Uniting Kingscliff

Performance Report

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**Commission ID:** 2719

**Provider name:** The Uniting Church in Australia Property Trust (NSW)

**Site Audit date:** 5 April 2022 to 8 April 2022

**Date of Performance Report:** 25 May 2022

# Performance report prepared by

Tara Wurf, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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;
* Infection control monitoring checklist completed 5 April 2022; and
* the provider’s response to the Site Audit report received 11 May 2022.

**Preamble**

The approved provider in its response to the Site Audit report outlined several externally impacting factors which were implied to be responsible, or partly responsible, for deficiencies identified in the Site Audit report.

The approved provider stated that the Assessment Team gave little consideration to the recent events experienced by the service, especially significant staffing issues due to two recent floods and challenges associated with COVID-19 outbreaks and exposures. Within this performance report these matters are referred to as ‘external factors’. The approved provider stated that risks in the services were being effectively managed during these times.

While these external factors are not disputed, they do not relieve the approved provider of its obligations under the Aged Care Quality Standards. The approved provider remains accountable for delivering safe, quality care and services and ensuring that it complies with the Aged Care Quality Standards, including in extenuating circumstances.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

Consumers spoke of their cultural needs being respected. Consumers also said staff supported their choices, including to take risks and gave examples of where this has occurred. Staff described ways in which consumers are supported to take risks and how risks are managed. Care documentation for consumers sampled described areas in which they are supported to take risks to live the life they choose, assessment of risks and strategies to manage the risks.

Consumers were positive about the type of information they received, including information about meals and lifestyle activities, saying it supported their ability to make choices. Consumers were also supported to maintain relationships of their choosing. Consumers were satisfied their privacy is respected and personal information is kept confidential.

Staff spoke about consumers in a respectful manner. Staff could describe consumer’s cultural needs and what matters to consumers, and how this influenced care delivery. Staff described the people who are important to each consumer and how consumers are supported to maintain relationships with family, partners/significant others and friends.

Care planning documents included information on consumers’ cultural needs and preferences and strategies to guide staff in delivering care and included evidence of consultation with consumers/representatives.

The service has organisational policies that guide staff practice, including on topics that cover dignity and respect, diversity and inclusions, risk management, and privacy and confidentiality. Staff are provided with online learning and education on various topics relevant to the Quality Standards including topics such as dignity and choice.

However, consumers and representatives were dissatisfied with the way staff supported their hygiene care and toileting and said this impacted consumers’ dignity. This was consistent with staff feedback that staffing delays impacted their ability to maintain consumers’ dignity, particularly in relation to hygiene care.

The Quality Standard is assessed as non-compliant as one of the six specific requirements have been assessed as non-compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

Consumers and representatives expressed dissatisfaction with the way staff supported aspects of consumers’ personal care, particularly in relation to hygiene care and toileting and said this impacted consumers’ dignity.

Four consumers/representatives provided feedback that consumers had experienced episodes of incontinence or had been left for extended periods of time in a soiled bed. Consumers reported feeling embarrassed and humiliated when this occurred. Another consumer said the continence aids they are provided fail to adequately manage odour and that as a result they often don’t venture into communal dining areas.

Whilst consumers’ care documentation identified those consumers who require assistance with toileting and staff demonstrated an understanding of consumers’ personal circumstances and preferences, staff said it was difficult to maintain the dignity of those consumers who require assistance with toileting, due to staffing limitations.

The approved provider’s response referenced the impact of external factors on staffing levels. The response to the Site Audit report asserts that monthly consumer experience surveys are conducted and that feedback in recent months has been positive with consumers generally reporting they receive the care they require.

For the consumer who raised concerns about odour, the approved provider states that prior to the site audit the clinical team had trialled various continence management options that included the involvement of a continence advisor, medical officer and medical specialists and that a complete reassessment of all domains of care has occurred following the site audit.

The response includes information that some of the consumers have complex behaviours and that one consumer has unrealistic expectations in relation to staff attendance. I note the approved provider states one of the consumers has dermatitis associated with incontinence and that this is improving. However, the response was silent in relation to the consumers’ claims that staff delays result in them experiencing episodes of incontinence and evidence to support that regular toileting occurs was not provided.

The approved provider says it has conducted case conferences for named consumers and reviewed assessments and care planning to ensure consumers’ current needs and preferences are documented.

Additional actions implemented by the approved provider include:

* staff education on privacy and dignity,
* memorandums and staff meetings to reinforce consumer care is to be prioritised,
* increased staffing hours in some areas of the service, and
* call bell review process to analyse response data.

Information about a named consumer not consulted prior to staff moving their belongings has been considered under requirement 4(3)(b).

