Performance

Report

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| Name of service: | Victoria Grange Residential Aged Care Facility |
| Service address: | 502-514 Burwood Hwy VERMONT SOUTH VIC 3133 |
| Commission ID: | 3822 |
| Approved provider: | Australian Unity Care Services Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 26 October 2022 to 28 October 2022 |
| Performance report date: | 7 December 2022 |

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

**This performance report**

This performance report for Victoria Grange Residential Aged Care Facility (**the service**) has been prepared by K. Spurrell delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives and others.
* the provider’s response to the assessment team’s report received 24 November 2022.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 1(3)(f) – The Approved Provider ensures each consumer’s privacy is respected and personal information is kept confidential.
* Requirement 7(3)(a) – The Approved Provider ensures the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

# Standard 1

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

Findings

The Assessment Team recommended Requirements 1(3)(a) and 1(3)(f), were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 1(3)(a), the Site Audit report identified several deficiencies, including;

* One consumer said they felt their privacy was not respected recently, when an agency staff walked into their room while they were on the toilet. They also said when they had their meal in their room, they felt rushed by staff frequently checking if they had finished.
* One consumer said they were sometimes provided with the wrong size continence pad, resulting in leakage. Management advised the continence allocation chart indicated the correct aid was recorded and they were not aware of the wrong size being allocated.
* One representative said staff had not attended to their consumer for a long time after they had urinated on their chair.
* Management issued a memo during the audit on 28 October 2022 to all staff reminding them about respecting consumers’ privacy such as by knocking on their door and seeking permission before entering the room and using the consumers’ names.

The provider’s response acknowledged there were some opportunities for improvement identified in the Site Audit report and said their plan for continuous improvement included corrective actions undertaken, commenced or planned.

I have considered the evidence related to respecting consumer’s privacy under Requirement 1(3)(f) of this Standard, where I consider it to be more relevant. I have considered the evidence related to continence care and toileting support under Requirement 3(3)(a), where I consider it to be more relevant.

The balance of evidence brought forward in the Site Audit report under this Requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 1(3)(a) compliant.

Regarding Requirement 1(3)(f), the Site Audit report found consumer’s personal information was kept confidential however, their privacy was not always respected. The following deficiencies were identified:

* Several consumers said their privacy was not always respected with staff entering their rooms either without knocking at all, or entering before they gave permission to come in.
* On multiple occasions the Assessment Team observed staff entering consumers’ rooms without knocking at all, or without waiting for permission to enter after knocking.
* One consumer said some staff were disrespectful of their privacy and enter their room without permission, often to deliver towels.
* One consumer said a staff member entered the ensuite toilet when they were using it despite telling them to ‘wait a minute’ when they knocked on their bedroom door.
* The Assessment Team observed multiple situations where sheer curtains were not in use and beds could be seen through the windows from communal pathways or balconies. Management advised they were going to install sheer curtains in rooms which required them.
* Management stated they would provide staff training on respecting consumer privacy and issued a memo to all staff during the site audit on 28 October 2022.

The Approved Provider’s written response acknowledged there were some opportunities for improvement identified in the Site Audit report and said their plan for continuous improvement included corrective actions undertaken, commenced or planned.

The evidence brought forward showed personal information was kept confidential however, each consumer’s privacy was not always respected. Therefore, based on the evidence before me, I find Requirement 1(3)(f) non-compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 1 are compliant.

Consumers were able to describe how staff acknowledged and valued their culture, values, and diversity. Staff could identify consumers from culturally diverse backgrounds and described how their care and services were culturally safe and this aligned with the information in their care plans. Care planning documents reflected consumers’ cultural needs and preferences and the lifestyle program was observed to includes activities aimed at meeting these.

Consumers and representatives said they were supported to exercise choice and independence when making and communicating decisions about their care and deciding who they wished to involve in their care and said they were encouraged to make new connections and maintain relationships with those important to them. Staff provided examples of how consumers made choices and decisions about their care and services, and how they helped them achieve their goals. Care documents identified consumers’ choices around when care is delivered, who is involved, and how the service supported them in maintaining important relationships.

Management explained how the service supported consumers to take informed risks to enable them to live their best lives. Staff could describe areas in which consumers wanted to take risks and how the consumer was supported to understand the benefits and possible harms when they made decisions about taking risk. Dignity of risk forms were observed, stating consumers’ preferences and documenting the benefits and risks of making such choices.

