Performance

Report

1800 951 822

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Performance report date: |
| Uniting Elanora Shellharbour | 27 July 2022 |
| Commission ID: | Activity type: |
| 0969 | Site audit |
| Approved provider: | Activity date: |
| The Uniting Church in Australia Property Trust (NSW) | 31 May 2022 to 2 June 2022 |

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

**This performance report**

This performance report for Uniting Elanora Shellharbour (**the service**) has been considered by Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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:

* 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 1 July 2022
* other information and intelligence held by the Commission in relation to the service.

**Assessment Summary**

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **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)(b) - The Approved Provider ensures that care and services are culturally safe
* Requirement 3(3)(a) - The Approved Provider ensures that each consumer receives safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being
* Requirement 3(3)(b) - The Approved Provider ensures the effective management of high impact or high prevalence risks associated with the care of each consumer
* Requirement 4(4)(f) – The Approved Provider ensures that where meals are provided, they are varied and of suitable quality and quantity
* Requirement 6(3)(c) - The Approved Provider ensures appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong
* 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)(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)(d) - The Approved Provider ensures effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers.

# Standard 1

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

## Findings

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

* Care and services are culturally safe.

The Assessment Team identified several Spanish speaking consumers who expressed disappointment and at times discomfort at not having staff to communicate in their native language and reported at times this impacted the delivery of care and services they receive. Some consumers reported difficulty communicating request and care needs to staff who would need to source a Spanish speaking colleague, other consumers described requiring assistance reading menus that were only offered in English.

In its response of 1 July 2022, the Approved Provider submitted further evidence in response to the Site Audit report, acknowledged the feedback and advised it has undertaken the following improvements: updated copies of the current food menu, newsletter; and activity calendar in Spanish (with other languages planned to be rolled out in future); and laminated Spanish cue cards that are now placed in consumers’ rooms. The Approved Provider has also committed to engaging an interpreter to assist with translation services.

I acknowledge the actions taken by the Approved Provider in response to the Site Audit, however, based on the evidence brought forward by both the Assessment Team and the Approved Provider I find the service is non-compliant with Requirement 1(3)(b).

I am satisfied that the remaining five requirements of Standard 1 are compliant.

Consumers and their representatives said staff treat consumers with dignity and respect and are aware of their heritage. Staff showed an understanding of consumers’ backgrounds and preferences and described how these guided how staff tailor care to meet consumers individual needs. Staff were observed treating consumers with respect and greeted them by their preferred names. Care planning documents reflected consumers’ cultural, spiritual and activity preferences.

Staff encouraged consumers to be independent and respected their choices. Care planning documents showed that staff completed risk assessments for consumers. Consumers said staff discussed individual risks with them and respected their choices to engage in activities involving risk.

# Standard 2

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

## Findings

The Assessment Team recommended the following requirements were not met:

* Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* 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.

The Assessment Team brought forward evidence of consumers and consumer care plans that did not record non-pharmacological interventions for pain relief, current treatments or current care needs. Risk assessments that did not consider and include consumer’s capacity and/or ability to use mobility equipment and consumers that should have had risk assessments in place without one or with missing information. A representative also raised concerns with the Assessment Team in relation to the oral, and personal hygiene care provided to consumers.

The Approved Provider’s written response, received 1 July 2022, included additional information regarding the issues identified by the Assessment Team. The Approved Provider submitted additional evidence to demonstrate how and when nonpharmacological strategies are applied by the service and noted that in some cases these had not been recorded correctly, however this had since been rectified.

The service uses the Abbey Pain Scale to assess and manage pain in consumer and staff outlined that when initial interventions were ineffective, alternative strategies were identified. The Approved Provider submitted evidence to demonstrate that risk assessments had been appropriately completed and uploaded into the electronic system.

In relation to the representative who raised concerns about care provided, the service advised that oral care routines are undertaken on a daily basis, undertook to provide additional education to staff in relation to this and engage with representatives to ensure expectations are being met.

I have considered the totality of evidence brought forward by the Assessment Team and the Approved Provider in its written response and I am satisfied the Approved Provider is meeting its obligations in relation to Requirement 2(3)(a).

The Assessment Team brought forward evidence relating to the consumer’s current needs and preferences, including end of life planning identified within the assessment and planning process reported by the Assessment Team that included; care plans that did not correctly reflect consumer care or meal preferences, care plans that included generic pain management strategies and a lack of individualised evaluations, representatives who raised concerns about the personal care provided to consumers not being in line with their preferences.

