Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Villaggio Sant Antonio Hostel |
| Commission ID: | 2909 |
| Address: | 35 Burkitt Street, PAGE, Australian Capital Territory, 2614 |
| Activity type: | Site Audit |
| Activity date: | 28 May 2024 to 30 May 2024 |
| Performance report date: | 11 July 2024 |
| Service included in this assessment: | Provider: 1658 Villaggio Italiano Ltd  Service: 1196 Villaggio Sant Antonio Hostel |

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 Villaggio Sant Antonio Hostel (**the service**) has been prepared by T Coulton, 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, consumers, representatives and others.
* the provider’s response to the assessment team’s report received 28 June 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not 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.

* Effective management of restrictive practices specifically in relation to chemical and environmental restraint, to ensure clinical care is best practice and optimises consumers’ health and well-being.
* The provision of quality meals that meet consumers’ needs and preferences.

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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 said consumers are treated with dignity and respect and consumers’ identity is valued. Consumers provided examples of how staff respect their choice of the gender of care staff providing personal cares. Staff demonstrated knowledge of consumers’ identity and their preferences for care and services. Management and staff advised they monitor consumers are treated with dignity and respect. The service provides staff training on dignity, respect, and culturally safe care, and staff confirmed they have received the training. Policies on consumer choice, dignity, cultural diversity, and inclusion are available to guide staff practice.

Consumers and representatives confirmed the service recognises and respects consumers’ cultural backgrounds. Consumers provided examples of how staff ensure their name is documented correctly as per their cultural background and staff ensure privacy when they are praying. Consumers and staff described the service’s process for collecting information on consumers’ birthplace, preferred spoken language, and religious and cultural needs and preferences. Care documentation evidenced consumers’ life history, cultural and religious preferences are completed on entry to the service.

Consumers and representatives said the service recognises consumers as experts in their own experiences and supports them to make decisions in relation to lifestyle, care, and service preferences. Staff described how consumers’ care and services are communicated to those who consumers wish to involve. Staff demonstrated knowledge of consumers’ preferences and relationships of importance to them; this aligned with information under care planning documentation.

Consumers and representatives explained how the service partners with consumers to support consumers to take risk and to live the life they choose. Management and staff described how they develop risk mitigation strategies in partnership with consumers and those who consumers wish to involve. Consumers’ care documentation identified risks consumers choose to take and the risk mitigation strategies discussed with consumers to facilitate risk-taking.

The service demonstrated information provided to consumers is clear and, in a language, consumers understand and supports consumers to exercise choice. Consumers and representatives explained how staff support them to understand the information the service provides.

Consumers and representatives described how staff ensure consumers’ privacy is maintained and were confident the service ensured confidentiality with personal information. Staff described practices to maintain consumers’ privacy during cares. Consumers’ personal information was observed to be locked in offices and the electronic care management system was accessed by password. The service has a privacy framework to guide staff practice.

For the reasons detailed, I am satisfied consumers are treated with dignity and respect, can maintain their identity, and make informed choices about care and services. I find Standard 1 is compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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

Having considered the Site Audit report and the provider’s response, I have decided Standard 2 and the associated requirements are compliant. Whilst the Site Audit report brought forward some deficiencies in assessment and care planning documentation and in review processes, these matters have been considered below.

Requirement 2(3)(a)

The Site Audit report brought forward deficiencies in relation to incorrect documentation of food texture, on entry to the service incomplete pain and fall risk assessments, incomplete paper-based admission checklists, and the management of restrictive practices.

In relation to the incorrect documentation of textured food for one named consumer, management reviewed and changed the consumer’s documentation to the correct texture during the Site Audit and the Site Audit report evidenced the consumer was receiving the correct meal texture as per the registered nurse’s assessment. The provider has provided evidence the consumer’s meal texture and diet has been reviewed by a dietitian twice in June 2024, staff have been provided with information to prevent choking and a referral has been made to a speech pathologist.