The service demonstrated information provided to consumers and representatives was current and communicated in a way that was clear, easy to understand and allowed them to make informed choices. Consumers and representatives are kept updated via the service’s newsletter, which is sent by email. The newsletter and consumer meetings provided up to date information on staff and consumers who had joined or left the service, feedback and complaints, continuous improvement activities and consumer suggestions. Staff reminded consumers about daily activities of interest and described ways they effectively provided information to consumers, including to those with cognitive impairments. Posters and flyers about upcoming activities were observed on noticeboards and in rooms.

# Standard 2

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

Findings

Consumers and representatives said they were involved in the care planning processes and they received the care and services they needed. Some consumer and representative stated they were not always consulted regarding the placement of beds and the beds were against the wall when they first arrived. Clinical staff could describe the assessment and care planning process and how it informed the delivery of safe and effective care and services. This assessment included the consideration of risks and identified the risk mitigation strategies to be implemented.

Consumers said staff identify their needs, goals and preferences upon entry and through conversations either in person, by telephone or at case conferences. They said staff speak to them regularly about their care needs including their end-of-life (EOL) wishes, if they chose so. Management said they determined what was important to consumers through monthly ‘customer of the day’ (COD) discussions and regular care plan reviews. The service had a policy and procedure to guide staff practice in assessment and planning, including advance care and end-of-life planning.

Management described how assessments and care planning were completed in partnership with consumers, their representatives (where appropriate) and any other providers involved in their care. Consumers and representatives confirmed they provided input into the assessment and care planning process, either through a formalised conversation or conference, or through regular feedback, and updates. Staff reported regular liaison and partnering with consumers and family members throughout the assessment and completion of care plans. Documentation showed other health professionals and services were included in the assessment and planning process.

Consumers and representatives stated they were offered a copy of the care plan, and most were confident they had an accurate understanding of the assessed care needs. Some consumers advised they did not fully understand the risks associated with the care and services provided or the care plan was not accurate, Management explained to the Assessment Team how they communicated the outcomes of assessments and planning to consumers and representatives. Staff confirmed they had access to care documents via the electronic care management system (ECMS) and frequently communicated the outcomes of assessments and care reviews to consumers and representatives.

The service demonstrated care and services were regularly reviewed for effectiveness when circumstances changed or when incidents impacted on consumers' needs, goals, and preferences. Consumers and representatives said they were regularly informed about changes to circumstances and when incidents occurred. Care documents showed evidence of review on a regular basis and when circumstances changed, or incidents occurred. Staff confirmed care plans were reviewed monthly through the ‘customer of the day’ process, or when health or care needs changed, or an incident triggered a review.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | 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. | 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 Assessment Team recommended Requirement 3(3)(a) was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 3(3)(a), the Site Audit report found most consumers received safe and effective personal and clinical care, in relation to the management of pain, skin integrity, falls, behaviours, restrictive practices and diabetes. However, the Assessment Team identified deficits in relation to continence management and toileting assistance. I consider the following relevant to Requirement 3(3)(a):

* Some consumers and representatives were not satisfied consumers received safe and effective continence management and timely toileting assistance in line with their assessed needs.
* One consumer said they were sometimes provided with the wrong size continence pad, resulting in leakage. Management advised the continence allocation chart indicated the correct aid was recorded and they were not aware of the wrong size being allocated.
* One representative said staff had not attended to their consumer for a long time after they had urinated on their chair.
* Some consumers and staff said there had been a shortage of towels. Management said they had not been made aware of this and would seek a solution.
* Care staff confirmed they were often rushed and were not always adequately staffed to meet consumers’ personal care needs including providing meal assistance.
* While regular staff and management showed they knew consumers’ personal and clinical care needs well, agency personnel were not familiar with consumers’ care needs.

The Approved Provider’s written response acknowledged there were some opportunities for improvement identified in the Site Audit report and their plan for continuous improvement included corrective actions undertaken, commenced or planned.

The evidence brought forward under this Requirement showed staff were able to deliver safe and effective personal and clinical care however, in some instances it was not provided in a timely manner due to staff sufficiency. I have therefore considered this evidence under Requirement 7(3)(a) where it is relevant. The evidence brought forward in the Site Audit report under this Requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 3(3)(a) compliant.

