Performance

Report

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| Name of service: | Performance report date: |
| Uniting Osborne House Nowra | 16 September 2022 |
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| Approved provider: | Activity date: |
| The Uniting Church in Australia Property Trust (NSW) | 27-28 June 2022 and 25-28 July 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 Osborne House Nowra (**the service**) has been considered by Melissa Buhagiar, 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:

* the Assessment Team’s Report for the Site Audit, the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Assessment Team’s report received 5 September 2022.
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: 27 consumers and 11 representatives provided feedback to the Assessment Team.

the following information received from the Secretary of the Department of Health (**the Secretary**): Exceptional Circumstances determinations dated 27 January 2021; 26 July 2021; 24 January 2022 and 13 July 2022.

**Additional information:**

This site audit was conducted at the same time as the site audit for the approved provider’s co-located residential aged care service.

The Assessment Team were on-site for the 2 site audits for part day on the afternoon of 27 June 2022 and for the day on 28 June 2022. The Assessment Team returned for a half day on 25 July 2022, full days on 26-27 July 2022 and a half day on 28 July 2022.

The service has 4 households where consumers are accommodated, known as: Grevillea, Jacaranda, Pyree and Terara.

The Deputy Service Manager (DSM) was on leave when the Assessment Team returned to the service on 25 July 2022. A Registered Nurse was assisting in that role for some of the days of the remainder of the site audit.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **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 2(3)(b) The approved provider must demonstrate that assessment and planning is reviewed with current needs, goals and preferences updated.
* Requirement 2(3)(e) The approved provider must demonstrate meaningful reviews of care plans are conducted when consumers' conditions or needs change. Review of incidents must show thorough investigation has occurred to determine the nature of the incidents and the contributing factors leading to the incidents
* Requirement 3(3)(a) The approved provider must demonstrate that clinical care provided to consumers is best practice or that it optimises their health and wellbeing and consumers with wounds, pain and weight loss are monitored regularly.
* Requirement 3(3)(f) The approved provider must demonstrate timely and appropriate referrals are made by service following referral from medical officer.
* Requirement 8(3)(d) The approved provider must demonstrate that the organisation’s risk management framework demonstrates that risks are assessed, and the effectiveness of strategies used to manage high impact/high prevalence risks are employed.

**Standard 1**

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| Consumer dignity and choice | | 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 | 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**

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

* Requirement 1(3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* Requirement 1(3)(b) Care and services are culturally safe
* 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.

* 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.
* Requirement 1(3)(f) Each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team interviewed consumers and representatives who responded in a positive manner in relation to staff knowing about their identity, culture and diversity and of the staff treating them with dignity and respect. Most consumers provided feedback that they are supported to exercise choice and independence, including in relation to decision-making and maintaining relationships of choice. However, one representative advised this is not happening for their consumer, with the consumer not being supported to maintain a relationship with their partner. Consumers and a representative sampled said they are given easy to understand and helpful information on an ongoing basis. Interviews with staff and review of key documents confirms this.

Consumers and a representative sampled provided feedback that their information and personal privacy is respected and maintained. Interviews with staff and observations made confirms this. Some consumers advised that they prefer to keep to themselves and the staff respect this and give them their privacy.

The Assessment Team reviewed care plans which includes information that is important to consumers. For consumers sampled, what is in their care and service records is consistent with what they told the Assessment Team and what management and staff knew about the consumers.

The organisation has shown a commitment to diversity and inclusion through plans such as the reconciliation action plan and through participation in programs such as rainbow tick accreditation. The organisation also has diversity and inclusion policy and procedure, which includes high level commitments and practical actions expected of management and staff.

The Assessment Team observed staff interacting with consumers respectfully. A consumer was seen and heard asking a passing staff member ‘can you spare a minute’. The staff member, who appeared to have purpose to where they were going/what they were doing, took the time to stop and listen to the consumer and assist them with their request. The Assessment Team observed staff maintaining consumer personal and information privacy.

* Requirement 1(3)(d) Each consumer is supported to take risks to enable them to live the best life they can.

