Performance

Report

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| Name: | Wellington Park Private Care |
| Commission ID: | 5362 |
| Address: | 16 Balmoral Street, WELLINGTON POINT, Queensland, 4160 |
| Activity type: | Review Audit |
| Activity date: | 27 August 2024 to 30 August 2024 |
| Performance report date: | 9 October 2024 |
| Service included in this assessment: | Provider: 1659 Superior Care Group Pty Ltd  Service: 3707 Wellington Park Private Care |

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 Wellington Park Private Care (**the service**) has been prepared by D Saunders, 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 Review 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 25 September 2024
* performance report dated 23 May 2023 in relation to a site audit conducted 12 April 2023 to 14 April 2023
* performance report dated 8 August 2023 in relation to an assessment contact 17 July 2023
* performance report dated 5 March 2024 in relation to an assessment contact 6 February 2024
* performance report dated 11 June 2024 in relation to an assessment contact 8 May 2024 to 9 May 2024

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* Each consumer is supported to take risks to enable them to live the best life they can.
* 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.
* Each consumer’s privacy is respected and personal information is kept confidential.
* 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.
* 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.
* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, thatis best practice**,** is tailored to their needs**,** andoptimises their health and well-being.
* Effective management of high impact or high prevalence risks associated with the care of each consumer.
* 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.
* Where meals are provided, they are varied and of suitable quality and quantity.
* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* 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.
* Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.
* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

# Other relevant matters

I have received information referred by the Commission’s Risk Intake and Analysis Team (RIAT) received 5 September 2024. The referral relates to a complaint made to the Commission. I place no weight on the information received in the referral. The report raises matters that may be relevant under requirement 1(3)(a), 2(3)(a), 3(3)(a), and 6(3)(d). Those requirements have been found not-compliant for the reasons given below and all of which are independent of the information in the referral. At the time of writing the complaint was open and no conclusion had been reached (by the area of the Commission that administers complaints) in respect to it. This is a further reason I place no weight on the referral.

# 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. | Not 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. | Not 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. | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

**Requirement 1(3)(a)**

At audit some consumers/representatives said staff do not treat consumers in a dignified manner or know what is important to the consumer. Some staff said they do not know where to access information about the consumer’s identity, culture or diversity. The Assessment Team observed consumers with their continence aids exposed and staff not interacting with consumers when providing meal assistance.

Examples of four named consumers were given by the Assessment Team. Each identified an observed instance incompatible with dignity and respect.

The service, in its response to the review audit report, did not dispute the findings or recommendation of the Assessment Team. The service explained that it has taken remedial action both in respect of the cited instances and also in relation to broader initiatives, such as additional rounds by the Head of Care, and daily and continuing education in relation to consumer dignity and respect.

I find this requirement not compliant.

**Requirement 1(3)(b)**

Most consumers said they receive culturally appropriate care and services. Interviewed staff provided examples of how they provide culturally safe care. A review of consumer’s care documentation included information about consumer’s cultural needs to guide staff practices. Examples in respect of two named consumers were provided, each detailing observations consistent with cultural safety.

I find this requirement compliant.

**Requirement 1(3)(c)**

Most consumers said they are supported by the service to make decisions about the types of care they receive and how care is delivered. Consumers said they can choose to involve their family in decisions about their care. The Assessment Team observed consumers maintaining social relationships by hosting visitors in their rooms.

I find this requirement compliant.

**Requirement 1(3)(d)**

Consumers/representatives provided examples of how interactions between staff and the consumer do not support consumers to make choices which involve risk.

A review of consumers’ care documentation demonstrated the service does not consistently conduct assessments to identify risk and risk mitigation strategies to support consumers to participate in risks to live the life they choose.

Three examples of named consumers not supported in taking risks of the type contemplated by the requirement were provided by the Assessment Team.

The service accepts that more information and support for staff is needed to ensure they have a solid understanding of the rights of consumers to take risks and how that can be supported.

I find this requirement not compliant.

**Requirement 1(3)(e)**

The Assessment Team identified consumers/representatives do not have a shared understanding of how to access or subscribe/unsubscribe to the additional services packages or the costs associated with the use of the additional services package or allied health services.