I am satisfied that some consumers have experienced delays in staff supporting them with their toileting and hygiene needs and that this has impacted the consumers’ dignity in a negative way. Additionally, staff confirmed consumer feedback and said they are not able to meet consumers’ care needs in a timely manner.

I am confident that the actions taken by the approved provider will address the deficiencies identified under this requirement however, at the time of the site audit, consumers’ dignity was not consistently upheld.

For the reasons detailed above, I find this requirement non-compliant.

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

Consumers/representatives are satisfied with the service’s assessment and care planning processes. Consumers said staff involve and consult with them through initial and ongoing care planning and assessment. Other people important to the consumer are also involved as are and relevant health professionals. They said staff understand and respect their needs and preferences. Consumers said they can access their care plan and staff explain relevant information to them.

Assessment and care planning is conducted for consumers on entry to the service and in response to changing care needs or preferences. Care and services are reviewed regularly. Registered staff utilise a suite of assessment tools.

Care planning documentation generally summarised information relevant to consumers’ needs and risks to their health and well-being, including in relation to pain management, skin care, mobility, behaviour management, and nutrition and hydration. Consumers’ care planning documents included advance care planning and end of life planning and detailed an ongoing partnership with the consumer and others in assessment, planning and review of their care and services. There was evidence of input from medical officers, specialists and allied health professionals.

Staff described what was important to the consumers in terms of how their personal and clinical care was delivered, and this information was aligned with information in consumers’ care plans. Staff reported they receive information about consumers during shift handover.

The service has a suite of policies, procedures and assessment tools relevant to Standard 2 available to guide staff practice, including in relation to assessment and planning, palliative care and advanced care planning. Staff receive training relevant to their role.

The Quality Standard is assessed as compliant as five of the five specific requirements have been assessed as compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The majority of consumers interviewed by the Assessment Team considered they received care that was safe and right for them, although some consumers and representatives provided mixed feedback particularly in relation to staffing delays impacting consumers’ hygiene requirements such as toileting and skin care. After consideration of the information in the Site Audit report and the approved provider’s response this consumer feedback was considered under Standard 1 and Standard 7.

Consumers and representatives said consumers have access to medical officers and other providers of health care services. Clinical documentation reviewed by the Assessment Team confirmed medical officer involvement and referral to other allied health practitioners including a physiotherapist, speech pathologist and dietitian.

Clinical documentation demonstrated consumers’ specialised nursing care including the management of wounds and chronic pain is managed appropriately. Strategies to support consumers with risks associated with their care, for example choking and falls, were documented in care plans. For those consumers who had experienced a deterioration or change in their condition, clinical documentation evidenced care that was responsive and timely.

Clinical information systems supported the sharing of information that was specific to consumers’ needs and preferences, this included care planning documentation and handover conducted at change of shift. Staff were familiar with consumers’ care needs and could provide examples of how they support consumers with complex behavioural needs, pain or those at risk of pressure injuries.

Staff could provide examples of strategies they use to maximise comfort for consumers approaching end of life. This included specific equipment to promote skin care and strategies to increase comfort such as massage and mouth care.

Registered staff are available 24 hours per day and could describe high impact and high prevalence risks for consumers and were familiar with the clinical documentation in place to identify and manage those risks including incident forms, risk assessments and care plans.

Policies and procedures to guide staff included a risk management framework and infection control. Clinical incidents are monitored and analysed with upward trends identified.

The Assessment Team found some deficiencies relating to infection control, specifically in relation to the service’s outbreak management plan, staff training and the processes relating to visitor screening. However, this was addressed by the approved provider in its response. Systems and processes are in place to minimise infection related risks and promote the appropriate use of antibiotics, and the organisational clinical governance team have been involved in reviewing the service’s processes. Staff demonstrated knowledge of infection control processes and the service provided an example of how it had effectively managed a recent situation involving a case of COVID-19.

The Quality Standard is assessed as compliant as seven of the seven specific requirements have been assessed as Compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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.*

The Assessment Team found that consumers were not satisfied with the management of their personal care, specifically in relation to their hygiene needs.

The Assessment Team interviewed a number of consumers and representatives who raised concerns that staffing delays impacted the consumers’ ability to access the toilet in a timely manner. One consumer representative advised the Assessment Team that the consumer had developed a skin irritation as a result of being left in a soiled bed for extended periods of time.

The approved provider asserts in its response to the Site Audit report that consumers receive safe and effective personal care as evidenced by their clinical indicator data relating to pressure injuries and incontinence associated dermatitis. I note that the clinical indicator data submitted in the response identifies that skin-related incidents, including pressure injuries are generally stable.

For the four consumers named in the Site Audit report, the approved provider has completed a case conference and reviewed the consumers’ care plans. For one named consumer who was reported as having a skin related irritation associated with being left in a soiled bed for extended period of time the approved provider reviewed their clinical documentation for the previous 18 months and found that there had been no incidents of pressure injuries or incontinence associated dermatitis.