The Assessment Team reviewed care plans and found that for two of four consumers sampled review of care and service records and interviews with management and staff did not show that dignity of risk is being balanced with safety considerations. This is despite incidents occurring for those consumers, posing significant risk to them and to others. Management explained a new risk assessment tool is being implemented, but this has not yet been completed for all relevant consumers including the two consumers who experienced related incidents. When later completed for one of those consumers, the risk assessment did not show exploration of factors contributing to the risk or control measures proportionate to the risk. Follow-up interview with a staff member did not show the consumer was receiving the support they needed to take the risk. For a third consumer there was mixed information about whether they were adequately supported to take a risk to live their best life, and for the fourth consumer the information gathered demonstrated this has occurred. Overall, it has not been demonstrated that consumers sampled are supported to take risks to live the best life they can.

The Assessment Team found that this requirement was not met, however, the approved provider responded to the Assessment Team’s report and furnished additional documentation with positive risk assessments for consumers. I have reviewed the additional documentation and find that the provider has taken the necessary steps to address the issues identified within the Assessment Team’s report.

I find that the approved provider is compliant with this requirement.

**Standard 2**

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

**Findings**

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

**The following requirements have been found to be non-compliant.**

* Requirement 2(3)(b) Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

The Assessment Team found that the service demonstrated for consumers that generally their goals and preferences regarding advanced care planning and end-of-life wishes are shared. In relation to consumers’ current care needs, assessments and care plans do not consistently include current or comprehensive information for the consumers sampled. Some staff could describe what was important for consumers in terms of personal and clinical care needs; however, they were unaware that of a consumer who was receiving end-of-life care and the palliative care plan was not updated to include the palliative care needs. The Assessment Team identified assessments and care plans did not routinely record or address the consumer's current needs, goals and preferences.

The Assessment Team also identified that pain assessments and pain charts were not in place for all consumers or regularly monitored for consumers with pain assessments.

The approved provider responded to the Assessment Team’s report and furnished documentation to support their compliance. I have reviewed the documentation; however, the information has not persuaded me that the current needs of the consumer have been met, with deficiencies in pain assessments and documentation identified.

I find that the approved provider is not compliant with this requirement.

* 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.

The Assessment Team interviewed staff who advised that care plans are reviewed regularly. However, the files reviewed showed meaningful reviews of them are not conducted when consumers' conditions or needs change.

A review of the incident register shows that the service has reported increased falls in the last three months. A review of these falls incidents does not show thorough investigation has occurred to determine the nature of the incidents and the contributing factors leading to the incidents. A root cause analysis has not occurred, and appropriate strategies have not been implemented to minimise further occurrence. There have also been inconsistencies in the neurological observations taken post fall and in pain monitoring and review.

Review of consumer’s care and service records shows inconsistencies in identifying the nature of the incidents and conducting a thorough investigation to determine the contributing factors that led to the incident as required by the service’s falls management policy and procedure. Some gaps were noted in identifying and managing pain and completing neurological observations. Falls were also classified as “near misses” which does not correctly identify trends of falls. In some cases, incident reports have not been initiated and therefore not escalated for prompt re-assessment of the consumer.

The approved provider responded to the Assessment Team’s report and furnished evidence of incident reports. I have reviewed the documentation, and note that although there is an option for investigation, there is no recommendation for investigation to review contributing factors and strategies for the incident not to reoccur.

I find that the approved provider is not compliant with this requirement.

**The following requirements have been found to be 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.
* 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.

* 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.

The Assessment Team reviewed care planning documentation which demonstrates evidence of assessment and planning for the consumers sampled. Consumers are screened on admission to the service for risks associated with their health and wellbeing. The clinical and staff handover documentation includes information about each consumer's specific risks. Care planning documents demonstrate others are involved in the consumer's assessment and planning process. Discussions and communication with allied health and medical professionals are recorded when changes in consumer care are made or after the medical officer visit. The team identified that following a medical officer visit any change or adjustment of medications, is documented in the progress notes and from care staff when the families have been updated about the medical officer visit. Progress notes also show the involvement of medical officers, physiotherapists, speech pathologists and podiatrists. It is evident notes from these health professionals were considered by Registered Nurses while conducting a review of assessments.

