Performance

Report

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| Name of service: | Waterview Aged Care Facility |
| Service address: | 16 Cumberland Street, TERALBA |
| Commission ID: | 2391 |
| Approved provider: | Hunter Valley Care Pty Ltd |
| Activity type: | Re-accreditation site audit |
| Activity date: | 2 August 2022 to 8 August 2022 |
| Performance report date: | 28 September 2022 |

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

**This performance report**

This performance report for Waterview Aged Care Facility (**the service**) has been prepared by Gill Jones 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 19 September 2022

# Assessment summary

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

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

# Areas for improvement

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

**Standard 2**

* Requirement 2(3)(a) - the Approved Provider ensures 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, including in relation to managing risks for consumers with pain, experiencing falls, management of diabetes and palliative care.
* Requirement 2(3)(b) - the Approved Provider ensures 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. Ensure care plans are updated as required to reflect consumer's current conditions including their current needs, goals, and preferences, including advance care planning and end of life planning, if the consumer wishes it.
* Requirement 2(3)(c) - the Approved Provider ensures assessment and planning is based on partnership with the consumer and others the consumer wants involved in their care, the service should ensure the consumer and/or the consumer representative are always informed or consulted when assessment and planning occurs.
* Requirement 2(3)(d) - the Approved Provider ensures the outcomes of assessment and planning are effectively communicated to the consumer and that consumers or their representatives are involved in planning the consumers’ desired care outcomes. The service should ensure that the outcomes of assessment and planning are documented in a care and services plan that is readily available to the consumer.
* Requirement 2(3)(e) - the Approved Provider ensures that when circumstances change or when incidents impact on the needs, goals or preferences of the consumer, care and services provided are reviewed regularly for effectiveness. The service should ensure that all incidents are documented and potential and actual causes considered so that strategies to minimise risk to consumer’s health and safety can be implemented.

**Standard 3**

* Requirement 3(3)(a) - the Approved Provider ensures each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: is best practice; and is tailored to their needs; and optimises their health and well-being, particularly in relation to skin integrity, pain management and restrictive practices.
* Requirement 3(3)(b) - the Approved Provider ensures effective management of high impact or high prevalence risks associated with the care of each consumer, particularly in relation to falls management, behaviour management, diabetes management, restrictive practices and the use of cytotoxic mediations.
* Requirement 3(3)(c) - the Approved Provider ensures the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, and consumers or their representatives are given an opportunity to complete and advanced care plan or end of life pathway, at a time suitable to them, so that their comfort is maximised and their dignity preserved.
* Requirement 3(3)(d) - the Approved Provider ensures the deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.
* Requirement 3(3)(e) - the Approved Provider ensures information about the consumer’s condition, needs and preferences is documented accurately and communicated within the organisation, and with others where responsibility for care is shared.
* Requirement 3(3)(f) - the Approved Provider ensures all consumers receive timely and appropriate referrals to individuals, other organisations and providers of other care and services.

Requirement 3(3)(g) - the Approved Provider ensures minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection including a system to monitor infection rates and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

**Standard 4**

* Requirement 4(3)(c) - the Approved Provider ensures services and supports for daily living assist each consumer, particularly those unable to participate in the group activities, to participate in their community within and outside the organisation’s service environment, have social and personal relationships, and do the things of interest to them.

**Standard 7**

* Requirement 7(3)(c) - the Approved Provider ensures the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles, particularly in relation to assessment and planning, the provision of clinical care and management of risk.

**Standard 8**

* Requirement 8(3)(b) - the Approved Provider ensures their governing body promotes a culture of safe, inclusive and quality care and services by a variety of mechanisms including embedding their newly developed strategic plan and policies and procedures to guide staff practices, including those pertaining to clinical governance, to ensure the governing body demonstrates accountability for the delivery of quality care and services.
* Requirement 8(3)(c) – the Approved Provider ensures that organisation wide governance systems for information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints are operating effectively in the service and the Approved Provider continues to implement and embed improvements into their usual practice so effective governance improves outcomes for consumers.
* Requirement 8(3)(d) - the Approved Provider ensures effective risk management systems and practices, including but not limited to the following: (i) managing high impact or high prevalence risks associated with the care of consumers;(ii) identifying and responding to abuse and neglect of consumers;(iii) supporting consumers to live the best life they can (iv) managing and preventing incidents, including the use of an incident management system. The Approved Provider should continue to implement and embed improvements into their risk management practices so effective systems improve outcomes for consumers.
* Requirement 8(3)(e) - the Approved Provider ensures where clinical care is provided—a clinical governance framework, including but not limited to the following: (i) antimicrobial stewardship;(ii) minimising the use of restraint; (iii) open disclosure. The Approved Provider should continue to develop policies and procedures to guide staff practice in these areas, ensuring that a clinical governance framework is in place.