The Site Audit report brought forward deficiencies in the completion of the service’s paper admission assessment checklist for one named consumer. The consumer had not had a pain or falls assessment completed on entry to the service. The Site Audit report demonstrated the consumer had not experienced any falls at the service and the consumer was completing strength exercises with the physiotherapist. The medical officer was reviewing the consumer’s pain medications frequently to manage the consumer’s pain. The provider in their response demonstrated:

* The physiotherapist completed a mobility assessment and planning on the day the named consumer entered the service which included strength exercises to improve mobility and prevent falls.
* Progress notes and medication documentation demonstrated analgesia pain management strategies provided to the consumer.
* Non-pharmacological strategies to manage pain were documented in other areas of the consumer’s assessment and care plan. The non-pharmacological strategies have now been included in the pain assessment and planning document completed within the admission assessment and planning phase.
* A falls assessment and risk mitigation strategies have been completed by the registered nurse and physiotherapist.
* A case conference has been completed identifies effective non-pharmacological pain interventions and strengthening exercises have improved mobility.

In relation to assessment and planning the provider has made changes to systems to monitor consumers’ assessment and planning for risk is completed as per the assessment and planning policy and procedure.

* The paper assessment and planning checklist has been withdrawn from use.
* The electronic care management system has been updated to allow all assessments to be completed within 28 days of entry to the service.
* The senior clinical staff access the electronic care management system reports to identify outstanding assessment and planning and follow up with registered staff to complete.
* The assessment and planning policy and process has been reviewed and reflects the sequencing of consumers’ assessment and planning of care.
* Falls risk assessments have been allocated to registered nurses to complete.
* The service’s plan for continuous improvement identifies actions such as:
  + Consumers entering the service are allocated to senior clinical staff to monitor assessment and planning is completed within the timeframes of the assessment and planning policy and procedure.
  + To identify and complete outstanding consumers’ assessment and planning a desktop audit was completed on 21 June 2024.

The Site Audit report also brought forward deficiencies in relation to chemical and environmental restraint and this is considered under Requirement 3(3)(a).

In coming to this decision, I have considered information in the Site Audit report under these requirements and other requirements in Standards 1 and 3. I note there is evidence in the Site Audit report that staff complete assessments to identify consumers’ needs and preferences and that clinical staff and allied health professionals are involved in this process. Management and staff described the assessment and planning process including the identification of key risks using a range of assessment tools available in the electronic care management system. There is evidence in care planning documentation that staff have had discussions with consumers about risks including for example risks associated with falls, dehydration and weight loss. Having considered the Site Audit report and the provider’s response, I am satisfied the provider has rectified the deficiencies with monitoring the completion of assessment and planning to include the consideration of risks to consumers’ health and well-being, and care plans inform the delivery of safe and effective care and services.

I, therefore, find Requirement 2(3)(a) is compliant.

Requirement 2(3)(e)

The Site Audit report brought forward 2 named consumers who had not had a falls risk assessment review after experiencing a fall. However, the Site Audit report identified the 2 named consumers had individualised assessment and planning strategies to minimise the risk of falling and prevention of fall related injuries. The 2 named consumers had also had their care plan evaluated as per the 3 monthly care plan review.

The Site Audit report identified registered staff and physiotherapists did not have a shared understanding of whose responsibility it is to review falls risk assessments when a consumer falls.

Systems to monitor the completion of 3 monthly care plan evaluations were not able to be demonstrated. However, the Site Audit report identified systems to monitor monthly review of consumers’ care needs such as, but not limited to, skin assessments, weights, and nutritional needs. The monthly assessments were tracked and were being completed. Also, when changes to consumers’ needs and preferences are identified referrals and care plan reviews are completed.

The provider’s response included documented evidence of the evaluation of falls prevention strategies for the 2 named consumers. Evidence was provided that systems have been implemented to monitor care plan evaluations/reviews, case conferences and staff training on care plan evaluations. The electronic care management system alerts staff when 3 monthly care plan evaluations are due, and this is monitored by senior clinical staff. The provider’s plan for continuous improvement includes actions to complete case conferences with consumers and their representatives.

The Site Audit report also brought forward deficiencies in relation to chemical and environmental restraint and this is considered under Requirement 3(3)(a).