In respect of both areas multiple named consumers were identified and examples of the deficiencies in understanding were common.

The service has identified and commenced improvements in relation to both areas mentioned.

I find this requirement not compliant.

**Requirement 1(3)(f)**

Staff described how they respect consumers’ privacy and keep consumers’ personal information confidential. The Assessment Team observed care documentation to be stored securely. The consumer handbook outlines the service’s commitment to respecting the consumer’s privacy and keeping personal information confidential. Staff explained how they do not share consumers’ private information with other consumers, they ensure the door is closed and curtains are drawn when providing personal cares, and computers are locked when unattended. The Assessment Team observed nurses’ stations locked and information stored securely on password protected computers.

I find this requirement compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not 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. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

**Requirement 2(3)(a)**

The review audit report concluded that care and planning did not inform safe and effective care.

Care plans were reviewed across areas of continence management, diabetes management, pain management, and medication management. For some consumers assessments were identified as having not been done or done with deficiencies identified.

Adverse consumer outcomes were identified and attributed to the lack of assessment and planning. This included consumers reported as being in pain in the absence of pain charting.

Interviews with registered staff reported that assessments are not always completed. Registered staff explained the process whereby consumer’s initial information should be gathered by the clinical management team prior to entering the service however this does not always occur. Registered staff reported they do not always have sufficient time to undertake care planning.

The service has recognised within its plan for continuous improvement that there are deficiencies in assessment and planning.

The service did not dispute the above findings in its response to the report.

The service has established a seven point action plan to remediate the deficiencies identified above and this covers all aspects of care planning. Actions taken to remedy errant or absent planning for named consumers was explained.

I find this requirement not compliant.

**Requirement 2(3)(b)**

Consumers/representatives said they are involved with consumers’ advance care planning and said it reflects how consumers want their end of life care delivered. Staff said there is discussion regarding consumers’ end of life wishes when they enter the service, at care plan review, and if/when deterioration occurs. Documentation review evidenced advance care directives are in place, or there is evidence of a discussion with consumers/representatives regarding end of life wishes which is reviewed at each case conference every three months.

I find this requirement compliant.

**Requirement 2(3)(c)**

Overall, consumers/representatives said the service involves the consumer and other relevant individuals in the planning and delivery of care and services. Clinical management explained how the assessment process involves other organisations, service providers, and individuals in assessment and care planning. Registered staff provided examples of consumers engaging with allied health professionals including speech pathology, dietitians, and podiatrists. Registered staff also described utilising other professionals such as, specialists MOs, palliative care teams, wound specialists and Dementia Support Australia (DSA).

The clinical management team described the assessment and planning process and how consumers/representatives are included. Clinical management said, and review of care documentation demonstrated, staff consult with individual consumer’s representatives via telephone, face to face and through electronic messages to include them in care planning.

A review of care documentation demonstrated other providers of care are involved in the assessment and planning process. Examples of this included the input of physiotherapists, dietitians, speech pathologists, and podiatrists.

I find this requirement is compliant.

**Requirement 2(3)(d)**

The review audit report concluded that the service did not demonstrate effective processes to ensure the outcomes of assessment and planning are communicated to the consumer or others involved in care. Consumers/representatives said they have not been offered a copy of the consumers’ care and services plan. Consumers/representatives were unaware they could request a copy of their care plans.

Six consumers, some named, advised they had not received, nor been offered, copies of care plans and said they were unaware they could request a copy if they wished.

The review audit report also identified that the outcomes of assessment and planning processes were not consistently documented in the consumer’s care and services plan. It is a requirement that these outcomes are documented.

The service, in its response to the review audit report, did not dispute the above finding. The service explained that it was taking action in relation to the names consumers and was also implementing broader processes to ensure care plans were made available across the service.

I find this requirement not compliant.

**Requirement 2(3)(e)**

At audit the service was able to demonstrate care and services were reviewed regularly. Consumers/ representatives confirmed care and services were updated in response to incidents and declines in health or function. Clinical management was able to provide reports demonstrating consumers’ assessments had been reviewed and updated, following an incident or change in the consumers’ condition.

