Performance

Report

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| Name of service: | Uniting Eden |
| Service address: | 22 Barclay Street Eden NSW 2551 |
| Commission ID: | 0842 |
| Approved provider: | The Uniting Church in Australia Property Trust (NSW) |
| Activity type: | Site Audit |
| Activity date: | 29 November 2022 to 2 December 2022 |
| Performance report date: | 18 January 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 Uniting Eden (**the service**) has been prepared by K. Spurrell, 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 6 January 2023.
* other information and intelligence held by the Commission in relation to the service.

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

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

# Areas for improvement

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

* **Requirement 1(3)(a)** – The Approved Provider ensures consumers feel respected and valued as individuals and members of the workforce are trained and competent in the organisation’s policies and procedures that supports the identity, culture, and diversity of consumers when delivering care and services.
* **Requirement 1(3)(c)** – The Approved Provider ensures each consumer is supported to communicate decisions about their own care, choices, and the way care services are delivered.
* **Requirement 1(3)(e)** – The Approved Provider ensures consumers are provided with current, accurate and timely information to assist them with making choices regarding how care and services are delivered.
* **Requirement 1(3)(f)** – The Approved Provider ensures consumer’s privacy is respected and ensures members of the workforce are trained and competent in the organisation’s policies and procedures for consumer privacy.
* **Requirement 2(3)(a)** – The Approved Provider ensures care plans are consistently completed, accurate or reflective of consumers current needs, goals, and preferences to inform those delivering care and services.
* **Requirement 2(3)(e)** – The Approved Provider ensures care and services are regularly reviewed for effectiveness, when consumer needs or circumstances change, or incidents occur.
* **Requirement 3(3)(a)** – The Approved Provider ensures consumers receive best practice care tailored to their needs and optimises their health and well-being, including personal care and nutritional needs.
* **Requirement 3(3)(b)** – The Approved Provider ensures effective processes are implemented to manage high impact or high prevalence risks associated with the care of each consumer.
* **Requirement 3(3)(d)** – The Approved Provider ensures 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.
* **Requirement 3(3)(e)** – The Approved Provider ensures the implementation of effective process to ensure consumer’s information is documented accurately and is reflective of the consumer’s current care needs.
* **Requirement 3(3)(f)** – The Approved Provider ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* **Requirement 4(3)(a**) – The Approved Provider ensures consumers are provided care and services that enables consumers to feel connected and have control over their choices.
* **Requirement 4(3)(f)** – The Approved provider ensures meals are varied and of suitable quality and quantity.
* **Requirement 4(3)(g)** – The Approved Provider ensures where equipment is provided, it is safe, suitable, clean and well maintained.
* **Requirement 5(3)(b)** – The Approved Provider ensuresthe environment and equipment are safe and well-maintained.
* **Requirement 6(3)(a)**- The Approved Provider ensures that consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.
* **Requirement 6(3)(b)-** The Approved Provider ensures that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.
* **Requirement 6(3)(c)-** The Approved Provider ensures that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* **Requirement 6(3)(d)**- The Approved Provider ensures that feedback and complaints are reviewed and used to improve the quality of care and services.
* **Requirement 7(3)(a) -** The Approved Provider ensures 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.
* **Requirement 7(3)(b) -** The Approved Provider ensures workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.
* **Requirement 7(3)(c)-** The Approved Provider ensures the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* **Requirement 7(3)(d)-** The Approved Provider ensures the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* **Requirement 7(3)(e)-** The Approved Provider ensures Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* **Requirement 8(3)(a)-** The Approved Provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* **Requirement 8(3)(b) -** The Approved Provider ensures the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* **Requirement 8(3)(c)** - The Approved Provider ensures effective organisation wide governance systems relating to the following:
  + information management;
  + continuous improvement;
  + financial governance;
  + workforce governance, including the assignment of clear responsibilities and accountabilities;
  + regulatory compliance;
  + feedback and complaints.
* **Requirement 8(3)(d) -** The Approved Provider ensures effective risk management systems and practices are in place, including but not limited to the following:
  + managing high impact or high prevalence risks associated with the care of consumers;
  + identifying and responding to abuse and neglect of consumers;
  + supporting consumers to live the best life they can
  + managing and preventing incidents, including the use of an incident management system.
* **Requirement 8(3)(e)**- The Approved Provider ensures an effective clinical governance framework, including but not limited to the following:
  + antimicrobial stewardship;
  + minimising the use of restraint;
  + open disclosure.

# 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. | Non-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. | Non-compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* 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.

* 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.
* Each consumer’s privacy is respected and personal information is kept confidential.

Requirement 1(3)(a)

The Assessment Team found the service had policies and procedures in relation to consumer dignity, respect, and diversity. However, several consumers brought forward concerns to the Assessment Team in relation to about how management and staff treated them. Consumers collectively advised they felt the service did not sufficiently seek their opinions on whether the newly introduced care and services model would benefit them. Additionally, the Assessment Team observed poorly written notes in care documentation that did not demonstrate care was delivered with care and respect and unkind staff behaviour towards one consumer during mealtime. This evidence considered further in Requirement 4(3)(f).

In its response, dated 6 January 2023, the Approved Provider acknowledged the Assessment Teams findings. The Approved Provider undertook to deliver toolbox talks and code of conduct training with staff and provide further guidance and training on the appropriate form of progress notes in care documentation. The Approved Provider provided evidence of further engagement with consumers throughout December 2022 to provide additional information on the new care and services model and plans further consumer satisfaction surveys in response to the consumer feedback regarding the care and services provided.

I have given weight to consumer, representative and staff feedback, as well as the Assessment Team’s direct observations during the Site Audit. I am satisfied the service failed to ensure staff provided care and services in a way that respected and maintained consumers’ dignity. I am satisfied the service is non-compliant with Requirement 1(3)(a).

Requirement 1(3)(c)

The Assessment Team found consumers were not supported to exercise choice and independence and found deficits in how the service communicated with consumers.

The Assessment Team brought forward evidence of two named consumers who raised concerns around how the service supported them to exercise choice particularly in relation to the delivery of care and services. The Assessment Team spoke with one named consumer with decreasing mobility due to a recent fall and required a mobility aid. This consumer expressed concerns over the scope and expectation of their independent activities under the new service model and the Assessment Team found a lack of individual assessments in place to assess consumer’s ability to perform tasks. Staff advised they understood the new service model’s intent was for more independence to consumers, however said the approach failed to support consumers with mobility or cognitive capacity as the organisation had not considered the unique requirements for the service and had not engaged staff prior to the implementation.

Although management confirmed consumers were not consulted individually about the ‘Household Model’ prior to implementation, they also said consumer families were advised during Representative meetings and were positive about the proposed changes.

In the written response, dated 6 January 2023, the Approved Provider undertook to provide additional education and engagement with consumers to ensure consumers understood the intention of the new model of care and were supported to make decisions and exercise independence appropriately. While I acknowledge these improvement steps being taken, and those planned, to remedy deficits identified in the Site Audit report, I remain of the view that the service did not demonstrate each consumer was supported to exercise choice and make and communicate decisions at the time of the Site Audit. I find Requirement1(3)(c) non-complaint.

Requirement 1(3)(e)

The service provides information to each consumer in a range of ways. Lifestyle staff said they often speak directly with consumers about activities they might wish to participate in to ensure they are aware that the activity is happening. However, the Assessment Team spoke with consumers and representatives who raised concerns with how the service provides information to them. Representatives raised concerns over how the service updates them on changes to care or incidents in relation to consumers. Consumers stated that they often do not know what is being served each mealtime, the Assessment Team observed the menu in the main dining area to be blank and no date or time information provided about upcoming resident meetings.

In its response, dated 6 January 2023, the Approved Provider acknowledged the Assessment Teams findings, and provided evidence of actions and communications undertaken since the Site Audit, which included the menu board in the dining room being updated daily and dates for resident meetings communicated in newsletters, admission packs and displayed on notice boards.