Having considered the Site Audit report and the provider’s response, I am satisfied the provider has rectified the deficiencies with monitoring the completion of care plan evaluations and yearly case conferences. In coming to this decision, I have considered information in the Site Audit report under these requirements and in Standards 1 and 3 demonstrating consumers’ care is reviewed.

I, therefore, find Requirement 2(3)(e) is compliant.

Requirements 2(3)(b), 2)(3)(c) and 2(3)(d)

Consumers and representatives advised the service ensures consumers’ needs, goals and preferences are considered during assessment and planning of care and services, including end of life planning. Registered nurses described the service’s procedures for undertaking assessment and planning to identify individual needs, goals, and preferences including end of life planning. Consumers’ care documentation evidenced individualised assessment and planning of consumers’ care and services. Consumers’ end of life planning included directions for staff in advance care planning.

Consumers and representatives said they were involved and partnered in the assessment, planning, and review of the consumer’s care and services and the service includes other organisations or providers as required. Registered nurses detailed the service’s procedures to partner with consumers and representatives for initial and ongoing assessment and planning of consumers’ care and services. Consumers’ care documentation evidenced consumer and representative involvement through routine care reviews, incidents and when changes occur to the health status of consumers. Care documentation demonstrates other organisations and individuals are involved in the assessment and planning process for consumers as required. The service has policies for consumer referrals to other organisations to guide staff practice.

Consumers and representatives said staff regularly discuss with them the outcomes of assessment and planning of care, incidents, and changes in care needs; and copies of the consumer’s care plan are provided. Registered nurses provided details of the service’s procedures for informing consumers and representatives of consumers’ assessment and planning outcomes, and when incidents or changes in care needs occur. Care documentation reflected regular contact with representatives to update them on consumer outcomes of assessment and planning and the offer of a care plan. The service has policies and procedures to guide staff practice in relation to assessment and planning including communicating the outcomes of these assessments to consumers and representatives.

For the reasons detailed, I am satisfied consumers are partnered with the ongoing assessment and planning of their care and service needs. I find Standard 2 is compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | 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

Consumers and representatives generally provided positive feedback in relation to personal care and clinical care consumers received. However, the Site Audit report identified deficiencies in relation to pain management and the management of chemical and environmental restraint. Further information relating to pain management can be found under Standard 2. In relation to deficiencies in chemical and environmental restraint the Site Audit report identified:

* For 3 named consumers:
  + Non-pharmacological interventions were not consistently trialled for changes in consumers’ behaviours prior to administering a chemical restraint.
  + Consumers’ behaviour support plans were not consistently individualised and did not include when to use chemical restraint for changes in consumers’ behaviours.
  + Changes in consumers’ behaviours were not consistently documented and reviewed for care needs.
* The psychotropic register used to identify consumers subject to chemical restraint was not kept up-to-date.
* Perimeter restraint, with a locked pin coded door, was not identified by the service as a form of restrictive practice. Consumers who require support to leave the service had not provided consent for environmental restraint, and assessment and care planning relatingto this had not been completed as required by legislation.

These deficiencies were raised with management at the time of the Site Audit and in response the service revised the plan for continuous improvement with the following actions:

* Review chemical restraint consent forms by 30 June 2024.
* Review behaviour support plans and ensure individual strategies are documented by 31 July 2024.
* Provide staff training on restrictive practices by 31 July 2024.
* Review consumers’ capacity to independently access the locked pin coded door by 30 June 2024.
* Consider other options to a locked pin coded door in the reception area by 31 July 2024.

