

**Performance Report**

**1800 951 822**

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| Name: | Villa Dalmacia Aged Care Facility |
| Commission ID: | 7234 |
| Address: | 27 Gorham Way, SPEARWOOD, Western Australia, 6163 |
| Activity type: | Site Audit |
| Activity date: | 15 October 2024 to 18 October 2024 |
| Performance report date: | 2 December 2024 |
| Service included in this assessment: | Provider: 9509 Fresh Fields Management (NSW) No 2 Pty Ltd  Service: 4761 Villa Dalmacia Aged Care Facility |

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 Villa Dalmacia Aged Care Facility (**the service**) has been prepared by J Wilson, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others; and
* the provider’s response to the assessment team’s report received 12 November 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not 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 | **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.

* Ensure the needs, goals and preferences are reviewed regularly and following changes to a consumer’s condition, including reviewing and updating relevant assessments, to inform the delivery of safe and effective care and services.
* Ensuring personal and clinical care is provided to consumers which is best practice, optimises their health and well being, and tailored to their needs, particularly in relation to wound care and fluid monitoring.
* Effectively manage the high impact and high prevalence risks associated with the care of consumers, including ensuring staff identify and action weight loss in a timely manner, and implement the directives of allied health professionals.

# 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. | Compliant |

Findings

Consumers and representatives confirmed consumers are treated with dignity and respect, with their privacy and confidentiality maintained by staff. Consumers described how they feel supported, accepted and valued, with their cultural identity respected, with care and services provided in a way which meets their needs and preferences and is culturally safe. Consumers and representatives confirmed consumers are able to make decisions about their care and services which are respected and includes undertaking activities of risk. Consumers and representatives described the various methods the service uses to communicate important information to them, and confirmed the information is presented in a way they can understand, is accurate and timely.

Staff were familiar with the background and preferences of consumers they deliver care and services for and described how they ensure care and services in a way that meets their cultural needs and preferences. Staff confirmed they provide consumers with options during care delivery and assessment and planning to facilitate choice and decision-making. Staff could describe methods to facilitate effective communication with consumers, including where language or cultural differences exist. Staff and management could describe systems and processes to support consumers with undertaking activities of risks, including undertaking consultation and assessment in partnership with consumers and representatives. Staff demonstrated practices which facilitated maintaining the privacy and confidentiality of consumers, including their personal information.

Care documentation was consistent with consumer and staff interviews, including accurate information in relation to the consumers needs, preferences, culture and background, and relationships of importance. Decisions regarding the consumer’s care and services and involvement of other individuals was documented in consumer files and respected by staff.

Management described systems and processes to ensure consumer’s personal information, which was documented in service documentation. Electronic care documentation systems are password protected with access restricted based on staff roles, with paper based care documentation stored securely and only accessible to management.

Service documentation demonstrated information available to consumers, such as activity calendars, newsletters and admission packs, were easy to read, accurate and up to date, and included pictures to facilitate communication and understanding to consumers. Training records showed staff had received training in the Aged Care Charter of Rights.

Based on the assessment team’s report, I find all requirements in Standard 1 Consumer choice and dignity compliant, therefore, the Standard is compliant.

# 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. | Not Compliant |

Findings

This Standard is non-complaint and one of the assessed requirements is non-compliant.

**In relation to requirement (3)(e)**

The assessment team recommended requirement (3)(e) not met, as they were not satisfied care and services were consistently reviewed for effectiveness. The assessment team’s report included the following evidence relevant to my finding:

