Performance

Report

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| Name of service: | Warrigal Care Queanbeyan |
| Service address: | 111 Campbell Street QUEANBEYAN NSW 2620 |
| Commission ID: | 0552 |
| Approved provider: | Warrigal Care |
| Activity type: | Site Audit |
| Activity date: | 7 February 2023 to 9 February 2023 |
| Performance report date: | 4 April 2023 |

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 Warrigal Care Queanbeyan (**the service**) has been prepared by M. Nassif, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* The Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers, representatives and others.
* The Approved Provider’s response to the Assessment Team’s report received 20 March 2023.
* Other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 1(3)(a): Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* 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.
* Requirement 3(3)(a): Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, tailored to consumer needs and optimises consumer health and well-being.
* Requirement 3(3)(b): Effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 4(3)(f): Where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 6(3)(c): Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d): Feedback and complaints are reviewed and used to improve the quality of care and services.
* 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.
* Requirement 7(3)(b): Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

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

Findings

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

Regarding Requirement 1(3)(a), the Site Audit report brought forward several deficiencies regarding ways in which consumers were treated by staff. I consider the following relevant to this Requirement:

* One consumer’s representative noted their loved one was left isolated in their room by staff for a significant period of time and the consumer was observed to not be included in afternoon tea service. Staff were unable to explain why the consumer was left in their room with their door closed during afternoon tea service. Management advised they would consult with staff to ensure such an event did not reoccur.
* One consumer said male staff would not provide them with assistance to use the bathroom at night or attend onsite social events. The consumer said sometimes staff do not respond to their call bell and stay clear of them.
* One consumer’s representative said their loved one had a plastic pillow and a towel over their bedsheet because, as staff told the consumer, they were tired of changing their bedsheets as a result of the consumer’s wound.

The Site Audit report brought forward other evidence in relation to staff interactions with consumers not being kind and caring which has been considered under Requirement 7(3)(b) where it is more relevant.

The Approved Provider’s response provided the following evidence in response to some of the deficiencies brought forward in the Site Audit report:

* Regarding the representative who reported their loved one was left in their room, the response provided evidence of the consumer attending the main dining room for main meals and participating in various activities, however this was only on 8 occasions during the month of February 2023. Most activities were evidenced to have been held in the morning and the response does not address why the consumer was not included in the afternoon tea service observed by the Assessment Team.
* Regarding the consumer who was not assisted with toileting at night or to attend social events at the service, the response only provides that, after a meeting with the consumer and their representative, the consumer will be attended to by female staff for personal care. The response does not address if the consumer receives toileting assistance at night or to attend social events at the service.
* The response did not address the consumer with a plastic pillow or towel over their bedsheet.

While I acknowledge the service has taken action to address some of the deficiencies, the response did not address all the specific deficiencies listed above. I also acknowledge that most consumers and representatives felt consumer’s identity, culture and diversity was valued. However, I have given greater weight to negative feedback from consumers and representatives and find the service did not demonstrate that not each consumer is treated with dignity and respect. Therefore, on the balance of evidence before me, I find Requirement 1(3)(a) non-compliant.

I am satisfied the remaining 5 requirements in Standard 1 are compliant.

Consumers and representatives said consumers’ care and services were aligned to their culture and the service understood their needs and preferences. Staff described assessing consumers’ cultural beliefs and practices on entry and accessing language resources, if required. Care planning documents demonstrated the service documented consumers’ cultural needs and preferences, and these are reviewed annually.

Consumers said they were supported to maintain relationships. Staff provided examples of how they help consumers to make choices and assist them to achieve their outcomes and these were reflected in their care planning documents.

Consumers said they were supported to take risks and live the best life they can. Staff were knowledgeable of consumers who wished to undertake activities which presented potential risks, undertook assessments, and ensured informed consent was obtained.

Consumers and representatives said they received information regarding care, activities, meals, infection control measures and events. Staff confirmed they communicated with consumers regarding service operations, including utilising multi-lingual resources, where required. Information being provided to consumers, such as activities calendar and menus was observed.