The provider in its written response to the Site Audit report has stated it is actively working to address the deficiencies in relation to chemical and environmental restraint as evidenced in the Site Audit report. Evidence provided included:

* The 3 named consumers’ behaviour support plans have been reviewed and include individualised strategies to manage behaviours including recommendations from community dementia care services.
* Chemical restraint psychotropic dosage has been reduced for one named consumer after a medical officer review.
* The medication system prompts nurses to document non-pharmacological interventions trialled prior to the administration of an as required chemical restraint.
* All consumers have been assessed in relation to perimeter restraint and consumers have provided consent for perimeter restraint.
* Registered nurses are reviewing all consumers prescribed a psychotropic medication to identify chemical restraint and develop individualised behaviour support plans.
* Senior clinical staff have been allocated responsibility for monitoring the effectiveness of actions taken in relation restrictive practices.
* Daily meetings with registered and senior clinical staff have been initiated to discuss consumers’ care needs.
* A perimeter restraint assessment has been added to the electronic care management system.
* Staff are receiving training on restrictive practices and behaviour management.
* The provider’s policies and procedures on restrictive practices has been reviewed.

While I acknowledge the service is actively addressing the deficiencies relating to the management of restrictive practice, the improvements are yet to be fully implemented and evaluated for effectiveness. For the reasons detailed, I am satisfied Requirement 3(3)(a) is non-compliant.

I found the remaining six requirements under Standard 3 compliant.

Consumers and representatives said the service manages risk associated with the care of the consumer. Review of care documentation evidenced risk such as pressure injury prevention and wound care, and weight loss was identified and effectively managed. Management provided examples of identified risk of weight loss for consumers in relation to the quality of the service’s food and strategies were put in place to negate consumers’ weight loss. The service has procedures and handover processes to guide staff practices to manage high impact and high prevalence risk associated with consumers’ care needs.

Consumers and representatives advised they were confident the service would support consumers’ preferences for end-of-life care needs. Registered staff explained processes for monitoring consumers’ palliative care needs and assessing, planning, and providing end of life care for consumers. Care documentation for consumers who received end of life care evidenced consumers’ end of life preferences and their comfort and dignity were preserved. The service has a palliative care and end of life care policy to guide staff practice.

The service has procedures and resources to guide staff practice in relation to the identification and management of consumer deterioration and changes to health status. Consumers and representatives advised they were confident the staff identified consumers’ deterioration and responded in a timely manner. Registered nurses and care staff provided examples of consumer deterioration and steps taken following the identification of consumer health changes. Care documentation evidenced the staff identify and respond appropriately to consumer deterioration or changes in physical and mental health, function, or capacity.

Consumers and representatives said they are satisfied information about a consumer’s condition is effectively communicated. The service has systems and procedures to ensure information about consumer care is documented and effectively communicated. Registered nurses and care staff had an understanding of consumers’ care needs. Care documentation evidenced information relating to consumers’ condition, needs, and preferences is available for staff in the electronic care management system.

Interviews with consumers and care planning documentation evidenced the involvement of medical officers, allied health professionals, and other providers of care which are initiated through a referral process. Clinical staff described their roles and responsibilities relating to the referral process. Care documentation evidenced referrals to be timely and appropriate.

Consumers and representatives advised the service minimises and manages infection related risks. Staff described practices to manage and minimise infections and facilitate antimicrobial stewardship. The service has implemented policies and procedures to guide staff related to antimicrobial stewardship and infection control management including management of outbreaks.

For the reasons detailed, and based on one Requirement being non-compliant, I am satisfied Standard 3 is non-compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers were not satisfied with the quality of meals provided at the service. Consumers provided negative feedback about the quality, taste, temperature and presentation of the meals.Some consumers said they were repeatedly served food they did not like and a small number of consumers received alternative meals from family. The service supports consumers to provide feedback and management said they were aware of consumers’ concerns and had taken action to address this. The risk of weight loss had been identified by the service and actions taken with food supplements to prevent unplanned weight loss.

The provider in its written response to the Site Audit report has stated it is actively working to address the consumer dissatisfaction with meal quality, as evidenced in the Site Audit report; and is continuing to explore strategies to improve the quality of provided food. Actions taken include:

* Staff training has been provided in relation to staggering meal service times to improve the temperature of meals.
* Consumers’ dietary requirements have been reviewed.
* Management is monitoring the quality of the meals, including tasting provided meals regularly.
* Monitoring of food focus meeting minutes.
* Additional catering equipment and crockery has been purchased.
* Medication and food trolleys are not to be pushed through dining areas during meal services to decrease background noise.
* Injectable and eye drop medication is not to be administered to consumers in dining areas.