I am satisfied the remaining 6 Requirements in Quality Standard 3 are compliant.

Consumers and representatives were satisfied with how the service managed high impact and high prevalence risks. Management explained how the service effectively managed high impact and high prevalence risks to consumers such as falls, behaviours, psychotropic medications and complex care. Care documents further supported that high impact and high prevalence risks had been identified and effectively managed by the service.

Consumers and representatives were confident, that when they required end-of-life care, the service will support them to be as free as possible from pain and to have their loved ones around. Staff said they prioritised consumers’ comfort and dignity during end-of-life care and explained how they attended to oral care, skin care, repositioning and personal hygiene. Management advised families were encouraged to be present and welcomed throughout the end-of-life stage. The service had policies and procedures directing the provision of end-of-life care.

Management explained how the service recognised and responded promptly to a deterioration or change in consumers’ mental health, cognitive or physical function, capacity or condition. Consumers said the service responded promptly to a deterioration or changes in condition. Staff explained when consumers’ health deteriorated, they communicated at handovers, informed clinical management, escalated to a medical officer and transferred them to hospital, if required. Progress notes and care plans showed a deterioration or change in condition was responded to in a timely manner, documented and relevant people informed.

Staff described how changes in consumers’ care and services were communicated through verbal and handwritten handovers, meetings, accessing care plans, and messages through electronic notifications. Care documents showed staff notified the consumer’s medical officer and their representative when there was a change in their condition, medication, an adverse event, transfers to or from hospital. Staff confirmed they received up-to-date information about consumers at handover.

Consumers and representatives advised the service facilitates timely and appropriate referrals to other relevant health services such as the medical officers, allied health services, geriatrician, Dementia Services Australia, and a palliative care team. Care documents showed appropriate referrals to other health care providers, as needed. Staff described the process for referring consumers to other health professionals and how this informed the ongoing care and services provided to consumers. Referral folders were observed in the nurses’ stations.

The service had policies and procedures in place to minimise and prevent infectious outbreaks, (including COVID-19) and promote antimicrobial stewardship. Consumer and representatives said they were happy with the precautions in place to prevent and manage infectious outbreaks including for COVID-19. The service had an acting infection prevention and control lead whilst they were recruiting to the position. Records showed staff had received relevant training and were provided with appropriate equipment.

# Standard 4

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

Findings

Consumers and representatives reported the services and supports for daily living met their needs, goals, and preferences. Consumers felt supported to maintain their independence, well-being, and quality of life through participating in activities of interest to them. Staff were aware of consumers' interests and correctly identified each consumer's needs, goals, and preferences when asked. Care planning documentation identified consumer needs and goals and provided information about the services and supports consumers needed to do the things they desired. A range of lifestyle activities were observed during the audit such as a visiting comedian, happy hour, and bingo. There was a wellbeing program for consumers who did not participate in group activities however, staff said some consumers had not received one on one contact as they were short-staffed.

Consumers and representatives described how the service promoted their emotional, spiritual, and psychological well-being. Staff provided examples of supporting consumers’ emotional and psychological well-being in line with their assessed care plans. Care documents detailed the individual emotional support strategies for consumers.

Consumers and representatives felt supported to participate in activities both within and outside the service and pursue their individual interests and important relationships. Staff identified several consumers who accessed the outside community freely and described the strategies in place to facilitate their choices. Care documents identified the people important to individual consumers and the activities of interest them.

Consumers and representatives said information about lifestyle needs and preferences was effectively communicated, and they did not have to repeat their preferences to different staff members or other providers of care and services. Staff described how consumers’ care needs and preferences were shared internally at handovers and recorded in the service's consumer files. Care documents provided adequate information to support staff in the delivery of effective care and services to each consumer.

The service demonstrated timely and appropriate referrals of consumers to other organisations, individuals and providers of other care and services. Care documents showed the service collaborated with external providers to support the diverse needs of consumers. Staff said the service engaged with external service providers to meet consumers lifestyle needs. consumers wished to participate in and were of interest to them. The Assessment Team observed the service worked with outside organisations to supplement the services they provided.