Consumers said their privacy was respected, including staff knocking on doors to enter and closing doors prior to care delivery. Staff described securing consumer information in the password protected electronic care management system. Staff were observed knocking on doors prior to entry and interacting respectfully with consumers.

# 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. | Non-compliant |

Findings

The Assessment Team recommended Requirement 2(3)(a) and Requirement 2(3)(e) not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and my findings are:

Regarding Requirement 2(3)(a), the Site Audit report brought forward deficits under this Requirement that related to lack of review of care and services when circumstances change or when incidents occur. I have considered this evidence under Requirement 2(3)(e) where it is relevant. The Site Audit report also brought forward deficits under this Requirement that related to lack of monitoring to manage high impact risks to consumers and lack of documenting care assessments. I have considered this evidence under Requirement 3(3)(b) and 3(3)(e) respectively where it is relevant.

I consider the evidence presented under this Requirement is insufficient alone to support assessment and planning, including consideration of risks, does not inform the delivery of safe and effective care and services. Therefore, based on the evidence before me, I find Requirement 2(3)(a) compliant.

Regarding Requirement 2(3)(e), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* Consumer A was not reviewed by a speech pathologist to further assess the swallowing capability post a choking incident. Management acknowledged Consumer A required a review by a speech pathologist. Further, Consumer A’s diabetic care plan was not updated followed review by a medical officer where changes were made to the frequency of checking their blood sugar levels.
* There was no evidence of review of pain or pain assessment following wrist pain reported by Consumer B.
* Consumer C said they were feeling drowsy and sleepy during the day however there was no sleep assessment. Consumer C was also assessed in relation to delirium due to a change in their behaviour, however there was no evidence of the outcomes of the assessment to determine if planning was required in relation to the consumer’s delirium.

The Approved Provider’s response disagreed with the Assessment Team’s finding of not met and provided in relation to:

* Consumer A, management acknowledged the above deficits relating to referrals and advised clinical staff will be provided further training on completing referrals.
* Consumer B, their wrist pain was reviewed by a physiotherapist. However, no evidence of the review by the physiotherapist was provided with the response.
* Consumer C, the response does not address if a review of the consumer’s sleep was undertaken or if planning was required as a result of the consumer’s delirium assessment.

While I acknowledge the service has taken appropriate actions to address some of the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Further, the response does not address all the deficits identified in the Site Audit report. Therefore, on the balance of evidence before me, I find Requirement 2(3)(e) non-compliant.

I am satisfied the remaining 3 requirements in Standard 2 are compliant.

Care planning documents contained information about consumers’ needs, goals, and preferences including end of life wishes. Staff demonstrated an understanding of consumers’ needs and preferences and discussed how they obtain information on end of life wishes.

Consumers and representatives confirmed their involvement in assessment and planning process which was consistent with care planning documents. Staff described the involvement of others in consumers’ assessment and planning and care planning documents confirmed this to be the case.

Records demonstrated the communication of changes to care and services to consumers and representatives. Staff said a copy of the care plan was provided to consumers and representatives as requested.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Assessment Team recommended Requirements 3(3)(a), 3(3)(b), and 3(3)(e) not met. I have considered the evidence presented by the Assessment Team in the Site Audit report and the Approved Provider’s response, and my findings are:

Regarding Requirement 3(3)(a), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* Consumers and representatives said staff numbers were insufficient to provide timely personal care. This has been considered under Requirement 7(3)(a) where it is relevant.
* Five consumers subject to environmental restraint had no consent forms in place and were not reviewed annually as per the service’s policies and procedures. Management acknowledged this deficit.
* Care planning documents for consumer A and C evidenced inconsistent or lack of monitoring of pain raised and experienced by consumers, including by Consumer A post a fall. Care planning documents also evidenced lack of evaluation of effectiveness were pain relieving medication was provided to consumers to ensure their pain was effectively managed.
* Care planning documents of 2 consumers evidenced gaps in wound management, including lack of a wound chart to monitor the progress of new wound sustained by Consumer A and incomplete wound information for Consumer C to properly assess the origin and cause of the wound.
* Consumer C’s sleep care plan included a directive to commence a sleep chart if there is any change in the consumer’s sleep pattern. Management confirmed this had not occurred following changes observed in the consumer’s sleep pattern.