The Assessment Team interviewed consumers and representatives who advised they participate in assessment processes that lead to developing a care plan. Most sampled representatives said case conferencing is used during admission to develop an initial care plan and consultation occurs after that with consumers and representatives on an ongoing basis. Allied health and other medical personnel also contribute to the information in each consumer’s care plan. Most consumers and representatives expressed satisfaction with communication concerning care and service assessment outcomes and having a copy of the care plan. Some sampled consumers and their representatives could not recall having a copy of their care plan. However, said staff regularly contact them and update them about any changes in their/their relative’s care or services.

**Standard 3**

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| 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. | 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. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

**Findings**

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

**The following requirements have been found to be 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.

The Assessment Team found that while consumers and representatives gave mostly positive feedback about clinical and personal care, the review of care and service records does not support that clinical care provided to some sampled consumers is best practice or that it optimises their health and wellbeing. Consumers with wounds or pressure injuries are not being provided appropriate preventative strategies, and wounds are not measured or dressed and reviewed appropriately. Consumers with weight loss have not been effectively managed. Recommendations post review for the sampled consumers are not consistently acted upon in accordance with their needs. Consumers with pain are not appropriately monitored and assessed; one consumer was not given pain relief while they were experiencing pain.

The service has a database/register for restrictive practices. There are no consumers with mechanical, physical or environmental restraint or who are subject to seclusion. Review of a psychotropic medication register shows that the service has no consumers deemed to be on chemical restraint. Currently, 71% of consumers are on psychotropic medication, which the Deputy Service Manager monitors closely. The Deputy Services Manager said the service has been working on reducing psychotropic medication with constant review and use of alternative non-pharmacological interventions. Documentation shows all authorities and consent for use of psychotropic medication are being reviewed and remain current.

The approved provider responded to the Assessment Team’s report and furnished documentation to support their compliance and noted there were some gaps in this requirement. The provider has initiated a number of actions including education following the receipt of the report.

I have considered the providers feedback and note that some evidence contains post audit initiatives. I acknowledge the work that the provider is implementing, however understand it may take time to reflect compliance, and therefore find that the provider is not compliant with this requirement.

I find that the approved provider is not compliant with this requirement at the time of assessment.

* Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team interviewed consumers and representatives who provided positive feedback regarding access to health professionals. Staff were able to describe the processes for referring to other health professionals. However, care and services documentation and, and follow-up with management and/or staff, showed that timely referral to the relevant health professional was not made for some consumers. Also, there was a lack of monitoring to ensure some referrals made were actioned in a timely manner by an allied health service provider.

The Assessment Team reviewed documentation and noted for some consumers, although a referral had been received from the medical officer, this had not been actioned by the service.

The approved provider responded to the Assessment Team’s report and furnished supporting documentation, I have reviewed this documentation, however this has not persuaded me that there are timely and appropriate referrals to individuals, other organisations and providers of other care and services.

I find that the approved provider is not compliant with this requirement.

**The following requirements have been found to be compliant.**

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.
* 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.
* 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.
* 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.
* 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.

The Assessment Team found that the service has a process for identifying and reviewing consumers deemed high risk based on clinical assessments and changing needs or care outcomes. This includes the risk of pressure injuries, medication management, nutritional issues, risk behaviours, and falls. Service management said risk assessments are conducted to identify consumers at high risk, and strategies are developed to reduce these risks in consultation with the consumers and their medical officers. These risks are highlighted in a risk register with preventative measures. Service management said there is a trend of increasing consumer falls, wounds and unintended weight loss that is highlighted through their clinical indicators. While some inconsistencies were noted in consumer care files reviewed, overall it was demonstrated the service has a process of identifying and effectively managing high-risk factors for most consumers.

The Assessment Team found that the organisation has systems in place for the end of life care of consumers. Staff were able to describe care delivery changes for consumers nearing the end of life and practical ways in which consumers' comfort is maximised when nearing end of life. Registered nurses said they support all consumers through their end-of-life processes by ensuring to keep them as pain-free as possible, having those important to them with them, and being respectful by following their cultural and spiritual choices. Staff said they follow medical officer directives for palliative care. Management said consumers with complex palliative care needs are referred to the community palliative care team or this occurs at the request of their family; otherwise, most of the palliative care is overseen by their medical officers.