The Assessment Team’s review of incidents demonstrated appropriate risk assessments and evaluations were occurring. Review of sampled consumers’ care documentation identified their care plans had undergone review at least 3 monthly in line with the service’s policy or following a change in circumstances or care needs.

I find this requirement compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not 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

**Requirement 3(3)(a)**

The review audit report identified departures from safe and effective care. This was in relation to both clinical and personal cares.

Registered staff interviewed reported that they do not

*Wound care*

A named consumer had a non-healing wound that progressed over eight months. The wound was not managed/escalated in accordance with wound management policies. The wound was ultimately diagnosed as cancerous and its management was complicated by the delay in escalation.

A second named consumer suffered a wound that was not being treated by the service in accordance with instructions received from that consumer’s wound specialist.

*Choking risk*

Four named consumers were observed or reported receiving meals inconsistent with assessed dietary or food texture requirements.

*Continence care and person hygiene*

Three named consumers reported deficiencies in continence care and toileting resulting in a loss of dignity and discomfort.

The service did not dispute the above findings for the three listed areas.

In respect of each named consumer the service has identified and commenced remedial actions required to ensure ongoing standard of an acceptable nature. The service has also identified improvements of a broader nature to ensure lapses in care do not arise in the future or more broadly.

*Restrictive practice*

The review audit report identified that the service had sound practices in this area and consumers interviewed and documentation reviewed supported this finding.

I find this requirement is not compliant due to the nature of the observations made at audit for the areas of wound care, choking risk and continence care.

**Requirement 3(3)(b)**

The review audit report concluded the service did not demonstrate effective systems and processes to ensure effective management of high-impact and high-prevalence risks.

It also identified gaps in management of risks in the areas of falls management, diabetes management and time sensitive medications. I consider these risks to be high-impact risks as they can give rise to large impacts for consumers when mismanaged.

Consumers/representatives do not feel confident the service was appropriately preventing or managing risks, when they occurred. The clinical management team did not demonstrate effective oversight or monitoring of risks. Review of documentation confirmed gaps in care management of falls, diabetes, and time-sensitive medications.

*Falls management*

A named consumer did not receive risk assessment and observations post fall in accordance with the requirements of the service’s policy in falls management. The service’s policy was sound, but not complied with.

*Diabetes management*

Three named consumers with diabetes had their care documentation reviewed at audit. This identified deficiencies in planning, non-compliance with documented plans and plans that were not individualised. This represents non effective management of a high-impact risk.

*Time sensitive medications*

Two named consumers did not receive time-sensitive medications within required time frames.

In its response to the review audit report the service explained how it was both responding to the deficiencies identified in relation to named consumers and also implementing broader strategy to prevent recurrent non-compliance.

I find this requirement is not compliant.

**Requirement 3(3)(c)**

The review audit report found the service demonstrates care delivery for consumers at the end of life ensures their needs are addressed, pain is managed, and the consumer’s dignity is maintained. Management and staff said palliative care support is available from a local palliative care service when a consumer is assessed as being at end of life. This was consistent with reviewed consumer files and documentation.

Staff described the palliative care pathway, resources available to them to support consumers nearing their end of life and ways in which they maintain the comfort of consumers at the end of life, including one-on-one support for the consumer and their family.

I find this requirement is compliant.

**Requirement 3(3)(d)**

At review audit consumers/representatives said the service identifies changes in a consumer’s health and wellbeing and responds in a timely way. Care documentation that was reviewed by the audit team confirmed staff recognise, report and respond to changes in a consumer’s condition. Registered staff explained the actions taken when a consumer has been identified with deterioration. Actions included assessment of the consumer, referral to a medical officer or other allied health professional, discussion with the consumer/representative and transfer to hospital, if necessary. Care staff explained how, if they identify any changes in a consumer’s physical or psychological wellbeing they report to registered staff straight away. Care documentation demonstrates staff record both general and specific observations.