Most consumers said the meals provided were varied and of suitable quality and quantity. The service had processes in place to allow consumers to influence the menu and to provide regular feedback on the food provided. Consumers were given flexible choices and their likes and dislikes were communicated effectively to the kitchen. Consumers said the new kitchen manager worked closely with them when they had complaints about the food. The consumer/representative meetings minutes showed consumers had regularly discussed concerns about food, and actions had been taken in response.

Consumers and representatives stated they felt safe when using the service's equipment and said it was easily accessible and suitable for their needs. Consumers were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items were repaired or replaced quickly when required. The maintenance officer described how maintenance requests were logged and actioned promptly and stated the consumers’ equipment was a priority. Equipment used for activities of daily living was observed to be safe, suitable, and well-maintained.

# Standard 5

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

Findings

The service environment was observed to be welcoming, easy to understand and support independence and interaction. Consumers’ rooms said they felt comfortable within the service, and it was easy to get around. Consumers’ rooms were personalised with photographs and artwork, and they were involved in choosing the colours of new communal furniture. Consumers were observed having morning tea, socialising and participating in activities. There were large living and dining areas, wide hallways and ample lighting and signage to support independent navigation.

Most consumers and representatives said the service environment was safe, clean, well maintained, and comfortable. Consumers said they could access all areas of the service and could move around freely, both indoors and outdoors. Doors were observed to be unlocked and consumers were supported to move where they wished. Staff demonstrated the electronic system used for logging and tracking maintenance issues. Staff described the laundry processes as effective with few personal items misplaced. The service environment was observed to be clean, however the walls on one level had a few chips and scratches in the paint. Cleaning staff showed communal areas were cleaned twice daily and consumers’ rooms were serviced daily.

Consumers confirmed the fittings, and equipment were safe, clean and well maintained. Maintenance logs were kept on the service's electronic system and tasks had been actioned in a timely manner. Equipment and furniture were observed to be clean and well maintained, and the call bell system was functioning effectively. Some furniture appeared worn and stained and some consumers did not have sheer curtains in their room for privacy. See Requirement 1(3)(f) for more detail in relation to this.

# Standard 6

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

Findings

The Assessment Team recommended Requirements 6(3)(c) and 6(3)(d), were not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 6(3)(c), the Site Audit report found the service took action in response to complaints but did not always use an open disclosure process when there was a complaint, or when things went wrong. I consider the following relevant to Requirement 6(3)(c):

* Consumers and representatives stated that while complaints were acknowledged, an apology was not always forthcoming.
* One consumer said no apology was offered when they complained about their meal being left on a tray outside their room, when it was not possible for them to carry it in.
* One representative said management or staff had not offered an apology to themselves or the consumer, on the occasions they had complained.
* Management advised open disclosure was captured in email communication and complaints were usually resolved within 10 days depending on the issue.
* The complaints register provided by management did not contain information relating to actions taken where open disclosure could be sighted and the Assessment Team issues in accessing the service’s electronic care management system has been an issue.
* Feedback forms and incident forms had no section to record an expression of regret or apology had been offered.

The Approved Provider’s written response acknowledged there was room for improvement and provided additional clarifying information and evidence in relation to the deficiencies identified in the Site Audit report. The provider advised:

* Open disclosure is actively practised at the service, and the Site Audit report sufficiently articulated any instances where the service failed to appropriately manage feedback and complaints.
* The provision of an apology had generally been documented on progress notes rather than the complaints register however, the service has identified an area for improvement in documenting whether an apology had occurred and why or why not.
* The provider clarified that one consumer raised concerns regularly and the service had worked extensively with the consumer and their family to meet their needs. The service detailed a number of examples where the service provided additional supports and services to meet their needs. The service explained that some of the consumer’s requests could not reasonably be met such as terminating an employee.
* The organisation had a comprehensive Managing Feedback and Complaints Procedure which did not stipulate that an apology was required in every instance of feedback or complaint being received.
* The service also undertook to review the Managing Feedback and Complaints Procedure to ensure full alignment with the open disclosure framework and guidance material.

I have considered evidence related to the quality of clinical and personal care under Requirement 3(3)(a) and adequacy of staffing numbers under Requirement 7(3)(a). I note the service provided numerous examples where issues were resolved satisfactorily at the individual level. I consider the evidence shows the service generally takes appropriate action in response to complaints and practiced open disclosure when things went wrong. While there is scope for improvement, the evidence brought forward in the Site Audit report under this Requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 6(3)(c) compliant.