The Approved Provider’s written response, received 1 July 2022, included additional information regarding the issues identified by the Assessment Team. In relation to the care plans that did not reflect individual preferences the Approved Provider submitted additional evidence or explanation in each instance of individual engagement or external referrals that have taken place to support consumers, the Approved Provider acknowledged that while pain management strategies were generalised, all consumers had a pain plan in place as per the internal policy and that pain was managed for all identified consumers. In relation to the representatives who raised concerns about personal care, the Approved Provider submitted additional evidence to demonstrate how it is meeting consumer care needs and where necessary, additional follow up and engagements with representatives to understand their feedback.

I have considered the information provided by the Assessment Team and the Approved Provider. At the time of the Site Audit and based on information available, I find that the service identified and addressed the consumer’s current needs, goals and preferences. Therefore, I find the service compliant with Requirement 2(3)(b).

I am satisfied that the remaining three requirements of Quality Standard 2 are compliant.

Care planning documentation demonstrated that consumers and representatives are consulted throughout assessment and care planning, and when required, input is sought from health professionals. Consumers and representatives confirmed they are involved in meetings with the service to discuss their care plans and provide feedback.

Consumers and representatives confirmed the outcomes of assessment and planning have been communicated and are able to access consumer care plans upon request. The outcomes of assessment and planning is documented within care plans, conference notes and progress notes and is accessible to staff and visiting health professionals.

Care planning documentation confirmed that care plans were reviewed on a regular basis, when consumer circumstances changed, or incidents occurred. Staff were aware of the incident reporting process and how incidents may prompt the need for a reassessment of care and services.

# Standard 3

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

## Findings

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.

The Assessment Team found deficiencies in the delivery of care in services in relation to the management of; pain, falls, wound, and medication.

Care plans lacked assessment or management plans and sufficient recording of treatment for consumers receiving care in relation to pressure injuries, skin integrity issues, diabetes management and general management of pain. The Assessment Team identified some gaps in the management of pressure injuries and identified two named consumers for who records did not show consideration of further strategies for wound improvement and a referral to a wound specialist and an unchanged dressing resulting in referral to a Medical Officer over concerns of infection.

In the written response of 1 July 2022, the Approved Provider responded to the issues raised relating to individual consumers and provided explanation of the care provided to individuals, including evidence of updated care plans. The service provided further detail in relation to the management of pressure injuries, including tracking and recording information electronically, which automatically escalates cases to wound management specialists, ongoing internal reviews and clinical governance oversight.

The service provided further detail of actions taken in response to the Site Audit, which included; additional staff training and communication, engagement with representatives and consumers to understand and address some concerns raised to the Assessment Team and engagement with external provider of care to ensure best practice delivery of care moving forward.

I acknowledge the additional explanation and undertakings provided by the service; however, based on the totality of evidence, find that at the time of the Site Audit, the service did not demonstrate effective delivery of best practice care and services. Therefore, I find requirement 3(3)(a) is non-compliant.

The Assessment Team brought forward evidence that clinical care was not consistently effective when managing high impact or high prevalence risks associated with the care of each consumer. The Assessment Team found that risks in relation to falls, skin and wound care and hydration are not effectively identified and managed by the service and identified the following examples.

* Consumers on ‘as required’ medications, administered for behaviour and pain management were not reviewed following administration and there was insufficient evidence to show that alternate strategies were attempted prior to use
* Consumers with a diagnosis of diabetes, without diabetic management plans in place
* A high number of representatives who reported that consumers had experienced one or more falls, some unwitnessed and some resulting in injuries, which aligned with service – wide falls data reviewed by the Assessment Team.

In the written response of 1 July 2022, the Approved Provider acknowledged some of the deficiencies identified by the Assessment Team and advised of the actions taken in response to the site audit, which included additional guidance and education for staff administering medication. The Approved Provider disputed some of the findings of the Assessment Team in relation to the management of diabetes and prevalence and management of falls risks and provided additional information in relation to these issues. While I accept the additional explanation provided by the Approved Provider, I find that at the time of the Site Audit the service did not demonstrate effective management of risks for each consumer. Therefore, I find requirement 3(3)(b) is non-compliant.

I am satisfied that the remaining five requirements of Quality Standard 3 are compliant.

The service was able to demonstrate consumers who are nearing end of life have their dignity preserved and care is provided in accordance with their needs and preferences. Deterioration or changes in a consumer’s health is recognised and responded to in a timely manner, as confirmed by care planning documents reviewed by the Assessment Team. Staff described examples regarding how they recognised and responded to consumers’ health deterioration.