# Standard 1

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

Findings

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

Consumers and representatives interviewed by the Assessment Team said consumers are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Consumers stated that their personal privacy was respected and felt their information was kept confidential. Consumers felt they can make decisions about their family and friends and who is involved in their care and communicate these decisions.

The Assessment Team observed staff interacting with consumers respectfully, greeting consumers and their family members with familiarity and interacting with consumers in a dignified and respectful manner during personal care. Staff spoke about consumers respectfully and demonstrated knowledge about consumer preferences, choices and backgrounds.

Care planning documents included up to date information regarding residents’ choice and preferences including where risk is involved. Care planning documents appropriately detail what is important to the consumer and includes a *‘key to me’* section which is completed in consultation with the consumer and their representatives. The documents outline the significant events in the consumer’s life, and any important people in their life including partners, family and friends.

Staff interviews, and care plan documentation demonstrated consumers are supported to take risks and engage in interests they enjoy. Staff displayed their understanding of policies and processes relating to the dignity of risk and duty of care to provide consumers with choices to engage in things they enjoy and ensure they are not hurt by explaining and managing potential risks.

The Assessment Team brought forward that regardless of the consumer’s ability to make their own decisions about care, representatives are asked to sign a medical consent form when the consumer enters the service which gives the representative power to make medical decisions for the consumer should they become incapable. The Assessment Team also identified that the consumer’s representative was able to dictate whether the consumer was provided with the door fob so they could exit the service, even when the consumer was capable of making their own decisions. I have considered the issue regarding access to the door fob in Requirement 3(3)(a) in relation to the use of restrictive practices.

The Approved Provider, in their response, stated that during the site audit they revised the form in use to better reflect that the consumer, first and foremost, is responsible for making their own decisions but the form now recognises they may need support if they agree to this. The Approved Provider stated that consumers inform staff on the admission whom they wished to involve in decisions about their care and staff know the consumers well enough to ensure their wishes are met. I note that the Assessment Team found consumers and their representatives complete the *‘key to me’* document on admission which outlines important people in the consumer’s life including partners, family and friends. I have considered that consumers have not voiced concerns about being supported to exercise choice and independence and decide who is involved in their care. While noting the Assessment Team’s findings, I find the Approved Provider’s response more compelling. The Approved Provider’s response demonstrates the service has systems in place for consumers to exercise choice and independence, including making decisions about their own care and making decisions about when family, friends, and carers should be involved.

# 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. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Non-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. | Non-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

I have assessed this Quality Standard as Non-compliant as I am satisfied that all five requirements in this Quality Standard are Non-compliant.

Risk to consumer’s health and well-being is not being managed effectively when assessment and planning is conducted. Additionally, initial assessment and care planning is not always undertaken when consumers move into the service. Risk assessments have not been considered and completed to ensure consumers safety with the use of bedrails, bed sticks and overhead bed bars. The risk care plans for some consumers had not been initially completed to identify their individual risk or updated when new risks are identified. These issues were demonstrated in evidence presented by the Assessment Team in relation to six consumers and pertained to the lack of assessment and planning to manage risks identified including pain, falls, diabetes management and palliative care.

Assessment and care planning documentation did not reflect the consumer's current conditions including their current needs, goals, and preferences, including advance care planning and end of life planning, if the consumer wishes it. Consumers are not offered the opportunity to complete an advance care plan and there is a reliant on verbal feedback from the consumer or representatives when consumers are palliating or at end of life. There is no documentation to guide staff practice in the management of advance care planning and end of life planning, only medical orders for life sustaining treatment (MOLST) for more medically invasive treatments. Palliative care plans are not completed, and the general suite of care plans are not updated.

There is not a clear process in place that demonstrates ongoing consumer and representative involvement in the assessment and care planning process on a partnership basis. Feedback from consumers and representatives advised although they were satisfied with the delivery of care and talked to staff, they were not involved in the process of care planning. There was minimal evidence of other service providers being involved in the assessment and care planning process.