* Three named consumers were identified as recording significant weight loss in the previous 3 months prior to the site audit. Care documentation did not show a detailed reassessment, including nutritional assessments had been reviewed over this period, nor were food and fluid charts evaluated following completion.
* A dietician review in August 2024 for one named consumer indicated recommendations for fortnightly weights and a follow up with the dietician to be discussed at the next monthly meeting.
  + Care documentation did not include any consideration or follow up by the dietician in the 2 months prior to the site audit. Weight charts demonstrate fortnightly weights had not been undertaken I line with the dietician recommendation.
* Two representatives provided feedback regarding the review and update of dietary preferences for consumers.
  + One representative described how the service had not reviewed the consumers preference for a normal diet until June 2024. While a dignity of risk form had been undertaken in June 2024, a speech pathologist review was not undertaken until October 2024.
  + The second representative requested a speech pathologist review to review the modified diet the consumer was commenced on following illness, however, has not had this occur. The consumer was receiving regular meals, which staff confirmed. Management were not aware this was occurring and a speech pathologist review had been completed following feedback.
* Service documentation indicated mini nutritional assessments should occur annually, or following acute events or illness. Additionally, consumers at risk of weight loss should have a detailed reassessment undertaken, including food and fluid charting evaluated in progress notes.
* Management and staff indicated care plans are reviewed every 6 months, annually and if a change is identified. Management said they only undertake mini nutritional assessments on admission.

The provider did not agree with the assessment team’s recommendations and provided the following evidence relevant to my finding.

The provider confirmed the mini nutritional assessment is not completed for consumers experiencing significant weight loss, only undertaken on admission and if there is a change in clinical status or clinically indicated. They confirmed the ongoing monitoring, evaluation and review of the nutrition and hydration status of consumers is undertaken through regular weight monitoring and monthly dietetic reviews.

For the 3 identified consumers the provider asserted they were all reviewed by a dietician with personalised strategies implemented, and a mini nutritional assessment was completed in April 2024. The provided mini nutritional assessment for the named consumer, indicated the consumer had not recorded weight loss in April 2024.

For the first named consumer who requested speech pathologist reviews, the provider included progress notes to demonstrate reviews by the speech pathologist had occurred in May 2024. For the second named consumer, the provider asserts the consumer was reviewed by a speech pathologist in March 2024, and again in July 2024.

While I acknowledge the providers response, I find the service does not review the care and services for consumers, following identified changes in their needs, goals and preferences, particularly in relation to weight loss and in undertaking reviews by the speech pathologist. In coming to my finding, I have considered the evidence within the assessment team’s report and the confirmation within the provider’s response which indicates nutritional assessments are not undertaken in response to identified weight loss. I acknowledge the providers assertion mini nutritional assessments are not undertaken unless clinically indicated or with a clinical change, however, I have considered the significance or weight loss as a clinical change, and the associated requirement to undertake reassessment following this change.

For the named consumer, I acknowledge the mini nutritional assessment undertaken in April 2024, however, the assessment indicates the consumer had not recorded weight loss and the identified risk was normal nutritional status. However, the assessment does not currently reflect the consumer’s current weight loss, and therefore an accurate risk score. In relation to the fortnightly weights not being undertaken, I have considered this in Standard 3, requirement (3)(b) where this is more aligned.

In relation to the consumer’s requesting reviews by speech pathologists, for one consumer the documentation with the provider’s response confirms the consumer was reviewed by the speech pathologist in May 2024. However, for the second consumer, while I acknowledge the provider’s assertion a speech pathologist review had occurred in Mach 2024 and July 2024, I have not been provided evidence to support this assertion. Therefore, in relation to the second consumer, I can not confirm a speech pathologist review had occurred prior to the assessment team’s feedback.

Based on the information above, I find requirement (2)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

In relation to **requirements (3)(a), (3)(b), (3)(c)** and **(3)(d),** consumers and representatives confirmed assessment and planning is undertaken in consultation, and includes assessments of needs, goals, preferences and risk. Consumers and representatives confirmed the service consults them on their end of life care wishes and advance care planning and were satisfied assessment and planning processes inform safe and effective care and services. Consumers confirmed a copy of their care plan is kept in their room.

Staff were knowledgeable of assessment and reassessment processes, including admission assessments, and reassessments of care and services, both routine and additional reviews following changes or incidents. Staff were familiar with the assessment of risks associated with the care of consumers and described mitigation strategies implemented to prevent harm. Staff described how they assess for needs, goals and preferences of consumers, and discuss advance care planning and end of life care when the consumer wishes. Staff were aware of referral processes to other providers of care and services where required and described engaging them in assessment and planning processes. Staff confirmed care plans are current and accurately reflect the needs of consumers and are accessible through the electronic care system.