Review of consumer weight, observation and behaviour charts evidenced consumers were being regularly monitored for changes in condition. The clinical management team said consumers with complex clinical care needs or changes to care needs are discussed at daily meetings with registered staff and weekly clinical governance meetings. The Assessment Team reviewed clinical governance meeting minutes which evidence discussions regarding identification and deterioration of consumers and actions taken.

I find this requirement is compliant.

**Requirement 3(3)(e)**

The review audit report reveals multiple instances of named consumers where information about their condition was not communicated within the organisation.

The (not communicated) information related to dietary requirements, meal modification and assistance, and pressure area care. As such the information related directly to the consumers’ condition, needs and/or preferences. The lack of availability of the information had adverse consequences for the named consumers.

In its response to the review audit report the service explained broad strategies (four key points) to address systemic deficiencies in this area and also explained the specific remedial actions taken in respect of the named consumers.

In light of the identified deficiencies in communicating information as required, I find this requirement is not compliant.

**Requirement 3(3)(f)**

The service was able to demonstrate assessments and processes which lead to timely referrals to allied health and medical professionals. Consumers/representatives said consumers are able to access external allied health services, specialists, wound care services and DSA. Clinical management and registered staff were able to describe assessment findings which would trigger referrals. They were able to describe the referral process and how information was received back from other providers of care and services.

Clinical management and registered staff were able to explain when and how to complete referrals to other services or providers, such as, but not limited to, dieticians, speech pathologists, physiotherapists, medical specialists, telehealth and afterhours MOs, wound specialists and DSA.

I find this requirement is compliant.

**Requirement 3(3)(g)**

The service was able to demonstrate effective infection control processes, outbreak management planning and antibiotic stewardship. Most consumers/representatives did not raise any concerns about the service’s infection control processes. Both registered and care staff were able to demonstrate knowledge of infection control and hand hygiene. The service had policies, procedures and processes informed by best practice resources to manage infection-related risks within the service.

The antibiotic stewardship policy reflects current recommendations from the Australian Commission on Safety and Quality in Health. The service has two infection prevention and control staff leads who have completed training.

I find this requirement is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

**Requirement 4(3)(a)**

At audit consumers/representatives said the service’s lifestyle and activities program provided them with opportunities to participate in activities of their preference. Staff demonstrated knowledge of consumers’ needs, goals and preferences and described the support individual consumers required to participate in activities or pursue individual interests.

The service develops an activities calendar for each area of the service and a separate calendar for each of the memory support areas. The calendar includes activities for a diverse range of interests and abilities such as cooking, church services, word games, circle of men’s group, silver memories, ball games, exercise sessions and weekly happy hour with music. Staff described how consumers from the memory support areas are also supported to participate in activities of interest to them. Staff demonstrated equipment to support consumers with limited mobility to participate in activities, such as table ball games.

I find this requirement compliant.

**Requirement 4(3)(b)**

At audit the service was able to demonstrate services are provided to support the varying emotional, spiritual and psychological needs of consumers. Staff described various processes for providing emotional, spiritual and psychological support to consumers. Consumers/ representatives were satisfied with the supports provided.

A range of positive examples were identified and reported by the Assessment Team. All of these supported that emotional, spiritual and psychological well-being were supported*.*

I find this requirement compliant.

**Requirement 4(3)(c)**

At audit consumers said they are supported to take part in a range of activities within the service or go out to visit family. Staff could describe the ways in which they support consumers’ relationships with their loved ones. Care planning documentation documents the people important to individual consumers, those people involved in providing care and the activities of interest to the consumer. Positive examples were identified and reported by the Assessment Team and no adverse findings were made.

I find this requirement compliant.

**Requirement 4(3)(d)**

At audit the service demonstrated it is ensuring the needs and preferences of consumers is communicated with visiting organisations providing care and services. Positive examples for named consumers were identified by the Assessment Team.

Positive examples about information sharing within the organisation were also identified.

I find this requirement compliant.

**Requirement 4(3)(e)**

The service demonstrated how they collaborate with other organisations or services to provide timely and appropriate referrals which meet the care and service requirements of individual consumers.