I acknowledge the actions undertaken by the Approved Provider. However, based on feedback and observations made by the Assessment Team, the service was not sufficiently providing information to consumers and their representatives at the time of the Site Audit. I find Requirement 1(3)(e) non-Compliant.

Requirement 1(3)(f)

While some consumers stated their personal privacy was respected, and the service had appropriate storage systems in place, the Assessment Team brought forward an example of the Catering Manager loudly and openly berating one consumer in front of other consumers in the dining room. The consumer’s care plan stated they had anxiety and at times, struggled with asking for assistance and staff should observe them closely throughout mealtimes and assist.

In their response, dated 6 January 2023, the Approved Provider addressed feedback regarding the named consumer, and said the staff member who displayed unkind behaviour apologised to the consumer at the time of the Site Audit. Additionally, the Approved Provider said hospitality staff had been on-site after the Site Audit, to provide support to staff and consumers regarding catering and meals. While I acknowledge the additional information provided by the Approved Provider, I remain of the view that there were deficits in the handling of consumer’s privacy at the time of the Site Audit and find Requirement 1(3)(f) non-compliant.

I am satisfied the remaining 2 Requirements in Quality Standard 1 are Compliant.

Care planning documents reflected consumers’ background and culture. Staff were aware of and delivered care and services that considered consumers’ preferences and needs in relation to their culture. Lifestyle staff advised there was at times minimal capacity to undertake specific cultural activities, however, the service held events such as Remembrance Day and various festive activities.

Most consumers felt supported to make decisions affecting their health and well‑being, other consumers were unsure about which day-to-day choices they had control over. During the Site Audit, the service provided the Assessment Team with evidence of consumers who were encouraged to take risks and found sufficient information in place to support consumers in those risks.

# 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.
* 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.

Requirement 2(3)(a)

While assessment and care planning processes included consideration of some risks, the Assessment Team found not all assessments and care plans were consistently completed, accurate or reflective of consumers current needs, goals, and preferences to inform those delivering care and services. The Assessment Team identified two named consumers had preferred smoking assessments in place however, the consumer’s behaviours of smoking in their rooms or in non‑designated smoking areas were not included in their care plans. Additionally for a third consumer who preferred to smoke, no risk assessment had been completed. Other evidence brought forward by the Assessment Team included one consumer who had been recommended a modified diet due to risk of choking and aspiration however, this said consumer’s care plan did not include risks of choking and management strategies. Another consumer who was high risk of falls did not have any current falls management strategies, including the consumer’s vision impairment as a risk of falls.

In its response of 6 January 2023, the Approved Provider acknowledged the deficits identified in the Assessment Team’s report and advised that in relation to the consumers who did not have appropriate assessments for smoking; all three consumers were reassessed to assess for risk factors and care plans and behaviour support plans updated where necessary to address the deficits.

I acknowledge the service had implemented actions to address the deficits identified by the Assessment Team. However, at the time of the Site Audit the service did not have an effective system to ensure assessment and planning, including consideration of risks were used to inform the delivery of safe and effective care. I find Requirement 2(3)(a) non-Compliant.

Requirement 2(3)(e)

The Assessment Team found the service did not review care and services for effectiveness when circumstances changed or when incidents impacted on the needs of consumers. Consumers care plans were not reviewed, updated, or changed appropriately following changes in consumers’ needs including in areas of skin integrity, weight changes, falls and behaviours. Although the service utilised a system to record incidents, not all members of the clinical workforce had access. Evidence brought forwarded included two consumers, whose physical function deteriorated post falls in November 2022, however the consumers’ care plans were not reviewed or updated until December 2022. The Site Audit report also brought forward evidence of consumers who had significant or consecutive weight loss who were not investigated or monitored as per the service’s procedures, and three behaviour related incidents were not documented as incidents or reported through the Serious Incident Response Scheme (SIRS). This evidence is further considered in Requirements 3(3)(b) and 3(3)(d).

In its response of 6 January 2023, the Approved Provider acknowledged the issues raised in the Assessment Teams report, however provided explanation of the incident management system used at the service. The response detailed the process for the recording of incidents and confirmed that all permanent staff have access to the incident system, however acknowledged that agency staff do not and instead complete any incident reports through a paper-based system and through handover processes. Should an incident require a new assessment or a change to care plans, this is then undertaken, however the Approved Provider noted that not all incidents require an update to care plans or assessments.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider; however, I have given weight to the examples brought forward by the Assessment team and the impact to consumers. I am satisfied the service was Non-Compliant with Requirement 2(3)(e).

I am satisfied the remaining 3 Requirements of Quality Standard 2 are Compliant.

The Assessment Team found some consumer’s care plans had their end of life wishes documented, and staff were aware of how to access this information in case of an emergency. Most care plans, however, were not individualised, and did not always include current needs, goals and preferences of the consumer. Management advised for consumers who did not have an advance care directive in place, the service was following an action plan to finalise this.

Feedback from consumers and representatives was that they are generally notified when changes occur in consumers’ condition. Consumers and representatives gave mixed feedback about communication relating to their care and services plan, while some stated that their care plan was not discussed in the past with them, some consumers and representatives stated that they have recently received phone calls from staff to discuss their care plan.

Assessments and planning are based on a partnership with the consumers and representatives, and mostly included other organisations or individuals that were involved in the care of the consumer when required. Staff described how they involved consumers and other relevant people in assessment and care planning.

# Standard 3

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.

* Effective management of high impact or high prevalence risks associated with the care of each consumer.
* 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.
* 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.
* Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

Requirement 3(3)(a)

The Assessment Team found consumers were not receiving best practice care, tailored to their needs or optimising their health and wellbeing including personal care and nutritional needs. Some consumers expressed they were receiving minimal to nil assistance with preparation of their breakfast, morning and afternoon tea which impacted on their nutritional intake and weight. The Site Audit report brought forward evidence in relation to four named consumers.

One named consumer with a high risk of choking and aspiration required a modified diet, however, was often served food which was not of the right consistency according to their dietary requirements. The consumer said they often do not eat the food served and relied on packet foods or snacks they purchased for themselves. Progress notes identified multiple entries where the consumer had advised staff of their food preferences, not liking the food provided and how they would often eat food purchased, in their room. Additionally, the Assessment Team found the consumers nutrition and hydration form did not include the preferred food list provided to staff, this consumer had a consecutive weight loss of 4.8kg since August 2022 the consumer had not been reviewed monthly as per the service’s procedures or after significant and consecutive weight loss. This evidence is considered further in Requirements 3(3)(d), 3(3)(e) and 4(3)(f).

A second named consumer, who was high risk of falls, did not have any current falls management strategies, including the consumer’s vision impairment as a risk of falls. The consumer’s care plan did not include all of their current behaviours and management strategies to manage difficult behaviours. The consumer’s Personal Preference Nutrition and Hydration form stated they required soft bite size foods. Progress notes reviewed however, identified the consumer had been observed by staff eating uncooked bacon. An incident form had not been completed and there was no evidence of any assessments or observations undertaken by clinical staff to ensure the well-being of this consumer and reduce the risk of reoccurrence.

For this same consumer, multiple progress notes identified the consumer required two staff assistance and a wheelchair for mobility and transfer. A physiotherapist had reviewed the consumer and recommended the use of a four-wheel walker and two staff assistance with mobility and transfer. The Assessment Team found however, the consumer was spending most of their time in bed or the wheelchair, and their care plan was not reviewed or updated to reflect their current care needs as per the service’s Assessment and Planning procedure, the consumer had developed pressure injuries on both heels. Staff advised they were not always able to assist the consumer with their showers due to staff being busy and the consumer refusing to have a shower and indicated that the consumer had not received a shower for over 21 days. Progress notes for this consumer identified the days lapsed in the consumer not having their personal hygiene attended to, which resulted in the consumer sustaining sores that required a doctor review and use of relevant medications. Evidence relating to staffing is considered and relied on in Requirement 7(3)(a). During the Site Audit, management advised interventions were in place for pressure care, wound charts had commenced, and staff were in the process of updating the consumer’s care plan.