Feedback from consumers and representatives obtained by the Assessment Team during the site audit was that they are notified when changes occur but are not involved in planning the consumer’s desired care outcomes. Consumers and representatives said they were not offered a copy of the care plan or been made aware that one was readily available on request.

Incident forms are not routinely completed when incidents occur. When incidents forms are completed there has not been an analysis to determine strategies to mitigate the risk and ensure the consumer’s safety. The Assessment Team cited the care provided to three consumers which demonstrated that their care and services were not reviewed comprehensively following incidents that occurred.

The Approved Provider responded to the site audit report and acknowledged some of the concerns raised by the Assessment Team.

The Approved Provider supplied evidence to demonstrate that risks were being managed through the interim care plans provided. Whilst these documents demonstrate that risk has been identified there is no accompanying care planning documentation to show how the identification of risk has informed the delivery of safe and effective care and services, including the risk mitigation strategies in place for individual consumers. The Approved Provider stated that risk assessments are completed for all consumers where risk is identified but did not provide evidence of this, neither did the information provided demonstrate how risk is managed to ensure the health and well-being of consumers. The Approved Provider included a Hazard Register currently in use however this did not include such items as bed rails, bed poles or other restrictive devices including low-low beds. Since the conduct of the site audit the Approved Provider has added an item to their maintenance schedule to ensure devices such as bed rails are checked regularly. In addition the care provided to the consumers cited in the Assessment Team’s report has been reviewed to ensure risks identified inform the delivery of safe and effective care and services and risk assessments conducted, where appropriate, for equipment in use.

The Approved Provider have reviewed their practices, post site audit, and have implemented new processes to ensure end of life care planning is conducted at an early stage, if the consumer/their representative wishes it, and reviewed at regular intervals. The Approved Provider also submitted assessment, care planning and referral documentation for activities conducted post audit for particular consumers to address their current needs, goals and preferences.

The Approved Provider stated consumers and representatives are involved in case conferences and care planning reviews and that a copy of the care plan will be given prior to case conferences. No further evidence was provided to show how long these initiatives have been in place or how consumers and their representatives are involved in the assessment and care planning processes.

The Approved Provider acknowledged that not all minor incidents were documented using incident documentation however they are addressing this with staff to ensure all incidents are recorded appropriately to enable a comprehensive review of care and services provided to each consumer following an incident.

The evidence compiled during the site audit persuasively showed sustained non-compliance for requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me that the service has addressed all the deficiencies in the site audit and that changes made to assessment and planning processes have had sufficient time to be embedded to result in improved outcomes for consumers. Accordingly, I am satisfied that requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) are non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | 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. | Non-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. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that all seven requirements in this Quality Standard are Non-compliant.

Consumers are not receiving best practice care that is tailored to their needs and is not optimising their health and well-being. The Assessment team provided detailed information in relation to the care of seven consumers and deficits identified in their care in relation to skin integrity, pain management, and restrictive practices.

Staff were unable to demonstrate an understanding of the legislation in relation to the use of chemical restraint. In relation to environmental restraint, the service does not have a process to distinguish which consumers have the ability to exit the service safely, by themselves, and it was unclear how these assessments of competence are made. Care plans sampled recorded representatives providing permission for their consumers to be provided with the keypad code, even when the consumer was able to make their own decisions.

The service is unable to demonstrate effective management of high impact, high prevalent risks. The Assessment Team identified a number of deficits in the management of high impact or high prevalence risks associated with the care of five consumers including falls management, behaviour management, diabetes management and restrictive practices. Staff were not minimising risk to themselves from the use of cytotoxic medications.

The service does not offer consumers or their representative an opportunity to complete an advance care plan or end of life pathway to direct and guide staff in the management of their preferred wishes and care. The service is reliant on verbal discussions with the consumer or their representative and staff knowledge of the consumer’s preferences at end of life.

Changes in a consumer’s condition was not recognised and responded to in a timely manner. Deficits were identified with the management of a post fall episode, including the initial and ongoing clinical and physiotherapy assessment, to ensure a fracture was appropriately managed.

Consumer’s information is not always documented accurately and is not reflective of the consumer’s current care needs. Feedback from management, representatives, staff members and allied health members identified conflicting information regarding the management of consumers and how information is shared. The Assessment team provided evidence in relation to three consumers affected.

The service is unable to demonstrate an effective and timely process is in place for the management of consumers requiring a referral to an allied health professional or specialist services. The Assessment team provided evidence in relation to four consumers affected.