Lifestyle staff said they regularly coordinate support for consumers from other organisations including a fortnightly order and delivery of books from the local library to a regular group of consumers who like to read. A men’s group visit the service and provide a forum for male consumers to network and provide support to each other. A community family group, with young children visit and interact with consumers.

I find this requirement compliant.

**Requirement 4(3)(f)**

All meals are prepared at the service’s two kitchens except pureed and minced moist main meals which are purchased externally and plated by kitchen staff.

Twenty consumers/representatives were interviewed by the Assessment Team about food quality, quantity and variety. Ten consumers were not satisfied with meals. Feedback on the quality and variety of the meals included that the meals were not nutritious and that packaged meals were common.

In its response to the audit report the service identified that it had increased the number of hours available for kitchen hands and to assist with more fresh food cooking. Further feedback will be sought from consumers and representatives in coming months and management will monitor the quality of food provided. A fresh food focus will be introduced. Soup will be cooked on site daily. Reliance on processed meats and frozen vegetables will be decreased or discontinued.

The Assessment Team did not identify deficiencies in quantity of food available. Quality and variety (food supplied in accordance with requests) was identified with an absence of nutritious or fresh food being a theme.

Management have identified improvements and adopted the findings of the audit team. The findings were not disputed.

I find this requirement not compliant.

**Requirement 4(3)(g)**

The service is providing equipment which is suitable for consumers and ensures it is cleaned and maintained.

The service has recently started hiring a bus to take consumers on bus trips in the local community and purchased a specific wheelchair to assist in mobilising consumers on to the bus. Lifestyle staff said they clean all equipment utilised by consumers for activities following use. Staff said, if they had any concerns with equipment, they would raise it with the physiotherapist or add to the maintenance folder.

I find this requirement 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

**Requirement 5(3)(a)**

The service environment is welcoming, with wide unobstructed corridors with all consumer’s rooms and common areas opening to outdoor areas providing a light and airy atmosphere. Consumers have their rooms decorated with furnishings and personal items reflect individual tastes and styles. The service has two large common rooms to hold regular activities and events connected to covered outdoor spaces. Each outdoor area provides spaces for consumers to sit and shelter from the sun or weather.

Consumers were observed sitting in outdoor courtyards relaxing individually or playing bingo as a group. The Assessment Team observed large pots of herbs planted by consumers who enjoy gardening in an outdoor common area.

I find this requirement compliant

**Requirement 5(3)(b)**

This requirement has two limbs.

The first limb is that the service environment is safe, clean, well maintained and comfortable.

The Assessment Team observed that the service environment was safe, clean, well maintained and comfortable. Consumers said their rooms are cleaned and sheets changed regularly. Deficiencies were identified in relation to maintenance registers and systems however these deficiencies did not detract from the amenity or environment in any reported way. A single consumer was observed at not being able to access an outdoor smoking area. Several matters relating to smoking and fire regulation were observed; the matters were technical in nature and the relationship to safety was not direct.

The service in its response to the review audit report explains that a smokers area is now available to all consumers who choose to smoke. It had identified the need to open a second area prior to the review audit and this is now completed.

In light of the positive observations of the service and the remedial actions that have been completed by the additional smoking areas, I find this limb compliant.

The second limb is that, in short, the service environment allows free movement. The Assessment Team considered that free movement was allowed and no adverse information was provided. I find this limb is compliant.

I find this requirement is compliant.

**Requirement 5(3)(c)**

Consumers/representatives are satisfied the furniture, fittings and equipment assists consumers to be independent and they are kept clean and well maintained. Cleaning and maintenance are scheduled and monitored by management and responded to in a timely manner.

Care staff described the process for cleaning equipment utilised for providing personal care and any maintenance issues are recorded in the reactive maintenance folders. The Assessment Team observed equipment to be clean and labelled by third-party contractors demonstrating they have been checked for safety and compliance.

I find this requirement is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

**Requirement 6(3)(a)**

Overall consumers said they feel encouraged and supported to provide feedback and make complaints. Staff described how they support consumers to provide feedback. A review of meeting minutes and communication to consumers/representatives from the service demonstrate consumers/representatives are encouraged to provide feedback.