The approved provider refers to consumer survey data which it states demonstrates high levels of consumer satisfaction and call bell response data which is monitored.

I note that the Assessment Team reviewed clinical documentation for 19 consumers and found that care was generally individualised, effective and tailored to the needs of the individual. Consumers sampled included those with specialised nursing care needs, wounds, those who have restrictive practices applied, and consumers with chronic pain.

The Assessment Team reviewed wound care documentation and found that wounds were being attended regularly, documentation was completed and reflected wound characteristics and that wounds were healing.

For consumers with complex or chronic pain, care included non-pharmacological interventions such as massage and heat packs as well as analgesia and involvement of allied health care providers such as a physiotherapist.

Where restrictive practices were applied, the service demonstrated compliance with legislative requirements and behaviour support plans included alternatives that were to be trialled prior to the application or use of a restraint.

Staff demonstrated an understanding of consumers’ personal and clinical care needs and policies and procedures generally guided staff in the delivery of care. Staff reported however that they have difficulty attending to consumers in a timely manner. This information has been considered under Standard 7.

Monitoring mechanisms included direct supervision by registered nurses, case conferences and care plan reviews, audits, surveys and analysis of clinical indicator data.

While the Assessment Team found that consumers were dissatisfied with some aspects of their care, I have considered this under Standard 1 and Standard 7 as the concerns arising from staffing pressures primarily impacts consumers’ dignity.

I accept that the approved provider has reviewed care plans and completed case conferences and that survey data includes positive feedback from consumers. I acknowledge that clinical indicators do not demonstrate an upward trend in skin-related incidents such as dermatitis associated with incontinence.

I am satisfied that consumers are receiving personal and clinical care that is safe, effective and optimises consumers’ health and well-being. The Assessment Team reviewed a significant sample of clinical documentation and found that overall care needs (including complex care needs) were being met. Staff were familiar with consumers’ needs and organisational systems and processes were established to monitor care delivery. Therefore, I find this requirement compliant.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

The Assessment Team found deficiencies in the service’s outbreak management plan and raised concerns about the monitoring of visitor access to the service.

The Site Audit report states the outbreak management plan did not include details about how to access the service’s electronic system and did not provide guidance on donning and doffing. The Site Audit report stated the service did not have a floor plan to support workforce planning and that staff training records identified some staff had not completed aspects of their on-line infection control training, including hand hygiene. Additionally, the Assessment Team observed visitors accessing the service without undertaking a screening process.

The approved provider’s response to the Site Audit report states that all visits to the service are pre-arranged and that staff are familiar with visitors’ vaccination status. It states that new visitors to the service are required to demonstrate their vaccination status. The approved provider states that closed circuit television footage for the period of the site audit was reviewed and identified one visitor who was not screened. The visitor was bringing a consumer back to the service and did not enter.

The approved provider asserts that following the identification of a positive case of COVID-19 at the service in December 2021, the service implemented its policies and procedures and was able to successfully contain the situation with no further consumers or staff testing positive as a result of this.

The approved provider included evidence of a floor plan in its response and states this was provided to the Assessment Team during the site audit. The approved provider states that the details referred to by the Assessment Team as missing from the outbreak management plan are found in other service specific documents.

With respect to staff training, the approved provider states that at the time of the site audit, all staff had completed practical education relating to hand hygiene and donning and doffing of personal protective equipment. It states that external factors relating to extreme weather events impacted staff capacity to complete online training modules at the time of the site audit. The approved provider asserts that this training is now completed and evidence of staff participation was included in its response.

To further enhance the service’s infection control processes the approved provider states that the organisational governance team is reviewing its documentation relating to COVID-19 to ensure guidance is current practice and aligned with current health directions.

In forming a view about compliance, I have also given weight to the related information in the Site Audit report and in the Infection Control Monitoring Checklist completed by the Assessment team during the site audit. For example:

* There are policies and procedures relating to infection control and antimicrobial stewardship.
* Registered nurses could describe the processes they follow when antibiotics are prescribed for a consumer and were familiar with strategies to minimise infection- related risks such as monitoring hand hygiene and consumers’ hydrations status.
* Care staff provided examples of how they minimise consumers’ risk of infection such as urinary tract infections and reported behavioural changes to the registered nurse if these were observed.
* Management advised that staff and consumer vaccination rates are monitored, with 100% of staff having current COVID-19 vaccinations.
* The service has a designated infection prevention and control lead.
* The Infection Control Monitoring Checklist included evidence that:
  + the service had sufficient personal protective equipment available to staff and staff were using this equipment appropriately,
  + staff were observed practicing social distancing and washing their hands frequently using an appropriate technique, and
  + the outbreak management plan included consumers’ details, processes to follow in the event of a lockdown, guidance about clinical information systems and when to transfer a consumer positive for COVID-19 to hospital.