The Assessment Team interviewed registered nurses who could describe procedures undertaken, such as referring a consumer to the medical officer or arranging a transfer to the hospital when a consumer’s condition deteriorated, or their condition changed. Other staff said they recognised and responded promptly when sampled consumers' conditions changed or deteriorated and were able to describe escalation procedures if they had concerns about a consumer's condition. Representatives advised the Assessment Team the service is responsive if their relative is unwell and notifies them of any changes as they occur. All of this was confirmed through review of the care and service records for the sampled consumers.

The Assessment Team found that care and service records such as progress notes, care plans and handover sheets showed information about the consumer's condition, needs and preferences is being shared within the organisation and with other organisations where responsibility for the consumer's care is shared. Information from specialist services, medical officers and allied health professionals was reviewed throughout the site audit and observed to be integrated within the consumer’s file and was accessible to staff and other health professionals.

The Assessment Team found that the organisation has policies and procedures relating to antimicrobial stewardship, including the process to minimise antibiotic use, and staff demonstrated knowledge of how this works in their day-to-day practice. The consumers and representatives sampled said service management provided information regularly about the COVID-19 pandemic and precautions taken around it. The service has implemented appropriate COVID-19 preparedness procedures, and consumers spoke of actions taken by the service in response. Care staff could articulate strategies to minimise and manage infection risks or outbreaks under current guidelines. Staff could describe how the service supports them in understanding and promoting appropriate prescribing of antibiotics.

The Acting Services Manager advised that the service has a government supply of antivirals and their local pharmacy also supplies when needed. She explained they were used for the first time during the April 2022 outbreak, with consent sought and obtained for their use by consumers.

**Standard 4**

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| Services and supports for daily living | | 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. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as 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.
* Requirement 4(3)(b) Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.
* 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.

* 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.
* Requirement 4(3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 4(3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team found that the service demonstrates that consumers receive the services and supports for daily living that meet the consumers’ needs and preferences. Consumers provided positive feedback on the services and support they were receiving for their daily living. Staff interviewed demonstrated a good knowledge of consumer interests with documentation supporting consumers’ goals and optimising their health and well-being for daily living.

The Assessment Team interviewed consumers who described how they were able to keep in touch with people who are important to them, however one consumer and a consumer representative provided feedback about a lack of support to maintain personal relationships. Review of the care and service records of one consumer did not show related support had been provided. However, overall it was demonstrated that consumers have been provided with services and supports for daily living to assist them to maintain their social and personal relationships and do things of interest to them.

Care and service records were sighted in the electronic care planning system and reflected consumer preferences for their daily living that supports their independence, health, well-being and quality of life. Documentation included a lifestyle form recording consumers’ areas of interests. They also contain a spiritual assessment that reflects consumers’ preferences and staff interviewed were able to describe how they recognise if a consumer is feeling down and how to support them. Consumers and representatives provided positive feedback about services and supports for consumer spiritual well-being. Most consumers and representatives provided positive feedback about services and support for consumer emotional and psychological well-being, however a consumer and a consumer representative provided feedback about a lack of support. However, overall it was demonstrated that services and supports for consumers’ emotional, spiritual and psychological well-being are being provided.

The service demonstrates that they have processes in place to share information about consumers’ conditions, needs and preferences. The information is up to date and staff were able to describe ways that information is communicated.

* Requirement 4(3)(f) Where meals are provided, they are varied and of suitable quality and quantity.

The Assessment Team interviewed consumers and representatives who provided feedback they get enough to eat, and some consumers provided feedback that they enjoy the meals, there is a varied menu and they get the assistance they need from staff to eat. However, some consumers gave mixed feedback and others entirely negative feedback about meal quality, variety and/or assistance to eat. Staff interviewed said if consumers are not happy with the meals, they offer them an alternative meal choice. A staff member said consumers complain about the meals, yet the catering manager did not seem to be aware of most negative feedback. A staff member provided information about a lack of guidance regarding how to prepare meals for consumers and about not having enough time to do this. Other records reviewed show there has been ongoing negative feedback to the service about the food and that improvement activity has been initiated. Management acknowledged the food complaint trend and indicated they have implemented several food improvement initiatives and are working to address this.