Representatives indicated the service provides regular communication between consumers, representatives and allied health professionals and are satisfied the consumer’s condition, needs and preferences are documented. Staff demonstrated that changes in the care and services of consumers are communicated within the service through progress notes and handover processes.

Care planning documentation evidenced timely referrals to medical officers, allied health therapists and other providers of care and services. Staff described how recommendations made by visiting allied health providers are documented within the consumer’s progress notes and care plan.

# Standard 4

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

## Findings

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

* Where meals are provided, they are varied and of suitable quality and quantity

The Assessment Team spoke with consumers who expressed dissatisfaction with the quality of the meals provided. Common trends identified through consumer feedback indicated that food is not served at a suitable temperature, meats are tough and dry and there is a lack of consumer engagement in the creation of menu choices.

Care plans for three named consumers did not identify their meal preferences and the Assessment Team observed during the first day of the Site Audit, that meals were presented in an unappetising manner. This was rectified by the third day, when the Hotel Food Specialist was on site and the food was presented in a more appealing manner.

The Approved Provider’s written response, received 1 July 2022, explained that meals are received from the Uniting Production Kitchen and individually packed with cooking/reheating instructions on the label for staff to quality check and set the appropriate oven temperature and time. The service acknowledged the feedback provided by consumers and outlined the systems and processes in place for the provision of food services. The service acknowledged the issue in relation to care planning documentation that did not identify meal preferences for three consumers; and have since updated the care plans of these consumers to be consistent with their preferences.

The Approved Provider also undertook steps in relation to the presentation of meal including meals being monitored to ensure quality is not affected. For example, not placing in the oven too early or being left in too long, the Care Coach eating with the residents and checking that the dining experience is good and the implementation of meal experience cards,

Whilst I acknowledge the immediate action taken by the Approved Provider to address the issues surrounding the quality of the meals provided, at the time of the Site Audit, based on consumer feedback, the service did not demonstrate the provision of meals that were of suitable quality. I therefore find Requirement 4(3)(f) non-compliant.

I am satisfied that the remaining six requirements of Quality Standard 4 are compliant.

Consumers and representatives felt supported to engage in their chosen activities and have the supports in place to allow them to achieve their needs, goals and preferences. Staff outlined assessments are completed with input from consumer and their representative upon and after entry to the service.

Consumers expressed the service provides support for daily living to promote the emotional, spiritual and psychological well-being for each consumer. Care planning documentation evidenced the identification of consumer’s interests and the supports required to support their emotional, spiritual and psychological well-being.

Care planning documentation included information about the interests of consumers and detailed the supports that assisted consumers to participate in their community, within and outside of the organisation's service environment, have social and personal relationships and do the things of interest to them. The Assessment Team observed consumers participating in group and individual activities and sharing meals together.

Consumers and representatives expressed that information about the consumer’s condition, needs and preferences are effectively communicated within the organisation and with others where responsibility is shared. Staff indicated that changes to consumers’ care and services are communicated through the handover process and alerts in the electronic care system.

Care planning documentation demonstrated the occurrence of timely and appropriate referrals to individuals, other organisations and providers of other care and services. Staff demonstrated a shared understanding of the external supports utilised by consumers and could identify the supports and external organisations available to consumers.

The Assessment Team observed equipment to be suitable, clean and well maintained. Consumers and representatives advised that they have access to equipment, including mobility aids, shower chairs and manual handling equipment, to assist them with their daily living activities.

# Standard 5

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

## Findings

Consumers felt like they belong at the service and described feeling safe and comfortable to the Assessment Team. Consumers’ rooms are personalised with furniture, photographs and artwork and consumers were observed interacting and participating in lifestyle activities in the café, chapel and library, and mobilising between different areas of the service. Consumers and representatives said they felt safe when staff provided care using mobility and transfer equipment.

The service environment enabled consumers to navigate freely and access outdoor areas such as the patio, garden gazebo, balconies and lawn area. External pathways were free of trip hazards and well maintained. Staff described the process followed when a potential safety hazard or equipment failure is identified and considered that maintenance issues are attended to promptly. The Assessment Team observed the maintenance officer undertaking repairs requested that morning.

**Standard 6**

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

## Findings

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

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team brought forward evidence that the service did not demonstrate appropriate action has been taken in response to complaints. Staff do not have a shared understanding of open disclosure and an open disclosure process was not consistently utilised and documented when things go wrong.

Consumers and representatives referenced concerns around the new care model, specifically issues that care has been affected, concerns that had been raised in relation to the quality of meals and meal service within the service and the management of risk within.