For a third consumer who had risks of Pneumonia, the Assessment Team found inconsistency with their care plan and Nutrition and Hydration documentation. The consumer’s care plan identified soft diet with thin fluids, however the Nutrition and Hydration states a normal diet, cut up by staff with additional sauces and gravy. The care plan also stated although the consumer can eat independently, staff will supervise and offer standby assistance when needed. The consumer depended on this level of assistance due to right sided weakness which made cutting up of meals, spreading butter onto bread/toast, pouring drinks difficult. This said consumer had a consecutive weight loss over six months and although a recent hospitalisation and intravenous diuretic contributed to some of the consumer’s weight loss, the Assessment Team found upon return to the service, the consumer had no further investigations to determine if reduced oral intake was a contributed factor to their weight loss. This same said consumer had not been referred to a dietician for weight loss management. Upon raising with management, they advised the consumer’s weight loss was due to regular diuretics from the recent hospital admission and therefore no further investigations were warranted.

In relation to a fourth consumer with decreasing mobility due to a recent fall and requiring a mobility aid, under the new Household model, this consumer was to make their own bed, prepare their afternoon tea and empty their bin. The consumer advised although they would attempt these, they expressed concerns on the ability to do so. This said consumer’s care plan stated they required a level of assistance with personal hygiene and grooming, had difficulty manoeuvring mobility aid in confined spaces and could become unsteady. The Assessment Team observed during the Site Audit, the consumer made afternoon tea, however the restrictions of the mobility aid posed safety risks, and the consumer’s mobility and capacity made the task difficult. Staff advised they understood the Household model’s intent was for more independence to consumers, however the approach failed to support consumers with mobility or cognitive capacity, as the organisation had not considered the unique requirements for the service.

Some consumers who resided in the service’s Memory Support Units (MSU) were on environmental and chemical restraint. Care staff described alternative non-pharmacological strategies used for consumers with challenging behaviours. The Assessment Team found although the MSU doors were kept open to allow consumers to move freely within the service, the exit and entry doors were key coded, and the code had not been displayed near the keypad. This same evidence is considered and relied on in Requirement 5(3)(b).

In the written response of 6 January 2023, the Approved Provider acknowledged the examples brought forward in the Assessment Teams report and provided a response to the issues raised.

In relation to the first named consumer, the Approved Provider brought forward evidence of changes made to the menu display, providing the consumer opportunity to request an alternative meal. The Approved provider undertook a case conference with the consumer in relation to weight loss and agreed to provide alternate food and snacks within the service for the consumer. Additional nutrition and hydration assessments were undertaken throughout December to ensure the consumer’s nutrition and hydrations needs are being met, including a dietitian review.

In relation to the second named consumer the Approved Provider acknowledged that the care plan should have been updated in relation to mobility status and provided evidence that this was undertaken on 1 December 2022. The Approved Provider submitted additional evidence of skin assessments and the commencement of pressure injury management in December of 2022. In relation to the management of behaviours for this consumer the Approved Provider advised that while the care plan did include management strategies it has implemented additional actions such as additional staff training on behaviour management and monitoring and understanding dementia. In relation to the personal care issues raised by the Assessment team, the Approved Provider disputed that the consumer was not showered for 21 days, and advised that sponge baths, showers or personal care washes were consistently offered to the consumer.

In relation to the third named consumer the Approved Provider provided evidence that care plans were reviewed and updated on 14 December 2022 to reflect consistency in the texture of meals and assistance at meals times. The Approved Provider gave further context to the weight loss identified by the Assessment Team to demonstrate that while there had been recent losses, over the course of the preceding 12 months the service had monitored the consumer’s weight that showed some increases, attributing the recent losses to other diagnoses and concluded there was no requirement for dietician referrals of interventions.

In relation to the fourth named consumer, the Approved Provider submitted evidence that care plans were reviewed on 18 December 2022 to reflect current mobility and provided progress notes to demonstrate that support is provided by the service in the preparation of meals and changing of sheets. The services stated that consumers are assisted with these tasks at their request, with the intention of the current model of care to be to support consumer independence.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider’s response and have placed weight on the feedback received directly from consumers, and staff feedback, and considered the impacts to consumers. Based on the evidence available to me, I find the service did not demonstrate tailored and effective personal care was being delivered to all consumers consistent with their needs and preferences at the time of the Site Audit. I find Requirement 3(3)(a) non-Compliant.

Requirement 3(3)(b)

The Assessment Team found the service did not have effective processes to manage high impact or high prevalence risks associated with the care of each consumer in relation to incident management and reporting. Although management advised that for each incident, clinical staff refer to the service’s procedure and utilised relevant checklist to report and investigate an incident, the Assessment Team found staff were documenting behaviour related incidents in progress notes and behaviour charts and the incidents were not consistently reviewed as a part of the service’s clinical oversight. As a result, the incidents were not being reported, investigations were not conducted or followed up to prevent or reduce the reoccurrence of incidents. Additionally, multiple behavioural incidents had not been identified as serious incidents and reported appropriately. This has been explored further in Requirements 1(3)(e) and 8(3)(c).

In its response of 6 January 2023, the Approved Provider advised it had undertaken an internal investigation into the incidents the Assessment Team identified as serious incidents, conducted toolbox education talks throughout December of 2022 about staff reporting obligations under SIRS and included education about Open Disclosure, Incident Management, and progress notes. Staff attendance rates were 76%, 56% and 53% respectively. The service is conducting an audit of the service’s practices for deteriorating residents and the service has sought further formal training opportunities for further training on SIRS and behaviour management that will be ingoing in early 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider’s response and I consider overall the service did not demonstrate that high impact and high prevalence risks associated with the care of each consumer were effectively managed at the time of the Site Audit. I find Requirement 3(3)(b) non-Compliant.

Requirement 3(3)(d)

The Assessment Team found the service had not responded to consumers change of physical function in a timely manner especially in relation to weight loss. As outlined in Requirement 3(3)(a) for two said consumers who had consecutive weight loss, the Assessment Team identified an additional 17 consumers who had either had lost significant or consecutive weight and no consumers had been referred to or reviewed by a dietitian. The consumer’s Mini Nutritional Assessments (MNAs) were not being completed correctly which resulted inaccurate risk scores. Furthermore, the Assessment Team found where risks were identified to consumers, the interventions were not implemented or added to the consumer’s care plan. Food charts had not commenced when weight loss was identified, and consumers were not consistently being evaluated upon cessation to assess the current oral intake status.

Evidence brought forward included one consumer who had a total weight loss of 4kg in six months, one weight loss recording was in July 2022 and the next weight loss recording wasn’t until September 2022. Although the consumer was commenced on weekly weights and fortified diet as per progress notes in September 2022, the MNA stated the consumer had normal nutritional status and the recent weight loss was not considered which would change the nutritional status as being at risk. The service’s Malnutrition flowchart stated that malnutrition monitoring was to be conducted monthly, however this was not done monthly for this said consumer.

Another consumer who had a total weight loss of 7.6kg in six months was reviewed by a clinical palliative nurse in October 2022 and although progress notes identified the weight loss of the consumer and recommended commencement on resource drinks for weight management, the Assessment Team found medication charts identified the consumer had not yet commenced on the resource drink and the MNA in October 2022 stated the consumer was at risk of malnutrition. The service’s Malnutrition flowchart stated that malnutrition monitoring was to be conducted monthly, however this was not done monthly for this consumer nor referral to a dietician.