I acknowledge the actions taken and planned by the provider to improve consumer satisfaction with meal quality. I have also considered the actions have not been fully implemented or tested for their effectiveness. It is my decision the provider will need additional time to test improvement actions and gain further feedback from consumers relating to meal quality. Therefore, it is my decision Requirement 4(3)(f) is non-compliant.

I found the remaining six requirements under Standard 4 compliant.

Consumers said they receive services to support their lifestyle choices to optimise their quality of life, independence, and well-being. Staff were aware of consumers’ lifestyle choices and provided support to consumers to engage in activities of their choice. Staff described how they discuss activities with consumers to develop activity calendars to suit consumers’ preferences. Consumers were observed attending several different activities with staff assistance if required.

Consumers and representatives said consumers are provided emotional, spiritual, and psychological support. Staff discussed the consumers they provide one-on-one support to in their rooms to ensure their emotional and psychological wellbeing. Staff said they consider consumers’ social, emotional and religious needs when providing care to ensure consumers who wish to attend specific faith, religious services, or external activities are supported to be ready on time to do things important to them. Lifestyle staff said they engage with consumers the best way they can, using various methods appropriate for each consumer. Care planning documentation contained information about consumers’ emotional, spiritual or psychological well-being and how staff can support them. The Site Audit report evidenced staff were observed sitting and talking with consumers.

Consumers and representatives said consumers are offered services and supports to enable them to participate in the community, have relationships and do things of interest to them. Staff described how they support consumers to do things of interest to them, participate within and outside the service environment and have social relationships. Consumers’ care documentation evidenced information on individual consumer interests and identified the people important to them.

Consumers and representatives advised information about consumers’ daily living choices and preferences is effectively communicated. Staff described how information is shared through handover, daily updates on consumers’ care and services via the electronic care management system, and by speaking to the registered staff. Consumers’ care documentation included lifestyle preferences such as their birthday, preferred religious denomination, entertainment preferences and the celebration of special occasions.

Consumers and representatives confirmed timely and appropriate community referrals were facilitated by the service. Lifestyle staff advised consumers are assessed upon entry to the service, and they identified consumers’ community ties and facilitate ways to enable consumers to maintain those connections. Care documentation evidenced collaboration with external services to support the diverse needs of the consumers including referrals to several local churches, pet therapy and to the community visitor scheme.

Consumers and representatives stated they were comfortable raising issues if equipment needed repair, knew the process for reporting an issue, as were staff, who confirmed items were repaired or replaced quickly when required. Maintenance staff were able to describe how maintenance requests are logged electronically, prioritised and signed off when completed. Equipment used for activities of daily living were observed to be safe, suitable, clean, and well-maintained. Reviewed maintenance documentation identified reactive maintenance schedules and preventative maintenance logs for items such as hoists, weigh chairs and other equipment used by consumers were up to date with no outstanding items.

For the reasons detailed, and based on one Requirement being non-compliant, I am satisfied Standard 4 is non-compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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 said consumers feel comfortable and at home at the service. The service’s indoor environment was welcoming, with unobstructed corridors and exits to outdoor garden areas. There were several areas for consumers and representatives to relax, socialise and congregate. Consumers had their rooms decorated with furnishings and personal items that reflected individual tastes and styles. The service had an allocated activity room, multiple indoor common areas for consumers and representatives to enjoy.

The service’s indoor and outdoor environments were observed to be kept safe, clean, comfortable, and well-maintained. Consumers residing in the secure memory support unit are escorted by care staff to attend activities in the large activity area or the community hall and chapel. The cleaning staff explained the cleaning schedules and how the cleaning regime is increased during infection outbreaks. Maintenance staff described the preventative and reactive maintenance schedules in place. Consumers were observed moving freely within the service, in the loungerooms, communal areas and gardens.