Care documentation included the use of assessments, including validated assessment tools, to identify the consumer’s current needs, goals, preferences and risks. Assessments included relevant strategies or interventions to inform the delivery of safe and effective care, with input evident from allied health professionals or other providers of care and services. Care documentation for consumers nearing end of life included advance care plans and palliative pathways with tailored interventions and strategies documented. Consultation with consumers and representatives were documented through progress notes and email correspondence. The organisation has policies and procedures in place to guide and support staff practices and ensure consistency.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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

This requirement is non-compliant as 2 of the assessed requirements are non-complaint.

**Requirement (3)(a)**

The assessment team recommended requirement (3)(a) not met, as they were not satisfied each consumer receives safe and effective personal or clinical care. The assessment team’s report included the following evidence relevant to my finding:

* Wound care documentation for 4 consumers showed wound care was not provided in line with the wound management plan.
  + A representative for one consumer expressed concern about the management of an ongoing wound infection and wound care, which care documentation demonstrated was not occurring in line with the wound management plan.
  + An additional consumer’s representative described how wound dressings had not occurred for months in the past, causing deterioration to the consumer’s skin. Wound documentation demonstrated dressings had not been changed in line with the care plan, and while management provided some evidence of refusal of care in behaviour charting, this was not evident for all missing entries.
  + Clinical staff described methods to check wounds, and described how wounds can be misassigned to night shift and missed. Clinical staff described reviewing individual charts for consumers with active wounds.
* Care documentation for 4 consumers with indwelling urinary catheters demonstrated urinary output was not monitored in line with the service’s policy.
  + Clinical staff indicated fluid output is only recorded and evaluated by night duty when a consumer is on a fluid restriction, and not consumers with indwelling urinary catheters unless indicated.
  + Care staff indicated they are required to record urine output for all consumers with an indwelling catheter.
  + One consumer with an indwelling urinary catheter confirmed they are not able to reach their drink and has to wait for staff to assist. Care documentation show fluid intake and output charts are not consistently recorded and evaluated.
    - Where evaluations are completed, documentation did not include actions or interventions to mitigate risks of dehydration or fluid restriction.
    - Management indicated toolbox education was undertaken to ensure fluid and call bells are within reach of consumers who require assistance.
  + An additional consumer with an indwelling urinary catheter indicated they have to prompt staff to empty the catheter bag, at times where an overnight bag was not available.
    - Management indicated they had provided education to staff regarding emptying catheter bags, and overnight bags were available in the treatment room.
* Care documentation for one consumer who requires oxygen therapy via nasal prongs, did not demonstrate nasal prongs are cleaned or replaced in line with the service’s policy.
  + Two clinical staff were not aware of the requirement to clean and change nasal prongs and had never attended this task.
  + Management indicated nasal prongs are cleaned and changed by clinical staff on weekends and in the afternoon, however no documentation was available to confirm this occurs.
  + Management amended the policy to change the frequency cleaning and changing of nasal prongs.
* Topical medication creams did not have opening dates recorded, while management and clinical staff advised the service policy is to have open dates recorded for all topical creams.
  + Management advised creams were discarded and replaced with education provided to staff.

The provider did not agree with the assessment team’s recommendations and provided the following evidence relevant to my finding.

In relation to wound care, the provider indicated and provided supporting documentation to demonstrate wound care education had been implemented in August 2024 and September 2024 in response to deficits identified through an internal audit.

In relation to fluid monitoring and indwelling urinary catheters, the provider included additional commentary regarding the consumers identified within the assessment team’s report. For the first named consumer, the provider confirmed through documentation the consumer requires full assistance with food and fluids, and described the consumer rarely using a call bell, instead calling out to staff. However, the provider acknowledged and confirmed the information within the assessment team which demonstrated education was provided to staff during the site audit. The provider asserted deficits within documentation regarding fluid output were identified through an audit in May 2024 and education provided to staff.

In relation to oxygen therapy, the provider asserts, nasal prongs and tubing are replaced on the weekends, and the clinical staff interviewed only work on Monday to Friday and therefore do not attend to this task. The provider indicated they have since provided education to all clinical staff, including those who do not work on weekends, of this process.