In its response, the Approved Provider set out the actions it took to address the identified deficits. Which included an internal review to identify any residents who had a BMI under 23 for further monitoring, the service conducted 24 Mini Nutrition Assessments, which identified that 3 of 82 residents were either malnourished or at risk of malnourishment and conducted an audit of the service’s practices for deteriorating residents. Any consumers overdue for dietitian reviews were referred and further training for staff was conducted, including in Swallow Assessment, Nutrition and Hydration, Mini Nutrition Assessment and Oedema and Weight Management. Further tool box talks were delivered between 19 and 28 December 2022, regarding Unplanned Weight Loss, Choking & Dysphagia, Choice, Dignity and Risk, with the majority of staff in attendance.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider’s response and have considered the impacts to consumers as a result of the examples provided. I consider overall the service did not demonstrate that appropriate responses to changes or deteriorations in consumer’s condition were effective at the time of the Site Audit. I find Requirement 3(3)(d) non-compliant.

Requirement 3(3)(e)

The Assessment Team found the service did not demonstrate effective processes to ensure consumer’s information was documented accurately and was reflective of the consumer’s current care needs. Feedback from management, consumers, representatives, and staff members identified conflicting information regarding the management of consumers and how information was documented and shared. Examples included: Multiple consumers raised concerns their dietary preferences were not being met even though they had provided information to the service repeatedly. This same evidence is considered and relied on in Requirement 6(3)(a). Furthermore, as outlined in 1(3)(e) and 3(3)(b), three SIRS reportable behaviour incidents documented in behaviour charts were not identified by the service prior to the Assessment Team raising these during the Site Audit. This same evidence is considered and relied on in Requirement 8(3)(c).

In its response, the Approved Provider set out the actions it took to address the identified deficits. Which included the distribution of a booklet on Privacy and Dignity to consumers, and organising additional information resources for service staff, the service has planned external training on interpreting progress notes and issued a memo to staff about the requirement to complete Code Of Conduct training. The service conducted tool box talks between 19 and 28 December 2022, about SIRS and Open Disclosure (76% staff attendance), Incident Management (56% attendance) and Choice, Dignity and Risk (60% attendance) to support staff understanding and delivery of care.

While I acknowledge the action taken by the Approved Provider in response to the Site Audit, I am not satisfied that information about the consumer’s condition, needs and preferences was documented and communicated within the organisation, and with others where responsibility for care is shared. I find Requirement 3(3)(e) non-compliant.

Requirement 3(3)(f)

Generally, consumers and representatives were satisfied with their access to relevant allied health professionals, medical officers, and other specialists, however as outlined in Requirement 3(3)(d), 17 consumers who had lost significant or consecutive weight were not referred to or reviewed by a dietitian. As outlined in 2(3)(a) and 3(3)(a) one consumer’s care documentation did not evidence a speech pathologist review since their admission to the service to address their high risk of choking and aspiration.

The Approved Provider response of 6 January 2023 detailed actions planned and undertaken to address the findings of the Assessment Team which included internal audits and investigation into residents with sustained weight loss or malnutrition, or who experienced aspiration and conducting further individual assessments of those residents. Auditing of the service’s practices concerning deteriorating residents and making overdue referrals, where appropriate. The service has planned additional training and toolbox talks to service staff to enhance awareness and continues to monitor weight loss and other consumer data.

I acknowledge the Approved Provider’s actions, however based on the evidence available to me I am of the view that at the time of the Site Audit, the service did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services. I find Requirement 3(3)(f) Non-Compliant.

I am satisfied the remaining 2 Requirements in Quality Standard 3 are compliant.

Consumers and representatives expressed confidence the service will support consumers to be as free as possible from pain and have those important to them with them when end-of-life care is required. The Site Audit report brought forward mixed feedback from one consumer representative who expressed dissatisfaction with how pain management was provided to the consumer during their end-of-life care. The consumer representative raised concerns with staff that the consumer was in constant pain and suffering following a recent stroke. Although clinical staff initially had concerns with administering doses of morphine, management advised that a consultation had occurred with the consumer’s representative and the consumer had commenced on morphine, for ongoing pain management.

Consumers and representatives were satisfied with precautions in place to manage infectious outbreaks, including those involving COVID-19. Staff demonstrated knowledge of hand hygiene, and the importance of wearing face masks. The service’s Infection Prevention and Control lead collaborated with senior management to oversee infection controls.

# 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. | Non-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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are non-compliant:

* 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.
* Where meals are provided, they are varied and of suitable quality and quantity.
* Where equipment is provided, it is safe, suitable, clean and well maintained.

Requirement 4(3)(a)

Most consumers said they received safe and effective supports for daily living that met their needs, goals and preferences. Staff understood what was important to consumers and what they liked to do, which mostly aligned with information in care planning documents. However, multiple consumers expressed dissatisfaction with changes to the delivery of services, how the service communicated changes to their support and believe that the new approach with regards to daily living have not improved their independence, health, well-being, and quality of life. Consumers said there had been no consultation with them directly about the change in service care and service delivery and said they only became aware of the changes to their care and service delivery model when they asked staff what happened to their breakfast, morning and afternoon tea service delivery and asked why some consumers had to make their own beds and empty their bins. Management said it held consumer representative meetings prior to the new service delivery model and received a positive response from family members.

The Assessment Team brought forward evidence from one named consumer who advised that as result of the changes to the service model they were now expected to make their own hot drinks, empty their own bin and make their bed and stated they had found these tasks progressively more difficult due to mobility issues and hospitalisations. The Assessment Team observed care plans for this consumer that detailed these mobility issues and spoke with staff who acknowledged the supports this consumer required.

In its response, dated 6 January 2023, the Approved Provider submitted explanation of the changes to the services model and advised it was designed and intended to promote consumer independence, the service provides access to snacks, tea and coffee to consumers 24/7 and the option to choose to make breakfast at a time of their choosing. In relation to the named consumer identified by the Assessment Team the Approved Provider disputed this consumer is expected to undertake these tasks and provided care documentation to demonstrate the consumer is supported to with meals and the consumer is supported in making their bed. The Approved Provider acknowledged there were opportunities for further improvements and consumer engagement and undertook to further engage with consumers and ensure plans are individualised and assessed to ensure each consumer receives appropriate support. The service intends to establish a specialised team to work through consumer and staff issues relating to the new service model and develop solutions, the ‘Fundamentals of Household Model’ brochure will be included in Admission Packs, and distributed to consumers, representatives and staff and a standing agenda item regarding the Household Model established in future Resident and Relative Meetings.

While the Approved Provider provided evidence of planned actions to address the deficits brought forward in the Site Audit Report, I have also placed weight on consumer feedback and find at the time of the Site Audit the service did not demonstrate each consumer received safe and effective services and supports for daily living that were meeting their needs and preferences, and did not optimise the consumers’ well-being, independence and health. I find Requirement 4(3)(a) non-Complaint.

Requirement 4(3)(f)

The Assessment Team found the service’s feedback and complaints register contained numerous complaints regarding food choices and quality. Most consumers felt the meals were lacking in quality, quantity and consistency, and no consumers had provided input into their choice of meals and menu preparation, as outlined in the service’s policies and procedures.

In the service’s feedback and complaints register one consumer raised concerns the Household Model does not provide for their preferences of not wanting to make their own morning and afternoon tea, this same consumer raised concerns the evening meals were being served on plastic plates with plastic cutlery and, they did not want to attend the dining room for their meals as they were a private individual. During the Site Audit, the Assessment Team observed staff asking this consumer if they wanted anything from the Supermarket. The consumer asked for fruit to be purchased as they no longer had fruit offered to them. Upon raising with management, during the Site Audit they were advised this said consumer now receives fruit from the kitchen and the plastic plates and cutlery were only temporary. The service further advised crockery and cutlery were now being provided at mealtimes.