The Assessment Team inspected records that identified a significant number of unresolved complaints and for those that had been resolved, there was inconsistent outcomes to demonstrate open disclosure was used, despite the service having an open disclosure policy.

In its written response of 1 July 2022, the Approved Provider disagreed that the service had a significant number of unresolved complaints and advised of a recent review at a leadership level and logging of complaints into the continuous improvement plan. The Approved Provided submitted data to demonstrate that the number of complaints lodged over the preceding three years had remained consistent. In relation to the issues identified by the Assessment Team regarding a staff lack of understanding of open disclosure, the Approved Provider undertook to conduct additional training and education.

On the totality of evidence brought forward I am not satisfied that the service demonstrates appropriate action is taken and open disclosure used in relation to complaints. I find Requirement 6(3)(c) is non-compliant.

The Assessment Team found the service’s processes and systems for documenting and managing feedback and complaints did not consistently capture all sources of feedback and complaints. Some consumers and representatives expressed dissatisfaction with the service’s lack of response to complaints and reported dissatisfaction with the lack of improvements resulting from complaints.

The Approved Provider’s written response of 1 July 2022 provided additional information in relation to the service’s process for capturing feedback and explained how feedback is captured into the continuous improvement plan where appropriate and used to improve services. The Approved Provider referred to examples from the Site Audit report such as the new call bell system, food focus groups and monthly face to face visits from the catering manager to address meal concerns as actions taken in response to consumer complaints.

The written response further detailed the biannual review process whereby the service reviews complaints and processes directly with complainants to ensure issues have been resolved satisfactorily. The Approved Provider did acknowledge that complaints coming out of consumer and representative meetings were not consistently captured in the register and undertook to rectify this.

I am satisfied that the service demonstrates that feedback and complaints are reviewed and used to improve the quality of care and services within the service. I find Requirement 6(3)(d) is compliant.

I am satisfied the remaining two Requirements of Standard 6 are compliant.

Consumers and representatives advised they felt safe to raise feedback and concerns with staff and management. A review of the monthly consumer meeting minutes evidenced communication to consumers and representatives which encouraged them to provide feedback for improvements which can be submitted through various avenues including feedback forms and surveys.

Staff demonstrated a shared understanding of internal and external processes in place to provide feedback and complaints and could describe how they provide support to consumers with impairments to raise their feedback and concerns. Consumers were aware of and had access to advocates, language services and other methods for raising and resolving complaints. However, most consumers advised they felt safe raising concerns with staff at the service.

**Standard 7**

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

* 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.
* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team spoke with representatives and consumers, the majority of those interviewed, felt the service is short-staffed, staff cook and clean in addition to providing care and services and are sometimes not available to engage with consumers and representatives, agency staff are not familiar with consumers’ needs, call bells are not responded to in a timely manner and there are inadequate staffing levels especially at night. Consumers and representatives described feeling angry and frustrated at the impacts a lack of staffing had on consumers’ and the potential for increased risks to consumer safety. Most staff stated there were not enough staff to adequately care for and engage with consumers. Staff stated that under the new care model staff complete domestic chores in addition to caring tasks which increases pressure.

Management explained to the Assessment Team that under the Household Model of Care, all staff provide food service in the kitchen. At the time the new care model was introduced, staff hours increased by 81.9 hours a week. Management stated there was a significant turnover of staff in 2021 and agency staff were used to fill shifts.

The Approved Provider responded in writing on 1 July 2022. It considers there are sufficient and suitably qualified staff at the service, with adequate and appropriate coverage across the day. The Approved Provider identified COVID-19 impacted staffing at the service but confirmed additional recruitment is underway for additional staff and a new call be system will be installed that aims to reduce call bell response times.

I acknowledge the actions planned by the Approved Provider to increase staff number and reduce call bell response times. However, I am of the view these actions do not address the impact of current staffing levels on the provision of care and services to consumers. I find Requirement 7(3)(a) non-compliant.

The Assessment Team brought forward evidence of training and competency gaps, such as consumers and representatives who stated agency staff do not have the skills to prepare appropriate food and care staff were observed wearing face masks incorrectly. A representative provided an example of receiving conflicting information repeatedly from staff about the health of their consumer. Some staff had completed training on open disclosure, restrictive practice and the Serious Incident Response Scheme (SIRS) but could not provide examples of their application. A new staff member had not received training on these topics, while another staff member stated there is a lack of time to attend training.

In its written response of 1 July 2022, the Approved Provider stated all staff receive training on open disclosure, restrictive practice and the SIRS during orientation, that additional training has taken place and staff will undertake training on these topics through the online learning system.