In relation to topical medication creams, the provider confirmed the memo provided to staff in relation to recording an opening date of topical medications and eye drops. Additionally, the provider asserts they will undertake a review of the procedure to ensure they include direction to staff to record an opening date.

While I acknowledge the provider’s response and the information in the assessment team’s report, I find the service does not provide effective personal and clinical care to all consumers, particularly in relation to wound care and fluid monitoring. In coming to my finding, I have considered the intent of the requirement which states each consumer receives personal and clinical care which is best practice, tailored to their needs, and optimises their health and well being.

In relation to wound care, I acknowledge the information within the provider’s response which indicates wound care education has been provided to clinical staff prior to the Site Audit, however, I have also considered information within the assessment team’s report which indicates for one named consumer with active wound care, wound care has not occurred consistently in line with the wound management plan. Additionally, I do not have evidence before me which indicates wound care has been undertaken consistently to optimise wound healing.

In relation to monitoring fluid output, I acknowledge the education provided to staff in May 2024, however, the evidence within the assessment team’s report indicates ongoing gaps in the monitoring and recording of fluid output charting. The provider’s response, while including additional commentary on the second consumer named, did not include any additional information to demonstrate monitoring of fluid output is consistently occurring. Additionally, I have considered the provider’s acknowledgement of education provided to staff in relation to assisting consumers with food and fluids, however, I note this education occurred following feedback by the assessment team.

Based on the information above, I find requirement (3)(a) in Standard 3 Personal and clinical care non-complaint.

**Requirement (3)(b)**

The assessment team recommended requirement (3)(b) not met, as they were not satisfied high impact or high prevalence risks associated with nutrition, hydration, weight loss and skin integrity were effectively managed. The assessment team’s report included the following evidence relevant to my finding:

* Weight loss is tracked through the electronic care documentation system, which collates data each month for consumers. The collated data is used by allied health to determine consumers who require review. However, sudden weight loss is not being addressed promptly.
  + One consumers and 3 representatives expressed concern with the management of consumers nutrition and weight loss. One representative expressed concern regarding the assistance provided to the consumer in relation to nutrition and hydration.
    - Care documentation showed the consumer requires staff assistance to consume food and fluids and had been referred to a dietician due to weight loss. Weight charting indicated the consumer had lost 4.4kg over one and a half months.
  + Weight charting for one named consumer demonstrated a loss of 9.7kg over 15 days.
    - An initial weight was recorded as 60.1kg on 4 September 2024, with an additional weight on 12 September 2024 identifying a loss of 6.1kg. A further weight was recorded 7 days later on the 19 September 2024, where the consumer weighed 50.4kg, recording an additional loss of 3.6kg.
    - A food and fluid intake chart was not commenced until 24 September 2024.
  + Management indicated staff report weight loss to clinical staff, and a reweigh is to be undertaken to verify the weight loss. Management indicated the weight check is to be completed with the week of the initial identification.
  + The service’s policy and procedure did not provide detailed information on managing weight loss for consumers.
    - While a flow chart guides staff on undertaking a mini nutritional assessment, management confirmed mini nutritional assessments are only undertaken on admission.
  + Prescribed nutritional supplements, such as fortified drinks and smoothies, were left on bedside tables of consumers.
    - Medication competent staff confirmed they are responsible to administer and sign off on fortified drinks, but sometimes leave care staff to give the drinks.
* One consumer with advanced dementia was identified as often refusing personal care, increasing the risk of skin breakdown and infections. The representative of the consumer confirmed staff notify them when the consumer refuses care, and the consumer has gone days without having a shower.
  + Staff indicated they only provide a shower to the consumer once a month, or when requested by the family, and this was reflected in care documentation.
  + Management did not agree with feedback provided by staff, stating the consumer was showered when they attend the hairdresser, which occurs more than monthly.
  + An activities of daily living chart showed from 5 September 2024 to 18 October 2024 did not record any showers over this period.
  + Management updated the care plan of the consumer to receive a shower every 2 to 3 days following feedback.

The provider did not agree with the assessment team’s recommendations and provided the following evidence relevant to my finding.

In relation to the representative’s concern relating to weight loss and nutritional intake, with charting indicating a loss of 4.4kg, the provider included a weight chart which demonstrates weekly weights in October and November taken record the consumer’s weight as steady. The provider asserts, the 4.4kg weight loss was a mis-weigh, as the following weights have been consistent.