A second named consumer who had functional decline and limited mobility and whose care plan stated staff were to set up meals and fluids, including cutting up meals into bite-sized pieces, adding condiments of choice and pouring all fluids. The care plan stated the consumer was able to self-feed, however staff were to supervise and prompt to eat throughout meal service. During the Site Audit, the Assessment Team observed the consumer refusing their food. Members of the workforce removed the uneaten lunch, however, did not offer any alternatives to the consumer. The Assessment Team raised concerns with clinical staff, specifically relating to the options available to consumers who were not wanting to eat the meals provided. The service advised consumers could ask for other options including sandwiches or obtain their own food from the kitchenette. The Assessment Team noted this said consumer would not have this option available, as they were unable to get out of bed due to functional decline.

A third named consumer who required a modified diet due to their risk of choking, said they were often served food which was not of the right consistency according to their dietary requirements. Additionally, this consumer had advised staff on multiple occasions their preferences for no spice however they were still being served food that is not of their preference. For example: an evening meal was served with salmon and potatoes which were not mashed up moist food. The consumer asked staff to provide a sandwich instead however, staff advised they did not have time to make a sandwich. This resulted in the consumer returning to their room with the evening meal and having to pour a cup of soup over the meal in order for them to consumer it. The Assessment Team observed for the same consumer another mealtime where meat and vegetables were layered on top of one another and not to the consumer’s preference for them to be served separately on a plate. Furthermore, the Site Audit report brought forward three occasions where this same consumer was not served the right consistency meal as per their Nutrition and Hydration Form.

The Site Audit report brought forward evidence by the Assessment Team that several food items within the fridge of the Memory Support Unit (MSU) either had no labels or contained little evidence of when the items had been opened and should be discarded, and other food items were out of date. Additionally, for one said consumer, progress notes identified the consumer taking food from the fridge, including eating a large tub of yoghurt with their fingers, and uncooked bacon. Upon raising with management, they advised the service was aware of both incidents, and had instructed staff to reduce the quantity of food items in the MSU fridge. The Assessment Team found by comparison to the other fridges in the service, the food was substantially less in the MSU fridge.

In its response, dated 6 January 2023 the Approved Provider acknowledged some of the deficits identified in the Assessment Team’s report and provided evidence of actions taken or planned to address the deficits. The service has implemented a menu board which is updated daily to provide consumers opportunity to request alternative meals and delivered intensive education and training for staff on the plating of meals, preparation of and provision of thickened fluids and offering alternative meal choices. MNA’s were undertaken for consumers to identify any consumers at risk of malnutrition and a review of all pantry items currently available to consumers was undertaken to ensure the products offered meet the needs of consumers and any unsuitable or out of date products were discarded.

The service has introduced one day per week for other alternatives on the menu such as bacon and eggs for breakfast and undertaken a review of the current menu to ensure additional vegetable options and modified food options are included.

While I acknowledge the actions taken by the Approved Provider both during the Site Audit and following, I have also placed weight on consumers’ feedback and Assessment Team’s observations I consider the meals provided were not of suitable quality or quantity at the time of the Site Audit. I find Requirement 4(3)(f) non-compliant.

Requirement 4(3)(g)

The Assessment Team found although the service had maintenance and cleaning routines implemented, the service had a lack of process controls for completing records, safely producing textile modified foods, complying with temperature control requirements, and ensuring all food and ingredients were fit for intended use and protected from contamination. Additionally, the service was found to have inadequately trained care staff to ensure food handling, cooking, and monitoring was within the requirements of the Food Safety Program. Observations from the Assessment Team found hospitality staff were not wearing the required hair masks, the kitchen’s cool room contained food supplies which were out of date, and the service’s freezer had been left ajar. Management advised the service was addressing each corrective action and had engaged a catering manager to address these issues. Furthermore, the catering manager will train care and hospitality staff on food handling and contamination requirements.

In its response of 6 January 2023, the Approved Provider submitted evidence of actions taken to address the food storage and preparation issues, including evidence of external audits. The service had introduced mandatory food safety training in November of 2022 and planned further training for January 2023 in food production and food safety training for all staff.

While the provider had commenced the implementation of some corrective actions identified in the Site Audit report, I find, at the time of the site audit, the service was not able to demonstrate where equipment was provided, it is safe, suitable, clean and well maintained. I find Requirement 4(3)(g) non-compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 4 are compliant.

Most consumers said they were connected and engaged in meaningful activities that satisfied them and can acknowledge and participate in cultural and religious practices that were meaningful to their culture or religion. Care plans contained information about consumers emotional, spiritual and psychological needs, goals and preferences. Consumers were supported by a Pastoral Practitioner three days per week along with two Religious Sisters who volunteered each week to provide emotional and spiritual support.

Consumers felt the service supported them with their interests, to maintain relationships to the level they wished, take part in community and social activities, and have day-to-day control over what they take part in, how they take part and whom they socialise with. Staff described how they work with other organisations, advocates, community members and groups to support consumers to follow their interests, engage in social activities and maintain their community connections, such as participation in ANZAC and Remembrance Days with wearing their medals and participating in the commemorations at the service.

Consumers provided mixed feedback on how the service generally coordinated their care needs in an efficient manner, and whether they benefited from different organisations working together and sharing information. Most consumers said they had consented to information about them being shared with others and, as a result, they have continuity of services and support and don’t have to repeat their story or their preferences to multiple people. Most consumer’s care plans provided sufficient information for staff to understand consumer’s interests, history and background.

The service had established networks with individuals, organisations and providers to ensure consumers had access to a range of services and supports. Consumers said where the service was not able to provide services or support, they were referred promptly to other organisations or providers to meet their needs, goals and preferences.

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* The service environment:

1. is safe, clean, well maintained and comfortable; and
2. enables consumers to move freely, both indoors and outdoors.

The Assessment Team observed most consumers moving freely around the service and gardens however, consumers within the Memory Support Unit (MSU) were not able to access areas freely due to the doors on multiple occasions being locked or malfunctioned. Although management advised consumers who were permitted to move freely inside and outside of the service had the door code, the service was not able to provide the details of which consumers had this code. The Assessment Team found the service was maintained in terms of cleanliness. However, cleaning staff said their hours and staffing levels had been significantly reduced as part of the Household Model which required care staff and/or consumers to clean consumers rooms. This evidence is considered further in Requirement 7(3)(a).

In its response, dated 6 January 2023 the Approved Provider acknowledged the deficits identified in the Assessment Team’s report and provided evidence of actions taken to address the deficits, which included the placement of the door code in proximity to each controlled door and the deactivation of sensors that now allow freedom and safety of consumers to use the door.

I acknowledge the actions taken by the Approved Provider in response to the Assessment team’s report, however, at the time of Site Audit the service did not support consumers to move freely to outdoor areas. I find Requirement 5 (3)(b) non-Compliant.

I am satisfied the remaining 2 Requirements in Quality Standard 5 are Compliant.

The Assessment Team observed the service’s front entrance was welcoming, bright and easily accessible. Consumers were encouraged to personalise their rooms. Staff described how they supported consumers to maintain independence and individuality. For example: several consumers participate in maintaining the service’s plants and gardens where possible.

Consumers and staff said they had access to sufficient, well maintained, safe and cleaned equipment. Furniture and equipment were maintained under a scheduled maintenance plan. Although maintenance staff confirmed the service had experienced disruptions to its maintenance service levels due to the service’s regional location, management demonstrated how maintenance requests were logged, recorded and actioned in accordance with the service’s procedures.

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

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that all 4 requirements in this Quality Standard are non-complaint.

Requirement 6(3)(a)

The service has an incident and complaints management policy and procedure that guides staff on feedback and complaints however, the Assessment Team found that management and staff were not following the process to ensure feedback and complaints are logged, reviewed, and appropriately managed. Consumers and representatives said that although they are provided the opportunity to give feedback, they are not provided with any follow-up or resolution regarding their concerns. Some consumers and representatives said they were aware of how to provide feedback, utilizing the feedback forms, however, preferred to speak to staff directly to raise any concerns. Feedback forms were observed at the front entrance amongst several other brochures and documents.