The Approved Provider’s response, provided clarifying information in relation to some of the deficits identified above:

* All 5 consumers subject to environmental restraint now have consent in place and have been reviewed and updated.
* In relation to pain management for Consumer A post a fall, the response provided evidence of pain assessment and evaluation of effectiveness of pain reliving medication on 2 occasions the day the consumer had the fall. In relation to pain management for consumer C, the response does not address the deficiencies identified however stated that the pressure injury, to which the pains related to, has healed.

While I acknowledge the service has taken appropriate actions to address some of the deficits identified, the response does not address deficiencies identified in relation to wound or sleep management. Therefore, on the balance of evidence before me, I find Requirement 3(3)(a) non-compliant.

Regarding Requirement 3(3)(b), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* In relation to consumer A:
  + There was no evidence of a review by a speech pathologist post a choking incident and the choking incident wasn’t reported to manage and prevent future reoccurrence.
  + There was limited evidence of neurological and vital observations conducted for post a fall.
  + There was inconsistent monitoring of the consumer’s blood sugar levels as per directive by medical officer.
* In relation to consumer B:
  + There was no evidence of a review by a speech pathologist to manage consumer B’s risk of choking and aspiration.
  + There was no or inconsistent monitoring of fluid intake despite the consumer on a fluid restriction.
* In relation to consumer C:
  + There was no evidence of the consumer’s weight being checked fortnightly or monitoring food intake consistent with dietitian’s recommendation as the consumer is underweight.
  + They were provided normal meals on 2 occasions despite their care plan stating they require soft and bite size diet.

The Approved Provider’s response, provided clarifying information in relation to some of the deficits identified above:

* Since the site audit, a referral and review by speech pathologist has been conducted for consumer A. A partial assessment by a speech pathologist was completed for consumer B in early 2022 and a referral to a speech pathologist has been sent.
* In relation to limited evidence of neurological and vital observations conducted for post a fall for consumer A, the response stated observations were conducted immediately post fall and throughout the night. The Site Audit report and response did not bring forward sufficient information regarding management of consumer A’s fall, therefore, I am unable to form a view and hence have not considered this example.
* In relation to inconsistent monitoring of consumer C’s fluid intake, the response acknowledged there was a period of time where fluid intake was not monitored however staff are now doing this daily and education has been provided on the importance of completing fluid intake charts.

The response does not address the 2 occasions where consumer C was not provided meals in line with their care plan however the Site Audit report and response did not bring forward any further information in relation to this. Due to insufficient information, I am unable to form a view and hence have not considered this example.

The response did not address deficits identified in relation to monitoring of consumer A’s blood sugar level in line with a medical officer’s directives and fortnightly checks of consumer C’s weight in line with a dietitian’s recommendation.

While I acknowledge the service has taken appropriate actions to address some of the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Further, the response does not address all the deficits identified in the Site Audit report. Therefore, on the balance of evidence before me, I find Requirement 3(3)(b) non-compliant.

Regarding Requirement 3(3)(e), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* Consumer A’s diabetic management plan was not updated to contain information about the frequency of monitoring their blood sugar level, or the method for testing their blood sugar levels, consistently with recommendations by a medical officer following a review. This information was only noted in progress notes. Management acknowledged the frequency to check the consumer’s blood sugar levels should be documented to direct staff.
* Consumer B is on a fluid restriction, however there was no documented medical directive for the fluid restriction. However, the consumer’s care plan does detail their fluid restriction requirements.