Regarding Requirement 6(3)(d), the Site Audit report found not all feedback and complaints were used to improve the quality of care and services. Relevant information to this Requirement included:

* Consumers and representatives described how the service sometimes used feedback and complaints to improve the quality of care and services.
* Management described how complaints were investigated and used to improve the quality of care and services, and improvement actions taken in response to feedback were evaluated in consultation with the consumer/representative.
* The Assessment Team identified several issues raised on the continuous improvement plan that had not yet been actioned such as an outdoor area had not been cleaned. Management explained the actions that had been taken and advised funds had been approved for some improvements.
* The service had a comprehensive Managing Feedback and Complaints Procedure and a documented Continuous Improvement Plan.

The Approved Provider’s written response acknowledged there was room for improvement and provided additional clarifying information and evidence in relation to the deficiencies identified in the Site Audit report. The provider advised:

* The examples identified in the Site Audit report mostly related to complaints from specific consumers. Individual consumer feedback and complaints does not always indicate a need for broader service improvements.
* One consumer raised concerns regularly and the service had worked extensively with the consumer and their family to meet their needs. The service detailed a number of examples where the service provided additional supports and services to meet their needs.
* The outdoor area had been cleaned and maintained regularly subject to inclement weather.
* The service provided examples of improvements made as a result of feedback and complaints. The service does examine all feedback and complaints information and, where appropriate, service improvements have been made, or are in progress as a direct result.
* Opportunities to record the provision of an apology on other documents would be investigated.

I have considered evidence related to the quality of clinical and personal care under Requirement 3(3)(a) and adequacy of staffing numbers under Requirement 7(3)(a). I note the service provided numerous examples where issues were resolved satisfactorily at the individual level. I accept the provider’s position that not every item of feedback or complaint will appropriately result in a service wide improvement action. The evidence brought forward under this Requirement showed the service had a documented process for reviewing feedback and complaints and using them to inform improvements to the care and services, where appropriate. While there is scope for improvement, the evidence brought forward in the Site Audit report under this Requirement does not sufficiently support a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 6(3)(d) compliant.

I am satisfied the remaining 2 Requirements in Quality Standard 6 are compliant.

Most consumers and representatives said they were supported by the service to provide feedback and make complaints or suggestions. Management stated consumers and representatives were informed about how to provide feedback and complaints through various avenues such as consumer/representatives meetings, newsletters, verbal feedback, and surveys. Feedback forms were made available throughout the service and a collection box was located in the main foyer for easy consumer access. The service had documented processes and systems in place for consumers or representatives to raise concerns about their care and services.

Most consumers stated they were aware of and have access to advocates. Management said they have partnership with interpreter services and some staff would put their name in a register if they can speak different languages. Management also said that information is captured in the monthly newsletters. Staff were able to describe how to identify consumers who may need help to raise a complaint and how they assist consumers to make complaints using interpreters or representatives.

# Standard 7

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

Findings

The Assessment Team recommended Requirement 7(3)(a), was not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 7(3)(a), the Site Audit report identified the following deficiencies:

* Most consumers and representatives interviewed said there were either not enough staff, or not enough staff who were familiar with their care needs to provide safe and quality care and services.
* Some consumers and representatives stated short staffing and use of agency staff impacted negatively on their care by increasing wait times which impacts on their dignity.
* Most staff reported they have sufficient time to complete their duties each day; however, they were rushed and worry about providing adequate supervision to consumers, timely care and in some cases, lifestyle programs were not delivered due to short staffing.
* Management stated they have implemented strategies to manage unplanned leave, retain existing staff and used agency staff to fill vacant shifts.
* Call bell data for the period 4 October 2022 to 10 October 2022 identified 93% of call bells were answered within 10 minutes, with the average call bell response time being 2.37 minutes. However, there were some significantly longer call bell responses recorded. Periods of high call frequency and longer response times typically occurred between 8am and 10am and 6pm and 8pm each day with the highest number of calls made on Sundays.
* Evidence brought forward under Requirement 3(3)(b) identified deficits in relation to continence management and toileting assistance due to insufficient staff during busy periods.
* The roster allocation indicated 14 unfilled shifts for the period 8 - 21 October 2022.
* Records showed a delay in call bell response time had been identified as a contributing factor in a serious fall incident associated with the death of a consumer in September 2022.
* Management stated they were actively recruiting ongoing positions and have explored referral incentives and initiatives to retain staff including a bonus program. Management stated they were utilising agency staffing in the interim to cover vacant shifts.