The Assessment Team found that this requirement was not met, however, the approved provider responded to the Assessment Team’s report and provided a summary of actions taken since receipt of the report including meeting with consumers to obtain a greater understanding of their preferences and dislikes. A traffic light report was also provided which obtained feedback at the time of the meal, which was mostly found to be positive.

I have considered the providers response and find that the approved provider is compliant with this requirement.

**Standard 5**

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| 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**

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as 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.
* Requirement 5(3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The Assessment Team observed the service to be a three-level site consisting of four households that are accessible with lifts or ramps. The entrance area is welcoming with a reception, sitting area and coffee shop. There is adequate signage for navigation and wayfinding. During the site audit, consumers were observed to be moving independently and were being assisted by staff to move freely around the service. They were seen sitting in lounge areas chatting with other consumers, knitting, watching television and participating in activities, such as a NAIDOC week celebration, bingo and chair exercises.

The Assessment Team interviewed consumers and representatives who spoke about being able to personalise their/their relative’s room and this helping them to feel at home in the service.

The service demonstrated it has processes in place to ensure furniture, fittings and equipment are safe, clean and well-maintained. This includes reactive and preventative maintenance schedules. Consumers did not raise any concerns in relation to their equipment or call bells and some provided positive feedback. The furniture, fittings and equipment were observed by the Assessment Team to be clean and they appeared to be well maintained and safe.

Observations of the furniture, fittings and equipment showed they were clean and appeared well maintained and safe. Documentation review verified that maintenance was complete and up to date. However, the Assessment Team observed the wheelchair frame for one consumer had a lot of dust and build-up of grime.

* Requirement 5(3)(b) The service environment:

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

The Assessment Team interviewed consumers and representatives who expressed dissatisfaction with the cleaning service, however most consumers said they feel safe. Observations made by the Assessment Team were some areas were not clean and they were cleaned during the site audit. Two consumers said they have difficulty moving around certain areas of the service in their wheelchairs, and the Assessment Team observed one consumer having difficulty. The catering manager indicated staff working in the households are responsible for consumer room cleaning and the Acting Services Manager indicated that ‘cleaning isn’t front of mind’ due to roster challenges and other pressures. However, she said they are looking at contract cleaners and aim to put more hours back into detailed room cleaning.

The Assessment Team interviewed staff who were able to describe the process for logging maintenance requests online. They indicated that maintenance requests were always responded to and repairs made quickly. Staff explained that if they identified a safety issue, that they would try make the area safe and then report it to the RN or other staff.

The Assessment Team found that this requirement was not met, however, the approved provider responded to the Assessment Team’s report and provided evidence of their compliance with this requirement. It was noted by the team throughout the audit that any area which was noted to be unclean, was immediately cleaned by the service. The provider has also met with consumers to obtain feedback on improvements that could be initiated with food, cleaning and staff interactions.

I find that the approved provider is compliant with this requirement.

**Standard 6**

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| Feedback and complaints | | 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

**Findings**

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

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

The Assessment Team interviewed consumers and representatives who provided feedback that they feel encouraged and supported to provide feedback and make a complaint, although one consumer said they did not know how to make a complaint. Interviews with management and staff and review of key documents confirms that consumers and others are being encouraged and supported to provide feedback and make complaints. Five consumers and a consumer representative provided feedback that they feel encouraged and supported to provide feedback and make complaints. This included some who had provided feedback and/or made a complaint. They spoke, for example, about being able to fill in feedback forms, talk directly with management and staff, and speak up at resident meetings. None of the consumers or the consumer representative had any concerns about options for lodging a complaint anonymously or confidentially.

All consumers and one consumer representative sampled said they had been given information about advocacy services and other ways to raise complaints. The consumer representative recalled being given information about the external aged care complaints handling body. Consumers who had given feedback and/or made a complaint thought in the main this was addressed or resolved satisfactorily, and they provided information about open disclosure being used, however one consumer said one issue in their complaint had not yet been resolved. Interview with the manager who handles complaints and review of complaint handling documentation confirms actions is taken in response to complaints and open disclosure is used when things go wrong.