Five consumers interviewed at a meal service advised that they were unhappy with their meals and the new care and service model and stated that they raise their concerns ‘again and again’ however the same issues arise. They also advise that their complaints have not been acknowledged, addressed, or actioned.

The Assessment Team observed two named consumer who, during two different meal services raised concerns over their meal, when brought to the attention of the catering manager, the meal was replaced, and the staff member was observed standing over each of the consumers and speaking loudly about the concerns raised. The Assessment Team observed one of the named consumer’s care plans required them to have soft meals, which was not provided during the meal and spoke with the representative of the second named consumer who confirmed they have made several complaints about the meals served. These complaints were not captured in the feedback log.

The Approved Provider responded on 6 January 2023 and advised that the service has undertaken a review of all feedback and complaints received in the preceding six months and followed up with complainants to ensure appropriate outcomes had occurred. Additional complaints feedback and management processes had been discussed at staff meetings, food focus groups had been held with consumers to understand preferences and feedback sought at mealtimes, updates to feedback will be circulated through resident newsletters and apologies made to consumers in relation to issues raised regarding meals.

I have considered the additional evidence provided by the Approved Provider as well as the evidence brought forward by the Assessment Team, while I acknowledge the actions taken and proposed by the Approved Provider to support consumers in making complaints, I have also placed weight on the feedback of consumers and consider that some of the planned actions, such as staff training and focus groups will take time to roll out and measure for effect. I find Requirement 6(3)(a) non-compliant.

Requirement 6(3)(b)

Consumers and representatives interviewed stated that they were not aware of other avenues for raising a complaint such as through the Aged Care Quality and Safety Commission (the Commission) or through a formal advocate service. There were posters on advocacy services on display at the reception in an area that were not easily visible and hidden behind a vase of flowers. Brochures were on display at the front entrance however there were no brochures regarding making a complaint in other languages. Staff did not demonstrate an understanding of external complaints and feedback avenues, including advocacy and translation services, available for consumers and representatives. Staff stated that any complaints raised by the consumers or representatives would be escalated.

The Assessment Team identified two named consumers from Culturally and Linguistically Diverse (CALD) backgrounds whose care plans stated they may have difficulty expressing their needs and require further support and potentially requiring language services, there were no supports in place for these consumers.

The Approved Provider responded on 6 January 2023 and acknowledged the findings of the Assessment Team and advised that follow up case conferences had been held with consumers to and capture any feedback in relation to the care and services provided, the service has also relocated posters and brochures on advocacy services throughout the service and provided information on how to make a complaint in different languages throughout the service. The service has also undertaken to provide additional training to staff in relation to external feedback, advocacy and translation services available to support consumers.

I have considered the additional evidence provided by the Approved Provider as well as the evidence brought forward by the Assessment Team, while I acknowledge the actions taken and proposed by the Approved Provider, I have also placed weight on the feedback of consumers in that the service did not provide access to advocates, language services and other methods for raising and resolving complaints. I find Requirement 6(3)(b) non-compliant.

Requirement 6(3)(c)

The service has policies and procedures regarding the handling of feedback and open disclosure however staff, consumers and representatives could not confirm an understanding or provide an example of open disclosure being used. The Assessment Team’s review of the service’s documents shows that management has not addressed concerns raised by consumers and staff which relate to incidents involving serious incident reporting requirements. A review of the service training matrix demonstrated that only 10% of staff completed Open Disclosure training in January 2022 via a toolbox session.

The Assessment Team brought forward evidence of one named consumer and their representative who had raised multiple concerns about issues with the laundry service and dietary needs and preferences not being met, verbally, via phone calls and emails to the Service Manager across two months, however, the issues continue, and the concerns were not addressed, or an apology given. The Assessment Team reviewed the feedback log that demonstrated one complaint by the representative in relation to food with no other issues documented. Management could not provide any further clarification on these issues at the time of the Site Audit. The Assessment Team requested examples of open disclosure by the service on a number of occasions and they were unable to provide any examples where open disclosure was used.

In its written response of 6 January 2023, the Approved Provider confirmed that case conferences had been held with the consumers and representatives named in the Site Audit reports to understand and resolve any outstanding issues and the consumer reimbursed for any lost laundry. The service has also undertaken to conduct further training in open disclosure, and serious incident reporting and advised this will continue throughout 2023. The Approved Provider also provided evidence of the policies in place to guide the feedback and complaints processes that include open disclosure.

I have considered the additional evidence provided by the Approved Provider as well as the evidence brought forward by the Assessment Team, while I acknowledge the actions taken and proposed by the Approved Provider, I have also placed weight on the feedback of consumers and consider that some of the planned actions, such as staff training will take time to roll out and measure for effect and am of the view that appropriate action was not taken in response to complaints and an open disclosure process used at the time of the Site Audit. I therefore find Requirement 6(3)(c) non-compliant.

Requirement 6(3)(d)

Management advised that the service trends feedback and complaints and the results are reported and shared at resident and staff meetings that occur monthly. However, a review of the service meeting minutes did not demonstrate the trends and analysis of feedback made by consumers and representatives are captured in the meetings and are used to inform continuous improvement activities across the service. Resident and representative meeting minutes could not demonstrate that changes and improvements made at the service are discussed and consumer input is considered.

Consumers and representatives sampled were not able to describe the changes implemented at the service as a result of feedback and complaints and were unable to provide examples of how any feedback is used to improve the quality of care and services. The staff interviewed were unable to provide any examples of changes made by the service in response to feedback and complaints.

In its written response of 6 January 2023, the Approved Provider further detailed the systems in place to use feedback to improve services, the Approved Provider advised that complaints are reviewed monthly and proposed actions discussed. The service further advised that a review of the resident meeting minutes will be undertaken, and outstanding items logged into the incident managements system, feedback data and trend analysis and feedback will be reviewed monthly, and any improvements made communicated to consumers. Staff will also receive further training on the complaints process, due to be completed by January 2023.

I have considered the additional evidence provided by the Approved Provider as well as the evidence brought forward by the Assessment Team, while I acknowledge the actions taken and proposed by the Approved Provider, I have also placed weight on the feedback of consumers and consider that at the time of the Site Audit the service did not demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. I find Requirement 6(3)(d) non-compliant.

# 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. | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that all 5 Requirement in this Quality Standard are non-complaint.

Requirement 7(3)(a)

The Assessment Team brought forward evidence that, while the service planned its workforce, the number and mix of staff was insufficient to deliver safe and quality care. Consumers, representatives, and staff provided feedback that they felt there were insufficient staffing levels to ensure the care and services are delivered and managed to ensure their quality and safety is considered and stated that a number of roles have been removed from the service. Staff said they did not have time to complete all their assigned tasks, as with the introduction of the new services model they were now also expected to undertake cleaning, meal preparation and lifestyle activities along with caring duties. Call bell response records showed patterns of response times exceeding 12 minutes. The Assessment Team reviewed progress note records for long call bell response times and found that staff had often missed entering those progress notes and the service had not reviewed the impact of long responses on consumers.

The Assessment Team raised these concerns with management on site who indicated that ‘a cultural issue’ within the service gave the perception of a staffing shortfall. Management also said the successful implementation of the Household model at other services was proof the model was viable.

In its response of 6 January 2023, the Approved Provider disputed some of the Assessment Team’s findings, stating that:

* The staff ratio at the service was sufficient and comparable to other services the Approved Provider runs.
* Staff had extensive support and training in the 14 months prior to the Site Assessment to prepare for changes.
* There had been an improvement in its call bell response times between July and November 2022 of 4.2%.
* The service had implemented a follow up process requiring staff to monitor long call bell response times and follow up with affected residents, among other initiatives.