The Site Audit report does not bring forward evidence of impacts on consumers as a result of the deficiencies identified. In relation to Consumer A, lack of updating their diabetic management plan post review by a medical officer has been considered under Requirement 2(3)(e) where it is relevant and resulted in a finding of non-compliant. Further, in relation to consumer B, though there was no medical directive, the response clarifies that requirements around the consumer’s fluid restriction was well documented and shared among staff during handover.

I consider the evidence presented under this Requirement is insufficient alone to support information about the consumer’s condition, needs and preferences is not documented and communicated within the organisation, and with others where responsibility for care. Therefore, based on the evidence before me, I find Requirement 3(3)(e) compliant.

I am satisfied the remaining 4 requirements in Standard 3 are compliant.

The service had policies and procedures in place to inform staff practice in relation to palliative care and end of life care. Care planning documents contained information to support consumers with end of life care. Staff described how the service liaises with a palliative care nurse to support them in providing consumers with end of life care.

Staff provided examples of how they identified and responded to changes in consumers’ condition. Care planning documents reflected the identification of and response to a change in a consumer’s condition.

Consumer and representatives acknowledged they were frequently contacted by the service prior to a referral being made. Care planning documents reflected timely referrals. However, there was no evidence of a timely referral to a speech pathologist for one consumer after a choking incident. This is considered under Requirement 3(3)(b) where it is relevant and found non-compliant.

The service had policies and procedures to guide staff in the delivery of clinical and personal care. Staff described the competencies they have completed including handwashing and donning and doffing of personal protective equipment.

# Standard 4

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

Findings

The Assessment Team recommended Requirement 4(3)(f) not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

Regarding Requirement 4(3)(f), the Site Audit report brought forward the following deficiencies:

* Majority of consumers interviewed provided negative feedback regarding the quality, quantity and variety of meals provided by the service. Comments from consumers included that the food was bland, the meat overcooked, and meal choices were limited.
* Documentation evidenced one consumer had been provided food that was misaligned to their dietary requirements and religious practices. Documentation also evidenced once consumer said they were hungry however there was no food available, and staff warmed up their own food for the consumer.
* Dining areas and kitchen appliances were observed to be dirty, including the presence of mould, spoiled food, and dust. Consumers also commented on the uncleanliness of the dining area. Management advised they would review the areas of concern and follow up with staff.
* A complaints register and continuous improvement plan evidenced numerous complaints regarding food and management acknowledged the issue was still current at the time of the Site Audit.

In the Site Audit report provided, management acknowledged issues raised regarding meal service and outlined a number of measures being taken to resolve these issues. This included resuming catering in house and providing staff with additional training.

The Approved Provider’s response reflected the abovementioned actions to improve issues around meals and further provided the following evidence in response to deficiencies brought forward in the Site Audit report:

* A cleaning schedule had been developed to check and clean the kitchenette and main dining room floors each day and between meals.
* The service was working with the contracted caterer to provide a more friendly dining experience.

While I acknowledge the service has taken appropriate actions to address some of the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. Further, the response does not address all of the deficits identified in the Site Audit report and I have given greater weight to negative feedback from consumers and representatives and find the service did not provide meals that were of suitable quality. Therefore, on the balance of evidence before me, I find Requirement 4(3)(f) non-compliant.

I am satisfied the remaining 6 requirements in Standard 4 are compliant.

Consumers and representatives said consumers were supported to do things of interest and spend time doing independent activities. Care planning documents identified the needs and preferences of consumers and consumers were observed engaging in a variety of group and independent activities.

Consumers provided examples of how staff supported them when they were feeling low. Staff explained how they identified when a consumer appeared to be low and supports for consumers’ well-being. Care documents included information on how to support consumers’ emotional, spiritual and psychological well-being.

Consumers and representatives said consumers participated in activities of interest within and outside the service. Staff identified each consumers’ interests and preferences for activities, and ways they accommodated needs and preferences. Care documents identified consumers’ needs, preferences, and activities of importance to their daily living.