Consumers said the equipment provided by the service is well-maintained, safe, and clean. Management and maintenance staff advised the furniture, fittings and equipment are assessed for suitability before purchase to meet consumers’ personal and clinical needs. Care staff ensure the consumers’ call bells are working and are always placed within reach of the consumer. Maintenance confirmed they maintain all equipment used by consumers including the call bells. The lounge chairs, outdoor furniture, standing machines and hoists were observed to be safe, clean, well-maintained, and suitable for use by consumers.

For the reasons detailed, I am satisfied the service environment optimises consumers’ sense of belonging, their independence and interaction. I find Standard 5 is compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| 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 service had systems in place to ensure consumers and their representatives were encouraged and supported to provide feedback or make complaints, including through the use of paper feedback forms that could be submitted in locked letterboxes, through electronic channels or during monthly consumer meetings.

Consumers and representatives said they feel encouraged, safe, and supported to share feedback and make a complaint. They could describe the various methods available, including speaking to management or staff directly, during consumer meetings, via surveys, and through written feedback forms. Staff demonstrated a shared understanding the organisation’s feedback and complaints submission processes and could describe how they support consumers to lodge their feedback and complaints.

Consumers and representatives were aware of advocacy services and other ways to make complaints such as the Commission’s complaints line if required. Management and staff were aware of advocacy and interpreter services available externally if required. Multilingual brochures for external advocacy services were observed in various areas of the service including reception, and the resident handbook is supplied to each consumer on entry to the service.

Consumers and representatives confirmed staff and management addressed their complaints and feedback and resolved any concerns they raised in a timely manner, and apologised when things go wrong. Staff and management demonstrated an understanding of open disclosure and explained how they would apologise to consumers and representatives in the event of something going wrong. The complaints and feedback register evidenced use of open disclosure and timely management of complaints, in line with the service’s complaints, feedback and open disclosure policies.

The service was able to demonstrate most feedback and complaints provided to the service are reviewed and used to improve the quality of care and services. Consumers and representatives interviewed said they felt the feedback and complaints provided at consumers’ meetings and through other mechanisms was used to improve the quality of care and services. Management was able to detail processes by which the feedback provided is used to improve services and were able to provide examples. Review of the service’s plan for continuous improvement evidenced improvements made to the service from consumers’ feedback. The service has documented policies in relation to using feedback and complaints information to identify areas for continuous improvement including guidance in registering feedback and complaints, trending the data and documenting improvement strategies.

Consumers raised concerns about the quality of the meals provided and management described the actions that had been taken to address consumers’ concerns and improve the quality of the meals. This information has been considered and given weight under Standard 4.

I am satisfied overall, feedback and complaints are used to improve the quality of care and services.

For the reasons detailed, I am satisfied consumers are encouraged and supported to provide feedback and make complaints. I find Standard 6 is compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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

Having considered the Site Audit report and the provider’s response, I have decided Standard 7 and the associated requirements are compliant. Whilst the Site Audit report brought forward some deficiencies in staff training, these matters have been considered below.

Requirement 7(3)(d)

In relation to restrictive practice staff did not consistently demonstrate a shared understanding of legislative requirements relating to restrictive practices. The Site Audit report brought forward the following deficiencies:

* Staff did not demonstrate knowledge that non-pharmacological interventions were to be trialled and evaluated prior to the administration of a chemical restraint to manage changes in consumers’ behaviours. The effectiveness of the administered chemical restraint and the triggers for consumers’ changes in behaviours was not consistently evaluated.
* The service did not recognise pin code locked doors used by consumers to exit the service was a perimeter restraint.
* Some registered staff and care staff said they needed more support in understanding the application of restrictive practice legislation for consumers’ care and services.

Management advised a plan for continuous improvement action has been documented for the educator to follow-up staff with overdue restrictive practice training requirements which was sighted and is for completion by 30 June 2024.