With regard to the issue that staff do not have time to attend training, the Approved Provider acknowledged it had been difficult to schedule training due to the impact of COVID-19. The Approved Provider noted that Teams sessions are recorded so they can be held at any time.

While the Approved Provider is taking action to ensure all staff receive training on open disclosure, restrictive practice and the SIRS, it did not demonstrate all staff were trained and supported to deliver the outcomes required by these standards. I find Requirement 7(3)(d) is non-compliant.

During the Site Audit, the Assessment Team identified staff who stated they hadn’t received a performance review or annual appraisal and management confirmed that not all staff have performance reviews or appraisals annually. The Assessment Team inspected employee files that were lacking in performance reviews or appraisals.

In its 1 July 2022 response, the Approved Provider noted it has included action to monitor staff performance in its Continuous Improvement Plan, which states the service will undertake continuous conversations with all staff members and provide education to Homemakers by 1 October 2022.

While the Approved Provider has continuous improvement plans at the time of the Site Audit it did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. I find Requirement 7(3)(e) non-compliant.

I am satisfied the remaining two Requirements of Standard 7 are compliant

Consumers considered interactions with care and support staff kind, caring and gentle. Staff were observed engaging with consumers in a respectful manner. The service ensures the competency of its workforce through establishing qualification requirements and core competencies in position descriptions and recruitment processes. There are processes to monitor that qualifications and competencies remain up to date.

**Standard 8**

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

## Findings

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

* Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement
* 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.

The Assessment Team spoke with consumers and representatives who did not feel supported to contribute to the development and delivery of care and services within the service. Those sampled raised concerns about the food and food service and sighted a lack of consumer and representative meetings and forums held by the service to engage with management and provide feedback. The Assessment Team noted that minutes of the most recent meeting were not readily available and general communication about upcoming meetings was generally lacking.

In its written response of 1 July 2022, the Approved Provider acknowledged that it has not been able to offer relative meetings regularly, due to COVID-19 restrictions, however stated that regular communication had occurred between the service and representatives and future meeting dates have been set and communicated. The Approved Provider described improvements to the food quality and service that had occurred in response to feedback and stated that further consultation about the menu would be undertaken.

While I accept the actions implemented by the Approved Provider, I find that at the time of the Site Audit the service did not demonstrate effective engagement with consumers and representatives that informed the development of care and services. I find Requirement 8(3)(a) non-compliant.

The Assessment Team identified that while the service had risk management systems in place these systems were ineffective in the management of high prevalence and high impacts risks. The Assessment Team found strategies to manage risk at an individual consumer were ineffective, risk assessments were not individualised, and consumer care plans did not consistently discuss individual strategies to minimise risk to the consumer and identified the ineffective governance system as the root cause of this.

In its written response of 1 July 2022, the Approved Provider advised that it used a risk register to identify high impact and high prevalence risks associated with the care of each consumer. The register includes any complex care needs to prompt the staff in reviewing current care needs in relation to specialised care. The Approved Provider further advised that risks such as falls, which have continued to rise across the service are considered in its plan for continuous improvement. The written response referred to several diversional sessions scheduled each week and undertook to review the falls data at the next Clinical Governance meeting. Additional staff education and training in relation to the Serious Incident Response Scheme (SIRS), open disclosure and further topics have also been commenced within the service and will remain ongoing.

I have considered the totality of evidence submitted by both the Assessment Team and the Approved Provided and acknowledge the implemented actions by the service in response to the Site Audit. However, I am of the view that the service did not demonstrate an effective risk management framework at the time of the Site Audit. I find the service is non-compliant with Requirement 8(3)(d).

I am satisfied the remaining three Requirements of Standard 8 are compliant.

The Assessment Team found that the service did not have effective systems relating to continuous improvement and feedback and complaints. The Assessment Team cited the format of the continuous improvement plan that did not capture critical incidents or timelines for improvements and a lacking open disclosure process in their reasoning.

On 1 July 2022, the Approved Provider responded and stated it has not had a critical incident that resulted in a change and reiterated that a continuous improvement plan was provided to the Assessment Team during the Site Audit that included examples of feedback that had been raised. The Approved Provider referenced organisation – wide changes that had come about as a result of critical incidents and provided evidence of its open disclosure process in practice.

Based on the evidence provided by both parties, I am satisfied that at the time of the Site Audit, the service demonstrated effective governance systems and find Requirement 8(3)(c) is compliant.

The service demonstrated that governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Board members have been trained in the Quality Standards. The service had a clinical governance framework that referenced antimicrobial stewardship, minimising the use of restraint and an open disclosure policy.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)