Care documents demonstrated adequate information regarding consumers’ lifestyle and activity needs and preferences. Staff described consumers’ condition, needs and preferences, and were familiar with the required processes to respond to changes.

Staff demonstrated an understanding of what organisations, services and supports were available in the community and how they access these or refer when appropriate. Care documents demonstrated timely and appropriate referrals to other organisations. Various brochures and resources were observed to support referrals to external organisations.

Consumers advised they had access to equipment to assist their mobility and independence, and stated equipment was readily available and clean. Documentation confirmed processes were in place for preventative maintenance and faults. Equipment was observed to be well maintained and in adequate supply.

# Standard 5

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

Findings

The Assessment Team recommended Requirement 5(3)(b) not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

The Site Audit report brought forward the following deficiencies:

* Consumers and representatives provided consistent comments on the cleanliness of the service, including lack of cleanliness in consumers’ rooms, insects in a consumer’s room, and linen not cleaned on planned days.
* Unclean linen and dining areas and kitchen appliances were observed to be dirty, including the presence of mould, spilt food, and dust. Management advised they would review the areas of concern and follow up with staff.
* The continuous improvement plan evidenced complaints regarding cleaning and laundry services and planned completion dates in 2022, however, the complaints remained unresolved at the time of the site audit.

The Approved Provider’s response outlined actions taken, and provided evidence of those actions, to address feedback from named consumers and representatives and observations made during the site audit, as discussed in the Site Audit report. In relation to complaints about cleaning remaining unresolved and not resulting in overall improvements, this has been considered under Requirement 6(3)(d) where it is relevant.

The Site Audit report noted areas of the service, including gardens and external patios were clean and tidy, schedules evidenced completion of routine cleaning and consumers were observed moving freely between various areas. Staff advised carpets were steam cleaned every 6 months, or more frequently if required.

On the balance of evidence before me, I consider the service did demonstrate the environment was clean, well-maintained, and comfortable. Therefore, I consider Requirement 5(3)(b) compliant.

I am satisfied the remaining 2 requirements in Standard 5 are compliant.

Consumers and representatives said they found the service welcoming and provided them with a sense of belonging. The service included navigational signage, a café, and outdoor courtyards for exercise. Consumers’ rooms were observed to be personalised.

Consumers said furniture, fittings and equipment were safe, clean, and well-maintained. Management advised equipment was assessed for suitability prior to use and all maintenance requests were electronically tracked and referred to contracted specialists for action. All equipment was observed to be adequately maintained.

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

Findings

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

Regarding Requirement 6(3)(c), the Site Audit report brought forward the following deficiencies:

* Several consumers and representatives stated when they made a complaint, they do not receive an apology and there is no follow up to know the outcome of their complaint and some had not yet been resolved.
* The service’s complaints register evidenced that not all complaints made were recorded and therefore appropriately addressed. Management acknowledged deficiencies in registering all complaints and expressed concern that doing so would adversely impact staff capacity to perform duties.
* The complaints register also did not provide evidence of the use of an open disclosure process.

The Approved Provider’s response addressed each of the named consumer and representative examples brought forward in the Site Audit report and attempts they made to resolve complaints. The response also outlined several strategies the service has or will undertake to address the deficiencies brought forward in the Site Audit report. These included the employment of a Complaints Officer to improve management of feedback and complaints processes, review of current systems of documenting and addressing complaints and feedback and additional staff training regarding open disclosure.

While I acknowledge the service has taken appropriate actions to address the deficits identified, there has not been sufficient time to demonstrate the sustainability and effectiveness of the changes. The service did not demonstrate appropriate action was taken in response to complaints and the use of open disclosure process. Therefore, based on the evidence before me, I consider Requirement 6(3)(c) non-compliant.