For the second named consumer with significant weight loss, the provider asserts the consumer was reviewed by a dietician on 2 August 2024, with an increase in nutritional supplementation. The provider asserted on review the weight documented on 19 September 2024 was incorrect and should have been recorded as 54.4kg. The provider asserted all strategies implemented in August 2024 were appropriate and the consumer’s weight has now stabilised between 55-56kg.

In relation to the final consumer named, who was identified as refusing care, the provider included additional commentary to the consultation and care documentation in relation to the personal care provided.

While I acknowledge the provider’s response, I find the service does not effectively manage the high impact and high prevalence risks associated with the care of each consumer, particularly in relation to weight loss. In coming to my finding, I have considered the intent of the requirement, and place weight on the requirement being for each consumer.

In relation to weight loss, I have considered the information for the second consumer which shows a significant weight loss over a 15 day period. The assessment teams report demonstrates no actions have been taken to address this weight loss following a dietician review prior to the weight loss occurring. I acknowledge the assertion by the provider the weight recorded on the 19 September 2024 was a mis-weigh, however, I have not been provided additional evidence to support this. Additionally, I note the consumer had recorded a loss of 6.1kg the week prior, and do not have evidence to show this had been actioned. In my finding, I have also considered evidence in Standard 2 requirement (3)(e) from the assessment team’s report which demonstrates weights had not been completed in line with dietician recommendations for one named consumer.

In relation to personal care delivery, I acknowledge the providers response and additional commentary and charting which indicates consultation between the representatives and the service in relation to the consumer’s refusal of care. Additionally, I note the behaviour charting and personal care charting which shows while a shower is not attended to consistently, the consumer receives personal care through bed baths. I have also considered there has not been impact to the consumer through the provision of personal care, either with skin integrity or infection.

Based on the information above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

In relation to **requirements (3)(c), (3)(d), (3)(e), (3)(f)** and **(3)(g),** representatives expressed satisfaction with end of life, and palliative care provided to consumers, describing staff take great care to ensure the consumer if comfortable. Consumers and representatives confirmed staff know their needs well and would recognise and respond to deterioration or changes in their condition appropriately. Consumers and representatives described undergoing reviews by medical officers and allied health professionals and confirmed staff adhere to infection control practices, including hand hygiene and the use of personal protective equipment.

Staff demonstrated knowledge of end of life care practices, ensuring the needs, goals and preferences of consumers are met, their comfort maximised and dignity preserved. Staff described how they collaborate and refer to medical practitioners, allied health and external services when required. Staff were familiar with the needs of consumers and described monitoring and escalation processes when deterioration occurs. Staff demonstrated knowledge and awareness of infection prevention and control and antimicrobial stewardship, including the use or personal protective equipment. Staff confirmed communication processes, such as handover and care documentation, to ensure changes to the needs, goals or condition or consumers is communicated and actioned.

Care documentation reflected referrals and consultation with medical practitioners, allied health professionals and external services where required. Consumers nearing end of life are monitored and commenced on palliative pathways, completed by staff, ensuring the needs and preferences of consumers are met. Care documentation demonstrated deterioration of consumers is identified, with appropriate actions taken, such as referrals or transfers to hospital. Infection prevention and control practices were reflected in consumer documentation, including the appropriate use of antimicrobials.

Multidisciplinary meetings with clinical staff discuss clinical concerns relating to the care of consumers, and the strategies implemented in response. Health care professionals have access to the electronic care documentation system, with verbal handovers used to inform staff of changes. An infection prevention and control lead is employed by the organisation, with outbreak management plans and kits available to staff in the event of an infection related outbreak. Alcohol based sanitiser, and handwashing stations are situated throughout the service, with adequate personal protective equipment available for staff, consumer and representative use.

Based on the assessment team’s report, I find requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal and clinical care compliant.