Minimisation of infection related risks through processes to monitor infection and antimicrobial stewardship is not in place. The service does not have an antimicrobial stewardship policy in place to guide staff practice and education has not been provided to staff about antimicrobial stewardship. The service has a system in place to record when infection incidents occur, although this is not routinely being followed which impacts clinical oversight and trending. Additionally, the Assessment Team found service does not have a monitoring system in place to accurately record staff influenza vaccinations.

The Approved Provider responded to the site audit report and did not dispute the concerns raised by the Assessment Team.

The Approved Provider supplied evidence to demonstrate the actions that have been taken to address the issues raised. The Approved Provider has taken specific actions for consumers identified by the Assessment Team including reviewing consumer’s care plans and providing guidance and education for staff in relation to the care of consumers.

All environmental restraints have been reviewed and now cognitively aware consumers are provided with the door fob so they can come and go freely. Furthermore, the Approved Provider stated that, for those consumers who may pose a risk to themselves by exiting the front door, a risk assessment is completed, although it was not clear in their response how the risk assessments are to be conducted and how the competence of consumers is assessed.

Education has been provided to staff on the use of cytotoxic medications.

Advanced care planning will be attended as part of the admission process and care plan reviews and case conferences will be scheduled quarterly to enable review so that consumer needs, goals and preferences and choices for end of life care can be discussed and their choices documented.

The Approved Provider, in their response, did not dispute the findings of the Assessment team regarding the management of infection and antimicrobial stewardship and provided commentary on the corrective actions undertaken and the education of staff. The Approved Provider, however did dispute that they did not have an accurate record of staff influenza vaccinations and I have accept this as their evidence corresponds with what was provided to the Assessment Team during the site audit.

The evidence compiled during the site audit persuasively showed sustained non-compliance for requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me that the service has addressed all the deficiencies in the site audit. The Approved Provider is still undertaking improvements and I encourage them to embed these improvements into their usual practice to ensure all consumers get personal care and clinical care that is safe and right for each consumer and is in accordance with each consumer’s needs, goals and preferences to optimise their health and well-being . Accordingly, I am satisfied that requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) are non-compliant.

# Standard 4

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

Findings

The Quality Standard is assessed as Non-Compliant as I am satisfied that one of the seven requirements have been assessed as Non-Compliant.

Most consumers are receiving safe and effective services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life.

Consumers are supported in relation to their emotional, psychological and emotional well-being. While some issues were identified in relation to the documentation and communication of consumer’s spiritual needs, consumers indicated that their spiritual needs were met.

Consumers are receiving timely and appropriate referrals to individuals and other providers of services and supports for daily living, when required.

Consumers are being provided meals that are of suitable quality and quantity.

Equipment provided to consumers is safe, suitable, clean and well maintained.

The Assessment Team found the service was unable to demonstrate that relevant information about each consumer’s condition, needs and preferences are communicated within the organisation and with others where responsibility of care is shared in relation to services and supports for daily living. This was in relation to the consumer’s spiritual needs but also dietary needs and preferences.

Consumers who are unable to participate in the group activity program do not have sufficient support provided to them or have stimulating activities and things of interest to do. Whilst the service offers a varied program of group activities, which many consumers reported are of interest to them, consumers who are unable to participate in the group activity program do not have support provided to them. Additionally, lifestyle assessment and care planning is not always reflective of consumer’s current activity goals, needs and participation.

The Approved Provider, in their response, made the point that no consumers had complained about the lack of activities. Whilst I acknowledge this point, I note that, with regard to the three of the four consumers cited in the Assessment Team’s report who did not have sufficient support provided to them or have stimulating activities and things of interest to do, their ability to complain was significantly impacted by their cognitive abilities. I also note that three of those consumers had not had their needs re-assessed when their lifestyle needs changed or have a lifestyle care plan that reflected their current needs. Neither could the Approved Provider, in their response, demonstrate what leisure supports was being provided to them at the time of the site audit, to cater for their needs. The Approved Provider explained that COVID-19 had a significant effect on the capacity of their lifestyle workforce to provide more individualised lifestyle supports for all consumers. The Approved Provider indicated that, in recent weeks, a new lifestyle co-ordinator has been appointed. They have identified gaps in relation to providing individual supports to those who need it. The Approved Provider provided evidence of a new program recently implemented to address the needs of consumers who are unable to attend the main group activities scheduled. The Approved Provider also stated that a review of all consumer lifestyle plans is in progress. Additionally, the Approved Provider has set up a system to ensure consumer’s spiritual needs are captured and can access chaplaincy and pastoral visitors for spiritual and emotional support.