The Acting Services Manager outlined the way she handled complaints, and this was consistent with the organisation’s policy. She was asked about her understanding of open disclosure and what this means for her complaint handling practice. The Acting Services Manager said it means being open and transparent, particularly when things have not gone to plan, there has been an incident or harm has been caused. It was explained when a complaint is receives the provider contacts the complainant and always apologises or expresses regret. Once the complaint issues have been worked through, if there were gaps an explanation will be provided to the complainant and the provider will seek to involve them in complaint resolution.

The Assessment Team identified that the organisation has an incident, complaint and feedback management policy, which incorporates commitments and expectations for encouraging and supporting consumers to provide feedback and make complaints.

Review of resident meeting minutes and newsletters shows consumers and others are encouraged on an ongoing basis to give feedback and make a complaint, if needed.

* Requirement 6(3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team interviewed consumers and representatives with some consumers and consumer representatives providing information that their feedback and/or complaint had led to an improvement in their/their relative’s quality of care and services. However, four consumers and one representative who had made complaints to the service raised concerns or expressed dissatisfaction on the same topic (predominantly food, also cleaning) during the site audit. While information from the management team and review of records shows individual feedback and complaints about the food are addressed and related improvement initiatives undertaken, a significant number of consumers raised concerns and expressed dissatisfaction with the food during the site audit. This does not show that overall there has been an improvement to the quality of the catering service.

The Assessment Team found that this requirement was not met, however, the approved provider responded to the Assessment Team’s report and provided evidence of the newsletters, continuous improvement log for food and cleaning and the meetings that the service has held with consumers to obtain their feedback on these and other areas. Although there was some negative feedback from consumers, the service has been very reactive in addressing the consumer’s concerns.

I find that the approved provider is compliant with this requirement.

**Standard 7**

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| Human resources | | 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. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

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

* Requirement 7(3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.
* Requirement 7(3)(c) The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Requirement 7(3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 7(3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team interviewed consumers and representatives who considered staff to be kind, caring and respectful of their identity, culture and diversity. Feedback provided was consistent with care plans and observations made.

The Assessment Team reviewed care plans which showed they identify and reflect consumers’ identity, culture, and diversity. Care plans used respectful language.

The Assessment Team generally observed respectful and kind interactions between staff and consumers. The Assessment Team observed staff, including management, speaking softly and kindly to consumers. Staff conducting activities with consumers with friendly interactions and inviting consumers to participate. Staff asked consumers what they needed and provided them with reassurance and staff knocking on doors to consumer rooms before entering.

All consumers and representatives interviewed felt that most staff were skilled enough to meet care needs. Management were able to describe processes used to determine if staff are competent and capable in their role. The service has documented core competencies/capabilities for different roles. All consumers and representatives felt staff are well trained and could not identify any major areas they require further training in.

The Assessment Team interviewed staff who considered they are well trained and if they ever wanted additional training they could request it from management. All staff could recall their last performance review and felt supported to progress and continue in their role and develop to other roles. Management were able to demonstrate how they identify staff training needs and how they monitor staff completion of training.

* 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.

The Assessment Team interviewed management who provided examples of how they ensure sufficient staff at the service and provided a record of low percentage of unfilled shift hours, however, on the balance of the evidence gathered, the service was not able to demonstrate that the number and mix of members of the workforce deployed enables the delivery and management of safe and quality care and services.

The Assessment Team interviewed management who considered the service did not have enough staff, and some consumers were able to provide examples of the adverse impacts staffing shortage had on their health and wellbeing. For example, not receiving timely clinical and personal care, not being supported for daily living or to exercise choice and worrying about staff being overworked. Feedback from staff corroborated consumer comments and staff felt staffing shortage meant they are unable to provide consumers with the one on one engagement they need.

The Assessment Team interviewed staff who mostly considered there were enough staff when all staff attend their shift. Staff said that a few staff can call in sick however management do their best to replace those staff. They said they have always been able to deliver the care and services needed by consumers, however this may not always be timely. Staff also said they do not have the time to provide consumers with the one on one engagement they need.

The Assessment Team found that this requirement was not met, however, the approved provider responded to the Assessment Team’s report and provided evidence of the workforce summary, shift report and onboarding reports. Whilst it is noted that consumers felt that there should be more staff and staff agreed, it was also noted by consumers that there were no impacts on them.