# 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 expressed satisfaction with the services and supports delivered, confirming the services and supports meets their needs, optimises their health, well being and independence and improves their quality of life. Representatives described how services and supports improve the consumers emotional, spiritual and psychological well being though individual and group activities and support. Consumers and representatives confirmed consumers are encouraged and supported to maintain relationships and do things of interest to them, both inside the residential community and within the broader community. Consumers felt staff know them and their needs and preferences well, and information about their needs and preferences is communicated to those involved in their services and supports, with timely and appropriate referrals undertaken when needed. Consumers provided positive feedback in relation to meals provided, confirmed they were of adequate quality and quantity, and describing various options available to them.

Staff were familiar with the needs, goals and preferences of consumers, and described how they ensure the services and supports delivered optimises the consumer’s health and well being and maintained their independence. Staff described how to support consumers emotionally and spiritually, and referral processes to external services and supports where appropriate. Staff confirmed information in care documentation was current, and processes in place, including handover and meetings, ensure changes are effectively communicated. Staff described processes to maintain and clean equipment used to support consumers with activities of daily living, including reporting processes where issues are identified. Allied health personnel confirmed referral processes and understood their role in supporting consumers with activities of daily living, including maintaining independence.

Care documentation was consistent with the consumer’s needs, goals and preferences, with referrals to external services and supports evident. Activity calendars include a range of activities to meet the needs of consumers, with additional calendars available in the memory support unit. Additionally, calendars for individual support is in place for consumers who prefer individual activities. The service has a 4-week rotational menu for consumers, with options for lunch and dinner for both normal and modified diets. There is an additional menu for consumers who do not like any of the meals provided in the main menu.

Based on the assessment team’s report, I find all requirements in Standard 4 Services and supports for daily living complaint, therefore the Standard is complaint.

# 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

Consumers and representatives described the service environment as welcoming, clean and well maintained. Consumers advised they can decorate their rooms with personal belongings, furniture and photographs and expressed they feel safe and at home in the service. Consumers expressed satisfaction with the furniture, fittings and equipment and confirmed they have access and ability to move freely around the service environment, including outdoors.

Staff described processes undertaken to ensure furniture, fittings and equipment are suitable for use prior to purchase. Staff confirmed they have sufficient and appropriate equipment available to undertake their roles and were familiar with processes to ensure equipment is clean, well maintained and any issues are reported. Maintenance staff described processes for preventative and reactive maintenance. The service has systems and processes in relation to cleaning and maintenance to guide and support staff practices.

The service environment is open and easy to navigate with various internal and external areas available for use by consumers. Walkways and common rooms are uncluttered, with handrails and space to allow consumers to easily mobilise with aids comfortably. Consumers rooms were individualised and decorated with personal effects. Consumers move freely throughout the service environments, and furniture, fittings and equipment were clean, well maintained and fit for purpose.

Based on the assessment team’s report, I find all requirements in Standard 5 Organisation’s service environment compliant, therefore the Standard is compliant.

# 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

Consumers and representatives expressed satisfaction with feedback and complaints processes, describing examples of providing feedback and complaints to management and the actions taken to address their concerns. Consumers feel safe and supported to provide feedback and complaints and were familiar with advocacy and language services available if they required assistance. Consumers and representatives confirmed complaints are actioned in a timely manner, and to their satisfaction, and were used to improve care and service delivery.

Staff described how they provide support to consumers in providing feedback and complaints and were familiar with advocacy and language services available. Management and staff were familiar with feedback and complaints processes and demonstrated open disclosure principles in relation to feedback and complaints. Management described how feedback and complaints are reviewed to inform improvements to care and service delivery.

Policies, procedures and training in relation to feedback, complaints and open disclosure are in place to guide and support staff practice. Information regarding feedback and complaints, and advocacy and language services is provided to consumers on admission and displayed throughout the service. A complaint register is maintained and demonstrates feedback and complaints are responded to in a timely manner, with actions, outcomes and open disclosure practices recorded and communicated. Service documentation, including meeting minutes and surveys, reflect consumer engagement and feedback, with identified improvements added to the service’s plan for continuous improvement.

Based on the assessment team’s report I find all requirements in Standard 6 Feedback and complaints compliant, therefore, the Standard is complaint.