In relation to relevant information about each consumer’s condition, needs and preferences being communicated within the organisation the Approved Provider responded to the findings of the Assessment Team and stated that systems were in place, at the time of the site audit, for staff to obtain information about those consumers requiring thickened fluids. Additionally the Approved Provider provided evidence that systems were in place for the kitchen to be appraised of consumer’s dietary needs. Whilst I note that the dietary needs for one consumer were not fully recorded in information available to kitchen staff, there was no negative impact noted by the Assessment Team for that consumer. I have therefore accepted the evidence supplied by the Approved Provider that systems were in place at the time of the site audit. I note that, following the site audit, the Approved Provider stated they have issued a memo to clinical staff reminding them about the importance of communication and sharing information with the lifestyle team. With regard to the assessing and documenting consumer’s spiritual care needs, I am satisfied that the issue has been addressed in Requirement 4(3)(c).

The evidence compiled during the site audit persuasively showed sustained non-compliance for requirement 4(3)(c). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me that the service has addressed all the deficiencies identified in the site audit with regard to the provision of services and supports for daily living that allow all consumers to do the things of interest to them. Furthermore, changes made to assessment and planning processes with regard to the provision of services and supports have not had sufficient time to be embedded to result in improved outcomes for consumers. Accordingly, I am satisfied that requirement 4(3)(c) is non-compliant.

# 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 Quality Standard is Compliant as three of the three requirements have been assessed as compliant.

Consumers and representatives reported that consumers feel at home in the service and that the service environment is comfortable. There is signage to assist consumers find their way around the service. The Assessment Team observed that the environment is comfortably furnished with multiple areas for consumers to meet with family, friends and to socialise.

Consumers expressed satisfaction with the cleanliness of the service. The service has a cleaning program in place and the Assessment Team observed the service to be clean, safe and well maintained. Consumers are able to move freely through the service and access a number of courtyards around the service.

The service has preventative and reactive maintenance programs in place which ensures that furniture, fittings and equipment are staff, clean and well maintained. Consumers indicated that any repairs are promptly attended to.

# Standard 6

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

Findings

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

Consumers and representatives said information about how to raise complaints is available and they know how to provide feedback and make complaints. They said management and staff are responsive to any concerns they may have. Staff were aware of their role in supporting consumers to provide feedback.

There is information about advocacy services and external complaint avenues in various locations through the service. Some consumers were aware of the external complaint services available to assist them in raising and resolving complaints, and others were not. Of those who were not, they indicated they did not need assistance from other services because the service was responsive to any concerns they may have.

Consumers and representatives consistently reported that management and staff are very responsive to any concerns they have, and that appropriate action is taken in response to complaints. Whilst the service does not have policies and procedures about open disclosure and staff were unaware of the concept, review of complaint documentation shows that management generally apologises when things go wrong.

Consumers and representatives said that improvements are made when they provide feedback to the service. Review of documentation, including the continuous improvement plan, shows that information from complaints, surveys and meetings with consumers is used to improve the quality of care and services.

# Standard 7

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

Findings

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

Consumers said they did not need to wait long to have staff attend to their needs and requests. Review of rosters shows that most shifts are filled, and measures are in place to mitigate impact on consumers if there are gaps in the roster. Most staff said they are able to complete their tasks in the designated time and staff were observed to calmly go about their duties without rushing consumers.

Consumers consistently reported that all, or almost all, staff are kind, caring and respectful and spoke highly of the kindness of staff and management.

The service has a schedule for completion of annual performance reviews. Review of personnel documentation shows that counselling is undertaken when deficiencies in performance is identified and staff are provided with education or required to undertake other actions to improve their performance which is monitored by management.

Although members of the workforce have appropriate qualifications in relation to their roles, deficiencies in relation to staff knowledge and skills was identified. This was in relation to assessment and planning activity and clinical care provision. The gaps identified in relation to care provision related to the workforce being insufficiently competent and having the appropriate knowledge to effectively perform their roles with regard to working in partnership with the consumer, or their nominated representative, to engage them in the assessment and care planning process so they can fully participate in making choices about their care delivery, including their palliative care. Staff lacked knowledge about the legislation regarding restrictive practices and the importance of conducting a risk assessment and obtaining consent prior to the use of restrictive devices and/or implementing environmental restraint. Staff also lacked knowledge about antimicrobial stewardship, the safe management of cytotoxic medication, the management of high impact, high prevalence risks and knowing when to refer when additional support is needed; incident management and open disclosure.

