

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)