The service had also undertaken a staff health check in November 2022 and established support teams to address issues in relation to food service and provide general support and resources to staff. The service continues to recruit additional staff and planned staff meetings for January 2023 to address workflow, engagement, and service model issues.

I have considered the evidence brought forward in the Site Audit Report and the Approved Provider’s response. I am satisfied that the evidence establishes that the service is not delivering quality care to consumers and that the number and mix of staff at the service was insufficient at the time of the Site Audit. Based on the evidence before me, I find the service non-compliant with Requirement 7(3)(a)

Requirement 7(3)(b)

The Assessment Team found that the service was ‘dismissive’ when consumers raised concerns and found the culture at the service was ‘not kind, caring and respectful’. The Assessment team spoke with staff who stated they tended to ‘brush off’ complaints about the service’s food and observed the Catering Manager being rude in response to a complaint the Assessment Team witnessed on site. Consumers stated that the service manager ‘does not care’ about complaints. The Assessment Team also found multiple entries in consumer files suggesting the service did not show kindness and care to consumers. Examples include staff telling consumers ‘we are not wait staff’ during food service, and other situations where tone and delivery conveyed rudeness.

In its response of 6 January 2023, the Approved Provider acknowledged that staff communication within progress notes may not have been respectful. Since the Site Assessment, the Approved Provider has sent a memo to staff about the appropriate writing of progress notes and delivered further training. The Approved Provider stated that management at the service had changed three times over the previous year. The Approved Provider also noted it had received two formal complaints since August 2022, and that it had followed up with the complainants but had received no further feedback.

I have considered the evidence in the Site Audit report and the Approved Provider’s response, I have placed weight on the examples of specific service staff behaviour and observations made by the Assessment Team. Based on this, I hold the view that, at the time of the Site Audit, the service did not demonstrate that its interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity. I find the service non-compliant with Requirement 7(3)(b).

Requirement 7(3)(c)

The Assessment Team could not confirm that the service’s workforce was competent, and that it had the knowledge and skills to perform its role. The Assessment Team reviewed several care plans and found that a staff member had completed two care plans when they were not qualified to do so. Other care plans did not accurately reflect consumers’ current needs. Staff were confused about their roles and cited the service’s implementation of its Household model as a causal factor. Eight staff stated they were not familiar with their changed role, or the service’s expectations of them. They also stated they had not received training on food service and did not feel confident serving food to consumers. Some consumers reported that they require food to be a specific consistency and staff did not know this, so they often received food inappropriate for them.

The Approved Provider’s written response of 6 January 2023 undertook to audit care plans and ensure only qualified staff have signed them off, additional training on the new service model was planned for January 2023 and all staff received additional training on food handling and service. Additional quality coaches and leadership were put in place from December 2022 to provide guidance to staff on the scope of their roles.

I have considered the Assessment Team’s evidence and the Approved Provider’s response and have placed weight on the feedback from staff who stated they were not familiar with their roles or expectations and have considered the additional training planned by the Approved Provider will take time to deliver and measure for effect. I am satisfied that the service did not demonstrate an appropriately competent and qualified workforce at the time of the Site Audit. I find Requirement 7(3)(c) non-compliant.

Requirement 7(3)(d)

The Assessment Team found the service did not provide sufficient education to its 72 staff concerning key aspects of the Quality Standards, and that it was overdue to provide education in several other areas. The Assessment Team reviewed the service’s training schedule, which showed that multiple staff members had not completed several training modules, across subjects including infection control, nutrition, managing deterioration, privacy, dignity and respect, managing risks, mandatory reporting, and the Serious Incident Response Scheme. Management advised that it offers various forms of training in addition to formal training, such as face-to-face, toolbox, and online modules through the service’s online platform, ULearn. Management also stated recent leadership changes, and COVID-19 outbreaks had impacted the service’s training schedules.

In its response of 6 January 2023, the Approved Provider stated that due to the service and staff having been acquired in the year preceding there had been a delay in staff training. The response detailed an action plan to engage with staff and ensure further staff training would be delivered and online training completed by staff throughout January 2023.

I have considered the evidence in the Site Audit report and the Approved Provider’s response, while I acknowledge the action taken and planned by the Approved Provider, based on the significant number of staff who had not completed core training modules at the time of the Site Audit, remain of the view that the service did not demonstrate the workforce was trained and equipped at the time of the Site Audit. I find the service non-compliant with Requirement 7(3)(d).

Requirement 7(3)(e)

The Assessment Team found that staff knew about the service’s performance management processes, however, all interviewed staff could not recall the last time they completed a performance review. In total, the Assessment Team found that 42 staff had overdue performance appraisals. A review of documentation found one performance appraisal document was marked as complete but the individual performance goals it contained had not been completed or signed off. Management advised that it utilises audits, consumer clinical evidence, and general staff competencies, in order to review, assess and monitor the performance of each staff member and monitors staff practices through regular activities, progress notes, review of care planning documents, and feedback from multiple sources.

The Approved Provider’s formal response of 6 January 2023 acknowledged the Assessment Team’s findings and undertook to have all staff appraisals completed by February 2023.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider and consider that while the service observed staff performance through various informal methods. The evidence did not show that they had an effective formal system to track and address staff knowledge gaps and assess performance at the time of the Site Audit, I therefore find Requirement 7(3)(e) non-compliant.

# 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. | Non-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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | 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. | Non-compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied that all 5 Requirements in this Quality Standard are non-complaint.

Requirement 8(3)(a)

The Assessment Team brought forward evidence that the service did not seek consumer input concerning changes to the care and services model. Consumers gave several examples relating to the food service and their dissatisfaction and stated that they previously received two hot meal options for each meal-service, following recent changes this has been reduced to one meal option per service. Consumers reported that the service did not consult them about this change. Five consumers reported they had asked for either sandwiches or salad to replace a meal and the service told them they either did not have a choice, or that it did not have time to prepare their selection. As a work-around, consumers reported using their own money to purchase food items, which they kept in their rooms. Consumers also said, in general, they were not included in discussions about their care, and the service did not seek their input or inform them of changes to their care. Consumers identified the transition to the Household model as a major source of friction, saying the service did not consult them enough about its implementation. The Assessment Team reviewed the service’s continuous improvement plan and meeting minutes while on site. These documents did not show the service had asked consumers for feedback about the move to the Household model.

In its formal response, of 6 January 2023, the Approved Provider disagreed with the Assessment Team’s findings. The Approved Provider said it originally engaged with residents about the change to the Household model prior to 1 October 2021, and again on 17 February 2022 and 17 March 2022. The Approved Provider also said the organisation held monthly ‘Resident and Relative’ meetings, where it circulated descriptions of the Household model to participants. The Approved Provider said the service also conducted a ‘Voice of the Customer’ survey on 28 and 29 November 2022 and claimed the results of the survey showed residents made ‘the general comment they were happy’.

I have considered the evidence brought forward by the Assessment team and the Approved Provider’s response, I have placed weight on the feedback from consumers and the impacts described in relation to meal service and the reported lack of engagement. While I acknowledge the undertakings from the Approved Provider to conduct additional consumer engagement, staff training and communication, I am of the view that at the time of the Site Audit the Approved Provider did not demonstrate consumers were engaged in the delivery of care and services. I find the service non-compliant with Requirement 8(3)(a).

Requirement 8(3)(b)

The Assessment Team submitted evidence suggesting the service did not demonstrate a culture of safe, quality care. The Assessment Team identified that the service’s assessment and care planning processes did not consider all risks to consumers’ health and well-being and some staff could not identify risks to consumers’ health, the governance and monitoring systems failed to consistently address, manage, or update care plans and assessments relating to consumers’ weight loss, health risks, and individual risk-taking behaviours. The service did not have specific procedures for incident management. Instead, it relied on staff using relevant checklists for different types of incidents.