The provider in its written response to the Site Audit report has stated it is actively working to address the deficiencies in staff knowledge and application of restrictive practice legislation. Actions taken by the provider include:

* Staff training on restrictive practice has been prioritised and documentation evidenced staff attendance and the service’s plan for continuous improvement evidence ongoing training.
* A pharmacist provided psychotropic medications and chemical restraint training to 9 registered staff on 23 June 2024.
* The service has added restrictive practices to new staffs’ onboarding checklist to facilitate learning of restrictive practices from senior clinical staff.
* The service’s plan for continuous improvement evidence senior clinical staff have been allocated responsibility to monitor effective management of restrictive practices.

Having considered the Site Audit report and the provider’s response, I am satisfied the provider has rectified the deficiencies with staff training in relation to the management of restrictive practices. Additionally, the Site Audit report includes evidence consumers are satisfied staff deliver effective care and the service has systems to train staff in relation to these standards.

I, therefore, find Requirement 7(3)(d) is compliant.

Consumers and representatives said there are enough staff to ensure consumers’ care and service needs are attended in a timely manner. Staff said they have adequate time to undertake their allocated tasks and provide care and services in accordance with consumers’ needs and preferences. Management said there is a service master roster for all staff which considers the changing acuity of consumers and their needs and care minutes to be provided. Review of the service’s roster for the previous 4 weeks demonstrated shifts were filled to meet the rostered shift requirements.

Consumers and representatives said the staff are kind, caring and respectful of consumers’ identity, culture, and diversity. Staff were able to demonstrate knowledge of consumers’ needs and preferences for care and services. Staff were observed treating consumers in a kind manner and supporting consumers to do activities important to the consumer. Staff confirmed they complete training for consumer choice, respect, and dignity.

Consumers and representatives advised they felt the workforce is competent and staff have the knowledge and skills to perform their roles. Management advised staff competency is facilitated through skills assessments and ongoing training relevant to the staff’s role. Review of staff mandatory training demonstrated a 95% completion rate. Processes are in place to monitor staff criminal record checks and registration renewals.

The service demonstrated effective systems are in place to monitor and review staff performance and ensure ongoing support and development for staff. Management advised staff performance is monitored through annual appraisals, observations, analysis of incidents and consumer/representative feedback. Any issues in performance identified through these monitoring mechanisms are addressed immediately. A review of records identified staff appraisals are up to date.

For the reasons detailed, I am satisfied the organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful, and quality care and services. I find Standard 7 is compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

Having considered the Site Audit report and the provider’s response, I have decided Standard 8 and the associated requirements are compliant. Whilst the Site Audit report brought forward deficiencies associated with governance systems and the management of restrictive practice; these matters have been considered below.

Requirement 8(3)(c)

The Site Audit report brought forward deficiencies relating to the management of restrictive practices in relation to regulatory compliance and workforce governance. Concerns related to staff knowledge of restrictive practices, development of individualised behaviour support plans, reducing the use of restrictive practices, and monitoring the effective management of restrictive practices. The weight of this information has been considered under Standard 3.

The provider in its written response to the Site Audit report has stated it is actively working to address the deficiencies in staff knowledge and the management of restrictive practices. Actions taken by the provider include:

* Staff training in restrictive practices.
* Systems to ensure new staff are provided training and support in understanding restrictive practices.
* Allocation and mentoring of staff to monitor the management of restrictive practices.
* External input into the audit of governance and policy processes.
* Review of clinical policies and procedures and procedures.
* Review of consumers’ documentation in relation to restrictive practices.

In relation to regulatory compliance the Site Audit report includes information the service is a member of an aged care peak body which provides information about regulatory changes affecting care and service delivery. Regulatory and legislative changes are disseminated by management staff through email, consumers’ meetings, newsletters, letters and memoranda. Policies and procedures including those relating to open disclosure, the Serious Incident Response Scheme and clinical governance reflected relevant legislative requirements.

The service has a suite of resources to inform staff and management of workforce expectations including requirements, roles and responsibilities; detailed position descriptions were in place. Additionally, the organisation actively supports the workforce to deliver safe and effective care and services and responds promptly when training opportunities are identified.

I am satisfied governance systems relating to regulatory compliance and workforce management are effective.