I am satisfied that the service has policies and procedures to minimise infection-related risks and to support the appropriate use of antibiotics. Staff practices were generally consistent with an effective infection control program and the service has previously effectively managed a situation where a consumer was positive for COVID-19. The approved provider has demonstrated online training is now complete and that the clinical governance team are reviewing processes relating to infection control to ensure current practice. Therefore, I find this requirement compliant.

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

Consumers/representatives provided mixed feedback in relation to services and supports for daily living.

Consumers/representatives said consumers are supported to remain independent and to keep in touch with those key people who are important to them. Consumers said they are able to exercise choice in relation to meals and that they have access to equipment that is safe, suitable, clean and well-maintained. Consumers and representatives provided examples of how the service had engaged with other providers of care such as the National Disability Insurance Scheme staff to support consumers.

Consumers/representatives raised concerns about the lack of activities and consumer engagement, particularly on weekends. They provided examples of how their physical limitations restricted their ability to participate in the activity program, that bus trips had ceased and that on weekends there is little to do and that they are ‘bored’. They said that while staff were caring and kind, staffing pressures meant they didn’t have time to talk with consumers and limited their ability to assist consumers to attend spiritual services.

Consumers, including those with specialised diets, were satisfied with the variety, quality and quantity of food. The menu demonstrated that consumers are provided with options including a vegetarian diet, soups, salads, sandwiches and other freshly prepared food. Catering staff could describe how they are advised of consumers’ dietary requirements and discussed the measures they take to ensure food safety.

Care planning documentation demonstrated assessment processes capture what and who is important to the individual consumer and this information is reflected in care plans to guide staff. Dietary needs and preferences were documented including for example whether the consumer required a texture modified diet.

Staff were familiar with consumers’ individual needs and preferences and knew who was important to consumers and how they liked to spend their time. However, they reported that at times they did not have the capacity to spend time with consumers to support them emotionally.

Care staff said there is no activities schedule that is developed and that this is developed on the day. This was confirmed by volunteer staff who also provided feedback to the Assessment Team that there is nothing specific planned for consumers on weekends.

The Assessment Team observed consumers engaged in individual and group activities both inside the service and outdoors. Consumers were doing things that were of interest to them.

The Quality Standard is assessed as non-compliant as two of the seven specific requirements have been assessed as non-compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) 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.*

### Requirement 4(3)(b) Non-compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team found the service did not support consumer’s emotional or spiritual well-being.

Consumers reported that whilst staff are kind and caring, staffing pressures meant they didn’t have time to talk with consumers and limited their ability to assist consumers to attend spiritual services. Three named consumers were interviewed in relation to this requirement.

One named consumer who had recently lost their spouse reported they were lonely and missed their spouse and their preference was to speak to staff, but staff did not have time. The consumer’s care documentation recorded the consumer had been sad and felt staff did not care about him, but did not include evidence of review, monitoring or interventions to support the consumer emotionally. Staff confirmed the consumer had been sad and the Assessment Team observed the consumer during the site audit to be emotional. The approved provider’s response acknowledged the consumers’ emotional state and support offered via pastoral care visits. It explained the consumer’s preference is to speak with a staff member who is currently on long term leave from the service, however support continues to be offered by staff and a pastoral carer, however the consumer has declined referrals to external support services. I reviewed care documentation submitted by the approved provider and acknowledge various entries made by registered staff and a pastoral carer that continued to document that the consumer was sad, however, there was no evidence of assessment of the consumers’ emotion state or specific strategies to support the consumer. I am of the view that the service has not adequately supported this consumer emotionally during a period of bereavement.

In relation to a second named consumer whose representative said the consumer is not supported to attend church services on a Sunday, I accept the approved provider’s evidence the service provides weekly non-denominational church services at the service and the consumer continues to participate in these and is satisfied with this option to support their spiritual needs. This is consistent with information in their care planning documentation.

A third consumer told the Assessment Team they felt depressed and staff do not have time to sit and talk to them. The approved provider met with the consumer following the site audit and reported that the consumer denied they said the information reflected in the Site Audit report and said they were satisfied with the time staff spend talking with them. I adopt no view on this.

Staff said that whilst they attempt to spend time with consumers who are feeling low, at times they did not have the capacity to spend time with consumers to support them emotionally. The approved provider’s response referenced the impact of external factors on staffing pressures.

The Site Audit report identified consumers’ care planning documents did not contain details about strategies to support consumers’ emotional, spiritual or psychological well-being, and did not identify consumer’s spiritual beliefs and preferences. The approved provider’s response provided completion rates that demonstrated that the majority, but not all, consumers had lifestyle and spiritual assessments completed.