I find that the approved provider is compliant with this requirement.

**Standard 8**

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| 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. | 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**

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

**The following requirement has been found to be non-compliant.**

* Requirement 8(3)(d) Effective risk management systems and practices, including but not limited to the following:

1. managing high impact or high prevalence risks associated with the care of consumers;
2. identifying and responding to abuse and neglect of consumers;
3. supporting consumers to live the best life they can
4. managing and preventing incidents, including the use of an incident management system.

The Assessment Team were provided with the organisation’s documented risk management framework, including policies describing how; high impact or high prevalence risks associated with the care of consumers are managed; How the abuse and neglect of consumers is identified and responded to; how consumers are supported to live the best life they can and how incidents are managed and prevented.

However, the service’s risk management systems and practices were not effective as the Assessment Team identified gaps including; lack of evidence that there are effective risk management systems to manage high impact/high prevalence risks. Not all risk assessments were undertaken appropriately to support consumers to live the best life they can as the incident register did not initially identify all incidents until some were raised by the Assessment Team and added soon after.

Management was not able to provide evidence that they assess, or were aware of, the effectiveness of strategies used to manage high impact/high prevalence risks at the service.

The Assessment Team reviewed the service’s risk register which identifies risks to individual consumers. The risk register identifies falls and weight loss as the most prevalent risks followed by pressure injuries and pain as equal third instead of restraint as mentioned by the Acting Service Manager. Management acknowledged that during the pandemic the risk register was neglected and is a work in progress to improve. They said the risk register is an administrative tool and is not the only mechanism used to keep track of high impact/high prevalence risks, daily clinical staff huddles, weekly clinical meetings with the Deputy Service Manager and monthly clinical governance meetings are other ways to keep track of risks. Management said a combination of mechanisms ensures that all risks are recorded and managed. The Assessment Team sampled some consumers who have risks associated with their care and noted their risks are recorded in the risk register.

The approved provider responded to the Assessment Team’s report and furnished the Organisation’s High Risk and High Prevalence Protocol and Risk Management Policy and Framework, consumer risk taking policy and their reportable incident registers. I have reviewed the documentation, however find that the gaps identified though the Assessment Team’s report indicate that these processes are not always followed.

I find that the approved provider is not compliant with this requirement.

**The following requirements have been found to be compliant**

* Requirement 8(3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* 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.
* 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.

The Assessment Team interviewedconsumers and representatives who considered the service to be well run and knew how they could take part in deciding how things are run or how care is delivered at the service. Information gathered through the assessment of other Standards showed some of the feedback given by consumers (or their representatives) has not led to improvement in the care and services. Management were able to provide examples of how the service engages consumers in the development, delivery and evaluation of care and services. The Assessment Team reviewed the service’s CIP which included input from consumers.

The service demonstrated that it is supported by a governing body that promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Management discussed how there are sub-committees to the Board that report key result areas on advance care planning, care planning, falls, polypharmacy, restraint, complaints and continuous improvements. This information is reviewed by the Board who then considers and provides feedback if necessary. For example, across the organisation there has been a decrease in the use of restraints, as a result the Board have provided feedback to report on any increases in staff injury or behaviours of concerns and how they can be better dealt with.

The Assessment Team found that effective organisation wide governance systems are in place to support information management, financial governance, workforce governance, and feedback and complaints. There were areas for improvement in relation to continuous improvement and gaps in relation to regulatory compliance, particularly incident management system obligations. However, the regulatory compliance gaps have been taken into account under another requirement in this Standard and overall, management advised, and some documentation indicated there are effective organisation wide governance systems in those 2 areas.

The Assessment Team interviewed staff who confirmed they can readily access the information they need, including policies and procedures, and there are no significant issues in relation to accessing up to date information about changes to consumers’ needs, goals and preferences. The service is guided and supported by a range of current policies and procedures to manage information including an information security policy, dated April 2022. The policy and procedures states the service is committed to providing an information security management system that protects the company’s information and support systems from a wide range of threats to ensure business continuity, system integrity and confidentiality. The policy also sets out the roles and responsibilities in relation to information management.

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