# 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. | 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

Consumers expressed satisfaction with the care and services provided, and felt there are adequate staff with the right skills and qualifications to deliver the care they need. Consumers and representatives described staff as kind and caring, and reported interactions with staff as supportive and respectful. Consumers and representatives expressed confidence in the ability of staff to perform their roles and described staff as competent and well trained.

Staff confirmed there are adequate staff to allow them to provide safe and effective care and services, with processes to cover planned and unplanned leave. Staff confirmed onboarding and induction processes, including being provided with position descriptions, employment contracts and pre-employment screening, with mandatory training also provided on commencement. Staff described undergoing regular performance management reviews and are provided opportunities to request additional training to support them in their role.

Management described how feedback systems and processes are used to monitor staff performance and interactions. Management and service documentation confirmed processes in place to monitor the number and skill of members of the workforce to ensure the delivery of safe and quality care and services, including with planned and unplanned leave.

Systems and processes ensure staff hold the required qualifications and registrations relevant to their role, and ensure police clearances, competencies and licences are current and maintained which was confirmed through service documentation. Staff information includes a handbook outlining the organisation’s values, and the Code of Conduct for Aged Care. The service has a comprehensive induction program, which includes mandatory training, while an ongoing training program in place. Training records are maintained and demonstrate strong compliance by staff in completing training. Systems and processes ensure the performance of staff is regularly monitored and reviewed, with documentation showing ongoing formal performance appraisals being undertaken, and additional support provided to staff when identified.

Based on the assessment team’s report, I find all requirements in Standard 7 human resources complaint, therefore the Standard is complaint.

# 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 representative described the service as well managed and are satisfied with the care and services provided. Consumers and representatives confirmed involvement in the development, delivery and evaluation of care and services and described the various ways they are encouraged to be involved, including through surveys and consumer and representative meetings.

The organisation has a consumer advisory body in place, and while there are no consumers or representatives involved from the service, management advised there has been no interest from consumers or their representatives, however, continue to engage with, and encourage consumers to be involved. Service documentation, such as case conferences, consumer and representative meetings, surveys and feedback forms, demonstrate consumer engagement in service improvements, and is included in the services plan for continuous improvement.

The governing body of the organisation is supported by an organisational structure and consists of representatives with diverse backgrounds, including legal, commerce and clinical practice. The organisation’s core values, priorities and strategic directions are promoted and communicated throughout the service, while the governing body is responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards.

Effective organisational wide governance systems are in place to manage and monitor information, continuous improvement, financial management, workforce governance, regulatory compliance and feedback and complaints. The service has policies and procedures in place to guide and support staff practices, with information management systems to ensure consumers, representatives, staff and external parties receive accurate information in a timely manner. Financial reports are completed monthly and reviewed by the executive management team and governing body. Effective systems and processes ensure the workforce is planned and supported to deliver safe and quality care and services though maintaining job descriptions, induction and orientation processes. Changes to legislation and regulations are monitored through subscription to a peak industry body and implemented and communicated to staff. Systems in relation to feedback and complaints ensure complaints are monitored, trended and reported on, and used to inform the continuous improvement program, with a plan for continuous improvement maintained by the organisation.

The organisation maintains a risk framework to manage high impact and high prevalence risks, and includes the assessment, monitoring and evaluation of risk mitigation strategies occur to identify and manage associated risks. Policies, procedures and training programs in relation to elder abuse and serious incidents are available to staff, with staff demonstrating an understanding of reporting processes. Consumers are supported to undertake activities of risk through a dignity of risk framework, which was demonstrated through care documentation and interviews with staff and consumers. Staff and management confirmed the use of an incident management system, and were familiar with processes to report, investigate and close incidents. Management analyse and trend clinical risks and incidents monthly, which are reported and tabled at clinical meetings and provided to the governing body.

The organisation has a clinical governance framework in place to guide staff and described responsibilities, accountabilities and delivery of safe and quality clinical care. Clinical incidents and information, including infections and restrictive practices, are analysed and trended monthly, and reported at an organisational level to the governing body. A suite of clinical policies and processes informs clinical care, and includes antimicrobial stewardship, infection prevention and control, restrictive practices and open disclosure.

Based on the assessment team’s report, I find all requirements in Standard 8 Organisational governance complaint, therefore the Standard is complaint.

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)