Improvement actions identified by the approved provider in response to deficiencies in the Site Audit report included:

* Ensuring all consumer have a lifestyle and spiritual assessment completed.
* Appointed a Leisure and Wellness Coordinator.
* Re-invigorating the leisure and wellness program.

I am satisfied the service is supporting consumers to access non-denominational church services and that following the site audit, the service has implemented actions to improve performance in this requirement. I note the reported discrepancy in some consumers’ experience and have given weight to other consumer and staff feedback about staffing pressures impacting on staff capacity to spend time with consumers.

At the time of the site audit, the service was not providing adequate emotional support to consumers. Therefore, I find this requirement non-compliant.

### Requirement 4(3)(c) Non-compliant

*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.*

Whilst the service supports consumers to have social and personal relationships, consumers are not supported to participate in activities inside and outside the service and of interest to them.

Consumers/representatives raised concerns about the lack of activities and consumer engagement, particularly on weekends. They provided examples of how their physical limitations restricted their ability to participate in the activity program, that bus trips had ceased and that on weekends there is little to do and that they are ‘bored’. I have considered feedback from a consumer about access to church services and the approved provider’s response under requirement 4(3)b.

Staff were unable to identify what is important to individual consumer or things consumers like to do. Care staff said there is no activities schedule and that this is developed on the day. This was confirmed by volunteer staff who also provided feedback to the Assessment Team that there is nothing specific planned for consumers on weekends. Management advised consumers decide what they would like to do, and staff are expected to facilitate activities.

The approved provider acknowledged that the service has never employed lifestyle staff to provide activities on weekends and that bus trips had ceased and referred to external factors that impacted on usual events. The response stated consumers were aware of reasons why bus trips were ceased and identified named consumer who can independently access the community in the absence of a service bus. Whilst I accept some consumers have the ability to access the community independently and may have been aware of the service’s limitations to support them, I give weight to the consumers’ reported dissatisfaction with how the service’s, services and supports to participate in their community and do things of interest to them.

The approved provider in its response to the Site Audit report included deidentified statements from consumers’ care plans about their goals in reference to this requirement, however, this does not evidence that the consumers’ preferences or goals were being met.

Improvement actions identified by the approved provider in response to deficiencies in the Site Audit report included:

* Lifestyle and care staff case managing consumers at increased risk of social isolation.
* Re-invigorating the leisure and wellness program and a community connections program.
* Purchase of a smaller bus that does not require a special licence to drive.
* Extending lifestyle programs to run seven days per week.

For the reasons detailed above, I find this requirement non-compliant.

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

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

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

Most consumers/representatives reported consumers feel at home and safe at the service. They said the service environment is comfortable and welcoming and they can find their way around the service. The also reported that visitors feel welcome and that the service has several private seating areas inside and outside.

Consumers were satisfied with the cleanliness of the service and their room and confirmed regularly cleaning occurs. Consumers said they feel safe with the equipment provided to them and the furniture is pleasant and appropriate to their needs. They said if there are issues reported to maintenance, they are followed up promptly.

Registered staff described the features of the service environment that are designed to support functioning of people with a cognitive impairment such as wide corridors, handrails, freedom to move in and outdoors, and signage on doors identifying the bathroom and toilet for those who need it.

Staff demonstrated an awareness of how to report and document maintenance issues. Maintenance staff described the service’s preventative and reactive maintenance schedules. Maintenance and staff said the mobility equipment such as hoists and wheelchairs are regularly checked and serviced to ensure they are safe and fit for use. Documentation reviewed identified reactive maintenance is attended to in a timely manner and preventative maintenance is undertaken as scheduled.

While the Assessment Team observed some instances of damage to walls, faulty equipment and maintenance required, documentation provided by management demonstrated the service was aware of these and repair orders were in place to rectify these areas.

Consumers were observed to be moving freely in the indoor and outdoor areas such as the internal courtyards, lounge areas, and gardens.

The Assessment Team observed the furniture, fittings and equipment at the service to be safe, clean and well-maintained. Mobility aids and hoists were in good condition and stored securely. Equipment in the kitchen and laundry was clean and appeared well maintained.

The Quality Standard is assessed as compliant as three of the three specific requirements have been assessed as compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

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

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Consumers/representatives reported they were aware of how to make a complaint, including via the service’s feedback and complaint forms or speaking directly to management and staff. Most consumers were aware of alternate feedback/ complaints mechanisms and external advocacy services available to them.

Staff described the service’s feedback and complaints processes and how they support consumers to provide feedback or make a complaint. Some staff could describe advocacy services available to assist consumers.

Information about the service’s complaints process, and advocates and language services are provided in the consumer handbook. Information about advocacy groups, language services and external complaints processes is displayed on noticeboards throughout the service.

The service has a complaints management system and policies on open disclosure, and incident management and complaints.