Regarding Requirement 6(3)(d), the Site Audit report brought forward the following deficiencies:

* Most consumers and representatives were not confident their feedback and complaints resulted in improvements.
* Management said trends in complaints include consumer care, food, cleanliness and laundry. These were reflected in the continuous improvement plan with planned completion dates in 2022. However, the entries in the continuous improvement plan remained unresolved at the time of the site audit.

The Approved Provider’s response disputed evidence brought forward in the Site Audit report regarding the status of complaints in the continuous improvement plan, stating items had been closed in late 2022 or shortly after the Site Audit. However, the response did not provide evidence of actions taken in response to feedback and complaints to evidence improvements had been made. Further, evidence brought forward under Requirements 3(3)(a) and 3(3)(b) demonstrated issues around consumer care are still ongoing, despite the response stating that items in the continuous improvement plan in relation to consumer care had been closed in 2022.

I consider the provider’s response was not persuasive and that the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Therefore, on the balance of evidence before me, I find Requirement 6(3)(d) non-compliant.

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

Consumers and representatives said they felt supported to provide feedback or make complaints to staff or management. Feedback forms and boxes were observed to be available to consumers around the service. Staff explained the internal and external processes for complaints and how they support consumers to provide feedback or raise a concern.

Consumers were aware of advocacy and language services to support a complaint and staff described referring to management to access interpreters, if required. Information regarding advocacy and language services was observed on posters and brochures throughout the service.

# Standard 7

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

Findings

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

Regarding 7(3)(a), the Site Audit report brought forward the following deficiencies:

* Consumers and representatives said staff numbers were insufficient to provide the required care and services. Examples of impacts staff insufficiency had on consumers included long wait times, not receiving timely personal care, not being provided care by female staff in line with consumer preferences, and not receiving assistance with meals. Staff were also observed to not be attending to consumers when they called out for assistance in distress.
* Staff said staff shifts are not replaced effectively and confirmed that some consumers do not receive timely personal care. Clinical staff said that staff shortage resulted in record keeping deficiencies and compromised consumer care.
* Documentation demonstrated that not all shifts are filled, consistent with feedback from staff.

The Approved Provider’s response outlined how the planned roster provides at least 200 minutes per consumer per day, meeting incoming legislative requirements. The response further provides the service employs a high percentage of female staff, presenting sufficient availability of female staff to meet consumer preferences. However, the response does not address why, despite a high percentage of female staff, consumer care preferences for female staff are not being met.

While I acknowledge the service’s staff roster and percentage of female staff employed, the response was not reflective of a continuous improvement approach in relation to staff sufficiency. Further, I have given greater weight to negative feedback from consumers, representatives, and staff and the impacts staffing shortage has had on consumers. I find the service did not demonstrate that the workforce is planned to enable the delivery of timely and appropriate support and services to consumer’s satisfaction. Therefore, based on the evidence before me, I find Requirement 7(3)(a) non-compliant.

Regarding Requirement 7(3)(b), the Site Audit report brought forward several deficiencies. I consider the following relevant to this Requirement:

* Most consumers and representatives noted staff often ignored their requests.
* Representatives said more patience and understanding was required by staff when caring for consumers with dementia.
* One representative said some staff were good while others were rude.
* One representative for two consumers described them as being frightened of a staff who raised their voice when interacting with the consumers.

The Approved Provider response brought forward results from the consumer survey conducted late 2022 and acknowledged a small percentage of consumers who said staff treated them with respect most of the time and they do not feel safe. While the response outlines actions taken to address the survey results, it is unclear if these actions are to address consumers feeling unsafe as a result of staff or for other reasons.

In relation to the specific deficiencies identified above, the response only addressed the representative who complained of a staff member raising their voice at a consumer. The response advised the staff member said they spoke loudly to the consumer as they are hearing impaired, and the staff member had been reassigned to care for other consumers. The response further noted training scheduled in the near future for staff to learn about caring for consumers with dementia.