The Approved Provider’s response refuted the Assessment Team’s submission. Concerning the service’s alleged failure to update consumers’ care plans and assessments the service’s response described actions it took concerning the care of specific residents. Concerning the Assessment Team’s finding that the service did not have adequate incident management procedures in place the Approved Provider noted this finding was based on statements the Service Manager made to the Assessment Team during the assessment. In contrast, the Approved Provider’s response stated that the service did have incident management procedures in place and that the service manager was unaware of this because they were new to the role.

I have considered the evidence in the Site Audit report and the Approved Provider’s response and considered the feedback from consumers and examples brought forward by the Assessment Team. I am satisfied that at the time of the Site Audit the service did not demonstrate a culture of safe, inclusive and quality care and services. I find Requirement 8(3)(b) non-compliant.

Requirement 8(3)(c)

The Assessment Team found that the organisation had governance committees to provide guidance and oversight for its care practices. However, the Assessment Team’s evidence suggested the service had not implemented its systems and practices effectively to ensure it provided safe, high-quality services. The findings concerned the following areas:

Information management

The service utilises an electronic care planning system that provides staff and management access to consumers’ clinical documentation. Other methods used to disseminate information to staff are handovers conducted at the beginning of each shift, staff meetings, training and education. Management advised that the organisation is a member of peak bodies to ensure the service remains updated with any regulatory or legislative changes that are then filtered down to staff and consumers through meetings and correspondence.

Continuous improvement

The service has a continuous improvement plan in place that has initiatives that come from a variety of sources, that include, management decisions, and audits, however, consumer and representative feedback trends and weight loss are not identified and entered into the continuous improvement plan to ensure high-quality care and services. Management was able to describe the process for implementing and reviewing the improvement initiatives however, a review of the continuous improvement plan identified that 19 out of 22 initiatives were overdue with one initiative being over 12 months old. A review of staff and consumer meeting minutes did not demonstrate any discussions of the continuous improvement plan with staff, consumers or representatives. A review of the Audit schedule identified that of the 9 mandatory audits to be completed for the month of November, one was 25% complete and the remaining 8 had not commenced.

Financial Governance

Management advised they are responsible for managing the annual budget for the service, and additional expenditures in excess of the annual budget or changes to the budget are referred to the executive management for approval. The organisation has implemented a ‘one hot meal choice’ for consumer meals as a result of wastage. All consumers are provided the one choice unless they have the capability to advise otherwise.

Workforce Governance

The organisation has processes in place to ensure appropriate recruitment and selection of staff and the service has a credentialing process in place as well as a mandatory training schedule that is required to be completed annually by all staff, however, the staff training records demonstrate several staff with outstanding training requirements.

The service did not give staff duty statements to guide them in their roles and workload prioritization. The service also had a performance review process, but numerous staff had outstanding reviews and previously discussed in Requirement 7(3)(c).

Regulatory Compliance

Staff were not effectively trained in regulatory compliance, and the service did not identify some incidents as Serious Incidents Reporting Scheme (SIRS) incidents. Consent forms are in place for restrictive practices related to chemical restraint, however, the service did not recognise that several consumers were subject to environmental restraint.

Feedback and Complaints

The service did not demonstrate how they partner and engage with consumer experiences to assist the service to evaluate the care provided. Consumers stated they are not involved in making decisions for service planning and evaluating care within the organisation. The process of documenting, investigating, resolving, and evaluating feedback and complaints was not effective and the service does not always capture consumer complaints and concerns in the feedback log.

In its response of 6 January 2023, the Approved Provider acknowledged some of the deficits outlined and provided a continuous improvement plan, to support a return to compliance. The plan contained several undertakings, including training to staff in multiple areas relating to service delivery, recording of care documentation, regulatory compliance and general topics relating to the delivery of clinical care. The Approved Provider detailed the system it has to manage risk and reporting and risk management and discussed the various policies, processes and systems the service had to receive feedback. The Approved Provider advised that it has created continuous improvement action items to address unresolved consumer feedback.

I acknowledge the service is taken appropriate steps to address the deficits outlined in the Site Audit Report. I also acknowledge the service has access to relevant organisational policies and procedures to guide practice, however, did not demonstrate these were effective in delivery. The service did not demonstrate workforce governance, continuous improvement, feedback and complaints or regulatory compliance systems were effective at the time of the site audit based on the evidence and outcomes above and throughout the Site Audit report. Information about consumers’ clinical and personal care needs were not accurately, documented or communicated, resulting in deficits in personal and clinical care delivered. The service had not accurately completed feedback and complaints logs or incident logs to ensure areas for improvement were identified and other monitoring processes did not identify areas for improvement as identified through the site audit. While the service has identified appropriate governance improvements to address the issues outlined, at the time of the Site Audit the service did not demonstrate effective governance systems. I find the service non-compliant with Requirement 8(3)(c)

Requirement 8(3)(d)

The Assessment Team found the service did not have effective risk management systems in place to effectively manage, report and prevent risks and incidents. The Assessment team identified:

* 29 consumers with significant weight loss
* Some consumers who were not assessed for ability to safely make their own breakfast, morning tea or afternoon tea, which was a requirement under the Household model of care.
* The service did not appropriately report some SIRS incidents
* The service had not considered the potential environmental restraint impacts on some consumers
* Smoking assessments for two consumers were not escalated through the service’s risk-governance structure

Staff training records showed that multiple staff had not received relevant risk training. During interviews, staff could not explain how risk management applied to their work. The Assessment Team found that a primary reason for the service’s deficiencies concerning risk management was that service staff didn’t escalate risks through its management structure, so that its risk triaging committees could address them.

The Approved Provider’s response of 6 January 2023 detailed the risk assessment and monitoring protocols in place across the service. The Approved Provider submitted that there are assessments in place to assess risks at an individual level and access to staff to escalate issues to clinical teams for support. The Approved Provider stated there is management oversight of high prevalence risks through Quality Forums and quality data is reviewed and monitored monthly through quality indicators and audits to identify potential risks. The Approved Provider provided evidence of policies and process guidance on the management of high impact risks in place.

While I acknowledge the additional evidence and explanation provided by the Approved Provider, I have also considered the evidence brought forward by the Assessment team and find that the application of the risk management systems and processes were ineffective at the time of the Site Audit. I find the service non-compliant with Requirement 8(3)(d).

Requirement 8(3)(e)

The Assessment Team found evidence that care staff at the service were not aware, and could not provide examples, of how the concepts of anti-microbial stewardship, minimising restraint, and open disclosure were relevant to their roles. Most staff advised they had received training about these concepts, but they did not recall the training. One sampled staff member had attended training a few days prior to interview and was able to explain the principles.

Management demonstrated an understanding of the underlying principles of open disclosure, however, were unable to provide examples of where an open disclosure process was applied. The Assessment Team also found minimal evidence the service practiced open disclosure when things went wrong, as discussed previously in assessment of the service’s performance against Requirement 6(3)(c).

The Approved Provider’s response of 6 January 2023 advised that the service has and established Clinical Governance Framework and Policy in place and a dedicated Clinical Governance Committee with leadership oversight with dedicated roles and accountabilities for quality and safety. The response also detailed the ongoing staff training through formal education, toolbox talks and memo’s that have been delivered or are planned to support staff in antimicrobial stewardship, minimising the use of restraint and open disclosure.

I acknowledge the service has identified relevant improvements to address the issues identified by the Assessment Team. However, at the time of site audit, the service did not have effective clinical governance, safety and quality systems in place to maintain and improve the reliability, safety and quality of clinical care, particularly in relation to open disclosure and minimising the use of restraints. Incident reporting and complaint handling was deficient, and consumers said the service did not apologise when things went wrong. Staff were not aware of principles of antimicrobial stewardship. Based on the reasoning and evidence outlined above, I find the service non- compliant with Requirement 8(3)(e).

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)