However, complaints were not effectively recorded and responded to, open disclosure was not consistently applied and understood by staff, and feedback and complaints were not used effectively to improve quality of care and services.

The Quality Standard is assessed as non-compliant as two of the four specific requirements have been assessed as non-compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Non-compliant

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

Consumers reported that when they raise feedback and concerns with management or staff, they are not provided a response or an apology. Numerous consumers advised they had raised complaints about lack of activities and bus outings and had not received an adequate response.

Whilst complaints recorded in the service’s complaints register were actioned, there was no evidence that open disclosure had been used. Consumer meeting minutes did not record any actions taken in response to consumer feedback and complaints raised at meetings. However, management and staff told the Assessment Team that consumer feedback and complaints are not always documented and responded to. Management stated they did not believe this necessary.

Not all staff had completed the service’s training in complaints management and open disclosure. I have also considered information under Standard 7 and Standard 8 that staff were unfamiliar with open disclosure.

In response to feedback from the Assessment Team during the site audit, management updated the service’s plan for continuous improvement with several actions relevant to processes and training on documenting and responding to feedback and complaints.

The approved provider in its response to the Site Audit report acknowledged deficiencies in documenting feedback in the service’s electronic management system, however stated there are alternate mechanisms to capture and respond to the feedback, such as via meeting minutes, maintenance systems and verbally with individuals. The response identified some instances where responses had been made in response to feedback and complaints, and others where it had not. The approved provider’s response stated that issues raised by consumers with the Assessment Team have now been actioned.

Whilst the response asserted staff apologise when a complaint and negative feedback is received, it acknowledged the feedback that staff were unfamiliar with open disclosure and training has re-commenced on this topic.

The approved provider response states management met with named consumers and, where appropriate, documented and responded to their concerns. It reported that some consumers confirmed that management had responded to their concerns and other consumers said they did not have any current concerns to raise. Whilst I note the varying versions of consumer feedback between that given to the Assessment Team and that reported by the approved provider, I have given weight to consumers’ feedback provided during the site audit and note that, at the time of the site audit, consumers remained dissatisfied with the service’s response to resolve their concerns.

Additional actions identified by the approved provider to address deficiencies in the service’s processes to document, action and respond to feedback and complaints, included:

* Engagement with consumers and representatives through meetings and memorandums to apologise and address complaint items.
* Staff training on open disclosure.
* Management and staff training in the service’s electronic management system.
* Enhanced meeting minute processes to ensure appropriate content is recorded and actioned.
* Monthly ‘health checks’ to be completed by the quality specialist, to review use of the electronic management system for recording feedback.
* Implementing a process to log actionable items from consumer surveys and consumer meetings in the electronic management system to formalise opportunities for improvement and monitor progress.

While the approved provider has commenced actions to address deficiencies identified by the Assessment Team, the above combined evidence is supportive of the finding that, at the time of the site audit, complaints were not effectively recorded and responded to, and open disclosure was not consistently used. For these reasons, I find this requirement non-compliant.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team found that feedback and complaints were not reviewed and used to improve the quality of care and services, including because the service was not consistently documenting feedback and complaints.

Consumers and representatives said their feedback and complaints had not resulted in changes or improvements at the service, except for improvements to cleanliness of consumers’ rooms. Most consumers have raised concerns with management and staff about insufficient staff to meet their needs, however, no changes or improvements have been made.

Management said feedback and complaints have not always been documented and responded to.

The service’s plan for continuous improvement did not include any improvement actions identified as a result of feedback or complaints. Consumer feedback/ complaints regarding insufficient staffing and lack of activities were not documented in the service’s feedback and complaints register or included on the service’s plan for continuous improvement.

Following feedback from the Assessment Team during the site audit, management updated the service’s plan for continuous improvement with actions to improve the service’s complaints management process.

The approved provider’s response to the Site Audit report stated the service collects feedback in various ways including from meetings and surveys, however, acknowledged feedback is not always recorded in the service’s electronic complaints system. The response also referred to the impact of external factors on the service’s meeting schedule for the beginning of 2022 and workforce issues.

The response identified that the service’s usual meeting practice has been reinstated and the service’s plan for continuous improvement was updated with items for cleaning, leisure and wellness (activities) and recruitment and staffing. Additionally:

* The quality specialist will track the number of complaints recorded in the electronic management system and review meeting minutes to ensure complaints and feedback are linked to the service’s plan for continuous improvement.
* Meeting minutes are accessible by the governance team via the service’s new intranet page.

While the approved provider has commenced actions to address deficiencies identified in the Site Audit report, the above combined evidence is supportive of the finding that, at the time of the site audit, feedback and complaints were not consistently recorded and used to improve the quality of care and services. For these reasons, I find this requirement non-compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

Consumers and representatives said staff are kind, caring and gentle and were satisfied staff are competent and have the knowledge to perform their roles. However, consumers and representatives were dissatisfied with staffing levels and provided examples of how inadequate staffing levels have negatively impact on their care and services.