The Site Audit report includes information the service has effective governance systems in relation to information management, continuous improvement, financial management and feedback and complaints. For example:

* The service is considering implementing a secure consumer portal for consumers, representatives, and staff to share information.
* The Board and management review quality performance data, clinical indicators, consumers’ feedback and complaints, and incidents to ensure the Quality Standards are being met.
* The Board has budgets for operational and capital expenditure and financial and prudential reporting requirements are met.

I have carefully considered the information in the Site Audit report and in the provider’s response. I have considered the weight of information relating to minimising the use of restraint and the management of restrictive practices under Standard 3. I note the service was responsive to feedback from the assessment team and initiated actions to address these deficiencies during the Site Audit. Further, the approved provider submitted a plan for continuous improvement as an element of the response. I am satisfied the organisation has effective governance systems in place.

I, therefore, find Requirement 8(3)(c) is compliant.

Requirement 8(3)(e)

In relation to minimising the use of restraint the Site Audit report brought forward deficiencies in relation to chemical restraint being used prior to the trial of non-pharmacological interventions for changes in consumers’ behaviours. Pin coded locked exit doors were not considered an environmental restraint, and the service had not developed interventions to ensure consumers who were safe to leave the service were supported to leave.

The provider in its written response to the Site Audit report has stated it is actively working to address the deficiencies in staff knowledge and the management of restrictive practices. Actions taken by the provider include:

* Consumers prescribed a chemical restraint have been reviewed by the medical officer and where appropriate the medical officer has reduced the dose or ceased the chemical restraint.
* Consumers have been reviewed in relation to perimeter restraint and where appropriate a behaviour support plan and environmental consent and authorisation has been completed.
* The service is reviewing the reception area to consider removal of the pin coded locked door.

Additionally, the Site Audit report identified the service has a clinical governance framework to guide staff on the provision of safe care and they are supported by policies and procedures on antimicrobial stewardship, and open disclosure. Staff were aware of these policies and described the application of these as relevant to their role. Management is responsible for implementing and overseeing the clinical governance framework within the service, with additional monitoring and oversight provided by the Board.

I have carefully considered the information in the Site Audit report and in the provider’s response. I have considered the weight of information relating to minimising the use of restraint and the management of restrictive practices under Standard 3. I note the service was responsive to feedback from the assessment team and initiated actions to address these deficiencies during the Site Audit. Further, the approved provider submitted a plan for continuous improvement as an element of the response that included staff education, documentation review and increased monitoring and auditing to ensure ongoing compliance with organisational requirements and regulatory responsibilities. I am satisfied Requirement 8(3)(e) is compliant.

Requirements 8(3)(a), 8(3)(b) and 8(3)(d)

Consumers and representatives said they are involved in how care and services are delivered, and their feedback and suggestions are considered by the service. The service has mechanisms to support consumer involvement in how services are delivered such as care planning reviews, feedback and complaints, residents’ meetings, consumer surveys, audits, and the consumer advisory and quality advisory bodies. Management provided examples of changes made to the delivery of services from consumers’ feedback.

The service demonstrated its governing body promotes a culture of safe, inclusive, and quality care and services. Whilst the Board does not have a clinical governance committee, membership has been increased in 2024 to include members with clinical and governance experience. The organisation’s Board receives monthly reports regarding the service’s performance, including but not limited to information on complaints and incident trends. The Board uses this information to ensure compliance with Quality Standards and safe and effective care and service delivery.

The service demonstrated effective risk management systems in place to monitor and manage risks, identify abuse, and support consumers to live their best life. Staff demonstrated an understanding of their role in risk and incident management. Management advised incidents and clinical indicator data is analysed to identify areas for improvement and reported to the Board at monthly meetings.

The service has a clinical governance framework to guide staff on provision of safe care and supported by policies and procedures on antimicrobial stewardship, and open disclosure. Staff were aware of these policies and described the application of these as relevant to their roles. Service management is responsible for implementing and overseeing the clinical governance framework within the service, with additional monitoring and oversight provided by the Board.

For the reasons detailed I am satisfied the organisation’s governing body is accountable for the delivery of safe and quality care and services. I find Standard 8 is compliant.

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