However, the response did not address all concerns raised by consumers and representatives or provide sufficient evidence. Therefore, the service did not demonstrate that workforce interactions with consumers were kind, caring and respectful of consumers’ identity, culture, and diversity. Therefore, on the balance of evidence before me, I find Requirement 7(3)(b) non- compliant.

I am satisfied the remaining 3 requirements in Standard 7 are compliant.

Consumers and representatives were confident staff were sufficiently skilled to meet consumers’ care needs. Management demonstrated systems on how they monitor to ensure staff are meeting the minimum qualification and registration requirements for their roles and ensuring compliance with current criminal history checks in place. Records evidenced staff held valid registrations and recruitment documentation outlined required qualifications, registrations, and abilities.

Training records and competency records showed annual mandatory training and competencies are undertaken and there is a high completion rate. Management said that responsive training is given to staff that is identified from trends and audit findings. Staff confirmed they underwent mandatory and supplementary training.

Staff participated in annual performance appraisals and records evidenced most staff had completed an appraisal or were scheduled for completion. Staff were knowledgeable of the appraisal process and management advised informal discussions occurred in response to performance issues to ensure prompt resolution.

# 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

The Assessment Team recommended Requirement 8(3)(c) not met. I have considered the Assessment Team’s findings, the evidence documented in the Site Audit report and the provider’s response and my findings are:

The Site Audit report brought forward the following deficiencies:

While the organisation had a governance system in place, the service did not demonstrate practices aligned to the system or implementation of guiding policies and procedures. For example:

* Feedbacks and complaints were not consistently captured, analysed and reported to the Board and used to inform the service’s continuous improvement plan.
* The service could not demonstrate there were always sufficient staff to provide quality care and services to each consumer.
* A reportable incident was not reported under the Serious Incident Response Scheme within legislated timeframes.
* Consent was not in place for 5 consumers subject to environmental restraint.

The Approved Provider response included clarifying information in support of compliance, including consent now being in place for all consumers subject to environmental restraint. In relation to reportable incidents not being reported, the response states that the incident was reported within legislated timeframes. The response provided other examples of reportable incidents also being reported within legislated timeframes. This appears to be an isolated event and no evidence of further occurrences was brought forward to suggest systemic issues of not reporting reportable incidents within legislated timeframes.

In relation to deficiencies brought forward that related to continuous improvement, feedback and complaints and workforce governance, the evidence provided in the Site Audit report does not show absence of organisational wide governance systems in place. However, the evidence provided does show there are deficits at the service level in relation to documenting and actioning complaints and ensuring adequate staffing to deliver care and services in line with consumer needs and preferences. I have considered this evidence under Requirements 6(3)(c), 6(3)(d) and 7(3)(a) where they are relevant and have resulted in a finding of non-compliant. Therefore, based on the evidence before me, I find Requirement 8(3)(c) compliant.

I am satisfied the remaining 4 requirements in Standard 8 are compliant.

Consumers and representatives said they were aware of opportunities to be involved in the development, delivery and evaluation of care and services through meetings, feedback, complaints, and surveys. Management confirmed encouraging consumer involvement and had increased consumer meeting frequency in response to trending complaints. Meeting minutes evidenced strong attendance by consumers.

Management said the organisation’s governance structure included direct feeding of information to the organisational management team. Through this process, the Board is made aware of the performance of all aspects of the service at regular monthly reporting and meetings.

The service had risk management systems and policies and procedures in place to monitor, assess and manage high-impact or high-prevalence risks associated with the care of consumers whilst supporting consumers to live the best life they can. Staff were knowledgeable of consumers susceptible to risks and demonstrated an understanding of what constitutes abuse and neglect and identifying and reporting these. While deficiencies identified under Requirement 3(3)(b) showed one incident was not recorded to manage and prevent further reoccurrence, there is no evidence of systemic issues that show ineffective risk management systems.

The service had policies and procedures which guided staff through infection control, antimicrobial stewardship, restrictive practices, and open disclosure. Staff confirmed participating in training for each topic and were knowledgeable of the principles and application of each.

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