The Assessment Team found the service has processes for the recruitment, induction and initial training and support of staff and provides ongoing online and face-to-face education for staff. However, the Assessment Team brought forward that education about key aspects of the Quality Standards has not been provided and that while education on some topics has commenced, not all staff have completed the education. The Assessment Team also brought forward that the training material available to staff in relation to reporting serious incidents was out of date.

The Approved Provider, in their response, focussed on the issue of care documentation and the work they are doing to ensure assessments are completed correctly and care plans are up to date. The Approved Provider acknowledged that staff required training on antimicrobial stewardship and open disclosure and are putting this in place.

The Approved Provider provided further information about the new online training system implemented in May 2022 to ensure all staff receive the education they need in relation to the Quality Standards. All staff are transitioning to the new system and have till 30 November 2022 to complete all education including medication and nursing competencies. The Approved Provider provided evidence that COVID-19 training is covered at induction and demonstrated high take up rates for this modular based training. Fire training is also covered during induction for all staff. The Approved Provider disputed that the training module on serious incident reporting was out of date. I have considered the Approved Provider’s response and note that the Assessment Team found staff knew about the Serious Incident Response Scheme and the service has reported incidents using the Scheme. I also note the information provided in the Approved Provider’s response and I am satisfied that the workforce is largely recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards. Deficits however were identified in the supports provided to clinical staff as documented in Requirement 7(3)(c).

The evidence compiled during the site audit persuasively showed sustained non-compliance for requirement 7(3)(c). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me that the service has addressed all the deficiencies identified in the site audit with regard to staff knowledge and skills with regard to assessment and planning and the provision of clinical care. Furthermore, changes made to assessment and planning processes have not had sufficient time to be embedded to result in improved outcomes for consumers. Accordingly, I am satisfied that requirement 7(3)(c) is non-compliant.

**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. | Non-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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as four out of five requirement are assessed as non-compliant.

Whilst the service consults with consumers in a range of ways and acts on feedback from complaints to make improvements the organisation was unable to demonstrate a process for active engagement of consumers in the development, delivery and evaluation of care and services as there was no documents such as strategic plan or policies or procedures which demonstrate the organisation’s commitment to engaging consumers in the development, delivery and evaluation of care and services.

The governing body was unable to demonstrate how they promote a culture of safe, inclusive and quality care and services and how they are accountable for its delivery. The Assessment Team identified that the organisation did not have a strategic plan or policies and procedures to guide staff that are contemporary and reflective of best practice and regulatory requirements in place. The governing body normally met monthly to provide oversight but due to the illness of the Approved Provider meetings were paused from April 2022 with gaps in meetings also noted between 1 December 2021 and 9 March 2022. Furthermore, meetings held by the governing body did not extend to clinical governance matters. As such the organisation’s governing body could not demonstrate how they promoted a culture of safe, quality care and how they were accountable for its delivery.

The organisation was unable to demonstrate effective governance systems in place. Deficiencies were identified in relation to information management including not undertaking appropriate assessments and documenting information to inform the delivery of care and services as well as not having policies and procedures reflective of best practice and regulatory requirements to guide staff practice. In relation to workforce governance, the organisation has not developed contingency plans to guide organisational personnel and ensure ongoing governance if the approved provider becomes incapacitated or unavailable. Deficiencies were also identified around the knowledge and competence of the workforce in relation to assessment and planning and the provision of clinical care which was shown to negatively impact consumers. In relation to continuous improvement, the organisation’s auditing program has not been effective in identifying deficiencies identified by the Assessment Team during the Site Audit.