Whilst staff demonstrated an understanding of consumers needs and preferences, staff consistently reported they did not have sufficient time to complete their work and meet consumers’ needs and preferences in relation to care and services. Management acknowledged gaps in the service’s base roster and cited challenges with staff recruitment and retention in 2021.

The approved provider acknowledged the service has faced staffing shortages and cited challenges associated with external factors, including the COVID-19 and floods. While these events are not disputed, they do not relieve the service of its obligations under the Aged Care Quality Standards to ensure there are sufficient skilled and qualified staff to deliver safe, quality care.

Processes to review staff performance and ensure staff receive training relevant to their roles were ineffective.

The Quality Standard is assessed as non-compliant as three of the five specific requirements have been assessed as non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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.*

Information under this and other requirements in the Site Audit report and approved provider’s response demonstrated there were insufficient staff to meet consumers’ needs and preferences.

Most consumers and representatives interviewed by the Assessment Team raised concerns about staffing levels and provided examples of where insufficient staffing had negatively impacted on them. Examples included waiting long periods for staff to respond to call bells, experiencing incontinence, delays in assistance with activities of daily living, meal preferences not being met, and lack of activities provided.

Staff provided feedback consistent with consumer/representative feedback that there were not enough staff at the service, which impacted on their ability to attend to consumers’ needs in a timely manner. Staff spoke about not being able to provide timely assistance with toileting and continence care and not having enough time to provide activities to consumers.

Management acknowledged gaps in the service’s base roster and advised the service had experienced various challenges in 2021 in relation to staff recruitment and retention, the New South Wales / Queensland border closures and the service’s introduction of a new position that includes a broad range of duties. The service was undertaking ongoing recruitment processes to increase the base roster.

Call bell response time data was not analysed or reported on. The approved provider’s response confirmed that call bell response time date was not analysed or reported on at the time of the site audit, however a process has since been commenced to review call bell data weekly, reported to management and be reviewed by the quality specialist.

The approved provider in its response to the Site Audit report referenced global aged care worker shortages and acknowledged that the service had faced staffing shortages and challenges related to external factors. The response specifically referenced the impact of staffing shortages on the leisure and wellness program, however, made general reference to staffing challenges throughout the submission.

The approved provider asserted that its clinical indicator data, including for pressure injuries, is low and demonstrates consumers received safe care.

In response to consumer feedback in the Site Audit report under this requirement, the approved provider’s response mostly referred to its responses to information under other requirements which I have addressed elsewhere in this report.

The approved provider identified staff recruitment and development strategies currently employed by the organisation to engage more staff. While I acknowledge the service is taking action to recruit more staff, the response did not demonstrate how the service monitors workforce sufficiency, manages staff shortages when they arise (apart from stating that that consumer needs are prioritised) including when the service is impacted by external factors.

I am satisfied that the workforce was not planned and sufficient to deliver care and services to consumers as the majority of consumers and representatives interviewed were dissatisfied with staffing availability and could provide examples of how consumers’ care had been compromised. Additionally, staff reported there were not enough staff at the service, this resulted in consumers experiencing delays and not receiving care in accordance with their needs and preferences. Finally, workforce challenges have been acknowledged by the approved provider. Therefore, I find this requirement is non-compliant.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The majority of consumers and representatives expressed confidence in the staff to deliver care and services, however, two consumers/representatives stated staff could benefit from additional training.

Whilst the service provides training to staff relevant to their roles, staff have not consistently completed mandatory training modules/requirements. Staff interviewed by the Assessment Team did not demonstrate an understanding of open disclosure.

The approved provider’s response identified the service has a process to track and report on staff with overdue mandatory training and acknowledged that completion of training has lagged due to external factors. Since the site audit, all staff with overdue training modules have completed the mandatory modules.

Staff knowledge, education and training has been added as an agenda item for the next consumer meeting and staff meeting to identify and document areas for improvement in the service’s plan for continuous improvement.

The approved provider acknowledged that staff were unfamiliar with the term open disclosure. Education and training on this topic have since been provided and will be discussed at staff meetings.

The approved provider has implemented a process whereby where the service’s training completion rate is non-compliant, an action will be put in the service’s plan for continuous improvement to promote return to compliance with mandatory training requirements.

While the approved provider has implemented a process to track training completion rates and ensure staff complete mandatory training, at the time of the site audit, staff had not completed training relevant to their role, including mandatory training. Therefore, I find this requirement non-compliant.

### Requirement 7(3)(e) Non-compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

Whilst the service has established performance development and management processes, the majority of staff had not received performance reviews in over 12 months and seven staff moved into a newly created role were not provided with performance and development plan relevant to their new role.