The Approved Provider’s written response acknowledged there were some opportunities for improvement identified in the Site Audit report and explained their plan for continuous improvement included corrective actions undertaken, commenced or planned.

While I acknowledge the service has taken appropriate actions to address the deficiencies identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. I have also given weight to consumer and representative feedback on the negative impacts staffing numbers had. The service did not demonstrate the number and mix of members of the workforce enabled the delivery and management of safe and quality care and services. Therefore, based on the evidence before me, I find Requirement 7(3)(a) non-compliant.

I am satisfied the remaining 4 Requirements in Quality Standard 7 are compliant.

Most consumers and representatives said staff were kind, caring and respectful. Most staff members were observed interacting respectfully and patiently with consumers when providing care and assisting with meals. Care documentation showed consumers’ cultural and religious preferences were recorded on admission and more information added overtime. Staff could describe specific consumers' needs and preferences and were observed being attentive and respectful in their interactions with consumers.

Most consumers said regular staff performed their duties effectively, and they were confident staff were trained appropriately and were skilled to meet their care needs. Management explained the recruitment process and other checks conducted such as police checks, verifying qualifications, professional registrations. Staff signed their position descriptions which specified the core competencies and responsibilities required the role. Standard operating procedures provided written guidance for staff undertaking specific tasks. There was a corporate onboarding process and a site-based induction program where new staff undertook mandatory training and underwent 2 buddy shifts to help familiarise themselves with their role and get to know the consumers.

Most consumers stated they were confident in the abilities of staff in delivering care and services and staff were well trained and equipped to perform their roles. Staff described the training, professional development, and supervision they received during the orientation/probation period and on an ongoing basis. Staff said they felt well supported by management. The service had an annual mandatory training and competency assessment schedule which was actively monitored and up to date. Mandatory training included fire and evacuation training, manual handling, hand hygiene, donning and doffing of personal protective equipment, restrictive practices, elder abuse and missing persons, privacy and confidentiality.

Management and staff confirmed the service had a probationary and ongoing performance review system in place. Performance appraisals were conducted annually and included discussion of staff learning needs and goals. The service had a suite of documented policies and procedures related to workforce management, monitoring of staff performance and the performance management of staff.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Consumers and representatives stated they had ongoing input into how consumer’s care and services were delivered through quarterly consumer meetings, lifestyle meetings, consumer surveys, food taste testing and the various complaint and feedback avenues. Meeting minutes showed consumers were actively engaged in raising issues and providing feedback on what mattered to them. Most consumers and representatives stated the service was well run and felt they had a say in the development, delivery and evaluation of care and services.

Management explained how the governing body promoted a culture of safe, inclusive and quality care and services. A robust organisational structure oversighted by a Board, monitored the quality and safety of care and services delivered to consumers. The Board received regular reports from the risk, quality and clinical governance committee and the risk and compliance committee, as well as various performance and incident reports from the service. The organisation communicated regularly with the service management, staff and consumers regarding updates to policies, procedures, or changes to legislation via meetings, emails, memorandums, newsletters and training. The organisation had a cultural diversity framework which outlined strategies and actions for inclusive care and service delivery. Management said all staff received training about the aged care quality standards.

The service demonstrated organisation-wide governance systems covering information management, continuous improvement, financial governance, workforce management, regulatory compliance, and feedback and complaints. Management described how the Board maintained effective oversight through a structured organisational reporting and management framework.

Management explained the service had effective risk management systems and practices in place addressing; managing high impact or high prevalence risks, identifying and responding to abuse and neglect, supporting consumers to live their best life, and managing and preventing incidents. Management identified the service’s high impact or high prevalence risks and explained the measures taken to reduce the frequency and impact of these incidents. Staff described how they use the services written policies, procedures and practices to minimise and manage risk to consumers.

The service demonstrated it had a clinical governance framework in place covering areas of clinical care including antimicrobial stewardship, minimising restraint, and open disclosure. Clinical staff said there was a trained infection prevention and control lead, and they followed the services antimicrobial stewardship policy and procedure, to reduce the likelihood of antimicrobial resistance. Care documents demonstrated compliance with the services antimicrobial stewardship policy.

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