The organisation was unable to demonstrate effective risk management systems and practices to manage high impact or high prevalence risks associated with the care of consumers. The organisation does not have policies and procedures to guide staff practice and deficiencies were identified in relation to the management of high impact and high prevalence risks for consumers. In relation to identifying and responding to abuse and neglect of consumers, the policy documents provided to the Assessment Team included a mandatory reporting and elder abuse policy which did not incorporate SIRS and was therefore not reflective of current regulatory requirements. Neither does the organisation have a policy for supporting consumers to take risks to live the best live they can. The organisation does have a waiver form in which consumers or their representative acknowledge risks the consumer wishes to take, however, measures to support the consumer to take the risk as safely as possible are not always included. Lastly, in relation to managing and preventing incidents, the organisation has a critical incident which mentions clinical incidents but is largely focused on organisational incidents. It makes no mention of key aspects of incident management such as investigation of contributing factors, review of existing measures for effectiveness, or development of further preventative measures. A review of incidents showed that an analysis of contributing factors, review of the effectiveness of any current measures and development of preventative measures is not undertaken following incidents involving consumers.

The organisation does not have a documented clinical governance framework and clinical oversight at the governance level could not be demonstrated. The organisation does not have a clinical governance committee and meetings of the governing body did not including clinical matters. Furthermore, the organisation does not have policies and procedure to guide the workforce in relation to antimicrobial stewardship and open disclosure. In relation to antimicrobial stewardship, the organisation has an infection control policy which has a statement that consideration should be given to “safe alternatives to an immediate antibiotic prescriptions” however staff were unable to demonstrate their knowledge of the issue. Additionally, the organisation has a restraint policy, however it has not been updated to be reflective of current regulatory requirements for minimising the use of restraint and this was affecting staff practices. Lastly, the organisation does not have a policy about open disclosure. Although management said staff have education about open disclosure none of the staff who were asked about open disclosure were aware of the term.

The Approved Provider, in their response relating to consumer involvement in the development, delivery and evaluation of care and services, included consumer surveys showing much positive feedback from consumers about care and services received. Since the site audit the Approved Provider has developed a strategic plan which includes a commitment to supporting consumers in their engagement in the development, delivery and evaluation of care and services. The Approved Provider submitted Resident Meeting Minutes from June 2022 to September 2022 and on reviewing these I am satisfied these there is plenty of opportunity for consumers to provide their input to the development, delivery and evaluation of care and services. The Approved Provider stated that they have sought interest from consumers to co-chair this meeting with staff support, and, whilst they have not had a volunteer as yet they will continue to canvas interest. The Approved Provider stated they discuss the service’s plan for continuous improvement during these meetings and that that these meetings are available by video conferencing for those unable to attend. Having reviewed the evidence collected by the Assessment Team I note that consumers are not expressing any level of dissatisfaction with the mechanisms in place for them to voice issues. I am therefore satisfied that currently there are sufficient mechanisms in place for consumers to contribute to the development, delivery and evaluation of care and services.

The Approved Provider, in their response to how the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for its delivery, evidenced that whilst the Approved Provider was ill they continued to speak with and hold meetings with management staff as required by phone. To address the deficits regarding the absence of contemporary policies and procedures for staff to follow and a lack of clinical governance, the Approved Provider stated that they have recently introduced new policies and procedures and that meetings of the governing body, commencing in September 2022, will include clinical governance.

The Approved Provider, in their response, to effective organisation wide governance systems including information management, stated new policies and procedures and a new online learning system have recently been implemented which are reflective of the Quality Standards and current regulatory requirements. In relation to workforce governance, the Approved Provider disagreed with the Assessment Team’s finding and stated that the current contingency arrangements in place during the Approved Provider’s illness enabled the organisation to function adequately. In relation to continuous improvement, The Approved Prover stated that their auditing activity undertaken as part of their continuous improvement had identified some of the issues identified by the Assessment team but did not provide further evidence to support this claim.

The Approved Provider, in their response, regarding the effectiveness of risk management systems and practices stated that the new policies and procedures recently purchased include managing high impact high prevalent risks. In relation to risk assessment, the Approved Provider stated that risk assessments are completed but did not provide evidence of how this is done with particular reference to developing risk mitigation strategies with the consumer. With regard to incident reporting the Approved Provider stated that they have provided education to staff on improved incident reporting.

The Approved Provider, in their response to having a clinical governance framework which included antimicrobial stewardship, minimising the use of restraint and open disclosure stated that the new policies and procedures and online learning system recently purchased will address these issues. The Approved Provider however did not respond on how they are considering addressing the issue of not having a clinical governance framework.

The evidence compiled during the site audit persuasively showed sustained non-compliance for requirement 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). While I note the Approved Provider has taken action in response to the information raised in the Assessment Team report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me that the service has addressed all the deficiencies identified in the site audit report with regard to effective organisation governance including clinical governance and risk management. Accordingly, I am satisfied that requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) are non-compliant.

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