Management described the service’s process to conduct performance appraisals and manage underperformance when required. Management advised that informal performance discussions had occurred with individual staff members.

Following feedback from the Assessment Team during the site audit, the service’s continuous improvement plan was updated to include an action to complete all overdue performance discussions. This was confirmed in the approved provider’s response to the Site Audit report.

The approved provider disputed the comment that staff who moved into a newly created role were not provided with a performance and development plan and said that these staff were provided with position descriptions which they signed on appointment. While I accept the staff have position descriptions for their new roles, this does not evidence regular assessment, monitoring and review of their performance in the new roles. I note that a designated change management coach will commence in May 2022 to support the staff in these new positions.

I am satisfied that at the time of the site audit, regular assessment, monitoring and review of staff performance was not occurring. Therefore, I find this requirement non-compliant.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Management and staff described the mechanisms used by the organisation to actively engage consumers in the development, delivery and evaluation of care and services. These included via consumer/representative meetings, complaints, case conferences and consumer surveys. Consumers reported being engaged and encouraged to provide to provide input and feedback about care and services.

The organisation has a clinical governance framework that focuses on safe and quality service delivery to consumers. The framework defines roles, responsibilities processes and reporting mechanisms. The organisation has strategic and operational plans. The service reports monthly to the organisation’s clinical governance committees and the Board.

The service monitors the performance of the service and provides regular reports to the Board, including on audit results, risks, human resources, training and compliance.

A risk management framework and polices have been implemented by the organisation. Staff have received training on the organisation’s risk management policies and provided examples of their relevance to their work. Staff demonstrated a shared understanding of what constitutes elder abuse and neglect and described their reporting responsibilities under the serious incident report scheme when they become aware or have a suspicion of a reportable assault.

The organisation has a clinical governance framework in place that addresses anti-microbial stewardship, minimising restrictive practice and open disclosure. Staff have received education about these policies. While staff demonstrated an understanding of anti-microbial stewardship and restrictive practices, they were unfamiliar with the principles and application of open disclosure. Management described open disclosure and, in response to the Assessment Team’s feedback, commenced actions to address the knowledge deficit with staff. This is addressed under Standard 7.

However, whilst the organisation has effective governance systems in place that include information management, continuous improvement, financial governance and regulatory compliance, governance systems relating to workforce management and feedback and complaints are ineffective.

The Quality Standard is assessed as non-compliant as one of the five specific requirements have been assessed as non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

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

### Requirement 8(3)(b) Compliant

*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) Non-compliant

*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.*

The service does not have effective organisational-wide governance systems in place in relation to workforce governance and feedback and complaints. This is reflected by a finding of non-compliance under Standard 6 and Standard 7.

Whilst the Assessment Team found information management systems were ineffective, this related to complaints not being documented and managed. I have considered this under Standard 6 and governance systems related to feedback and complaints. Based on other information in the Site Audit report, I am satisfied that generally the service’s information management systems were effective.

In relation to workforce governance, the service did not demonstrate sufficient staff were allocated to meet consumers’ needs and preferences. Consumers and representatives were dissatisfied with staffing levels. Staff raised concerns about their ability to perform their roles. Processes were not effective in ensuring staff had completed mandatory training and staff performance was assessed, monitored and reviewed.

In relation to feedback and complaints, the service was unable to demonstrate effective governance systems in place to ensure feedback and complaints are documented, dealt with in a timely manner, and inform continuous improvement activities. An open disclosure process was not well understood and used by staff.

The approved provider in its response to the Site Audit report identified actions to increase governance in relation to complaints and feedback. The response also identified a senior governance committee that will provide monitoring and oversight of implementation of improvement actions in response to the Site Audit report, and report to the organisation’s board.

I have also considered other information in the approved provider’s response and am satisfied the organisation has commenced and planned improvements to address deficiencies in relation to workforce governance and feedback and complaints.

While the organisation has commenced actions to address deficiencies, at the time of the site audit, the service did not have effective organisational governance systems relating to workforce governance and feedback and complaints. Therefore, I find this requirement non-compliant.

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

# 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.

* Consumer’s dignity is maintained, particularly in relation to hygiene care and toileting.
* Services and supports for daily living promote consumer’s emotional well-being.
* Services and support for daily living assist consumers to participate in their community (within and outside the service) and do things of interest to them.
* Timely and appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Feedback and complaints are reviewed and used to improve the quality of care and services.
* The workforce is planned and sufficient to deliver safe and quality care and services to consumers, including when the service is impacted by external factors.
* The workforce is trained to deliver care and services relevant to their role.
* Regular assessment, monitoring and review of staff performance occurs.
* Effective organisation wide governance systems are in place, particularly relating to workforce governance and feedback and complaints.