Care staff described how they would support consumers to provide feedback or make a complaint by helping them complete a feedback form. Staff also said they would inform registered staff if they were aware one of the consumers wanted to make a complaint. A review of consumer meetings conducted in March, June, July and August 2024 demonstrated consumers are encouraged to provide feedback and make complaints.

I find this requirement compliant.

**Requirement 6(3)(b)**

A sample of interviewed consumers/representatives said they have accessed advocacy groups to help facilitate communication between the service and the consumer. Staff described how the service would engage a language service if required. A review of the service’s consumer handbook provides contact information for external agencies to support consumers to resolve complaints. A review of the service’s complaints and feedback register demonstrated consumers have made complaints via external agencies. The Assessment Team observed information for advocacy groups displayed around the service.

I find this requirement compliant.

**Requirement 6(3)(c)**

This requirement has two limbs.

The first is that appropriate action is taken in response to complaints. In relation to this the review audit report identified the following.

Ten consumers interviewed (approximately 50% of sampled consumers) explained that complaints they made had not, in their view, been actioned appropriately or in a timely way. Consistent with this finding, the complaints register did not record all complaints that had been made. Some complaints were recorded correctly but were shown to not have been actioned in a timely manner, or at all.

The report gave examples of named consumers whose complaints had not been actioned or not been resolved in an appropriate way.

The second limb of this requirement is that an open disclosure process is used when things go wrong. No evidence was identified in the review audit report about this aspect of the requirement. The report concluded that open disclosure was not practised.

At audit, management conceded that its systems for addressing complaints were recently implemented (November 2023) and not consistently applied.

The service did not refute the above findings in its response to the review audit report.

I find this requirement not compliant.

**Requirement 6(3)(d)**

The service was able to demonstrate effective processes for reviewing all feedback and complaints to identify trends and areas for improvement.

A review of the service’s review processes demonstrated the service has implemented systems to ensure feedback and complaints are reviewed regularly to identify areas for improvement.

A monthly complaints and feedback summary report is compiled to facilitate trending and analysis of complaints to identify areas for improvement. A review of the summary report demonstrated this action has been completed. Feedback and complaints are included in fortnightly clinical governance meetings to identify trends and areas for improvement. A review of the minutes from the clinical governance meetings conducted in April and June 2024 demonstrate this occurs.

I find this requirement compliant.

# 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. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

**Requirement 7(3)(a)**

The review audit report concluded that inadequacy in staff numbers and availability impacted the delivery of safe and quality care. Most consumers interviewed support this view. Interviewed care staff, registered staff, allied health staff, and cleaning staff supported this view.

At audit management acknowledged challenges in filling shifts exclusively with employed staff and the service’s consequent reliance on agency staff.

In its response to the review audit report the service did not dispute the above findings and explained that it was exploring options to remedy the noted deficiencies.

The number and mix of staff does not deliver safe and quality care.

I find this requirement is not compliant.

**Requirement 7(3)(b)**

At audit some consumers/representatives said staff do not treat consumers in a dignified manner or know what is important to the consumer. The Assessment Team observed consumers with their continence aids exposed and staff not interacting with consumers when providing meal assistance.

Examples of four names consumers were given by the Assessment Team. Each identified an instance incompatible with dignity and respect.

In its response to the review audit report the service recognised that some staff have demonstrated the need for additional training with regards to the dignified and respectful engagement with consumers.

The service has arranged for that training and further stated remedial actions.

I find this requirement is not compliant.

**Requirement 7(3)(c)**

At audit no deficiency in staff competencies or qualifications were identified. Overall, the service was able to demonstrate staff are competent and have the qualifications and knowledge to perform their roles. Consumers/representatives said they believe staff have the knowledge and skills to provide safe, quality care and services that meet consumers’ needs and preferences.

Staff explained they have an orientation and onboarding process which includes competency training on commencement to the service and provided buddy shifts. Staff said they have regular ongoing competency checks with management. Management explained they perform reference checks on all applicants and ensure once satisfied of the applicant’s suitability for the role they ensure they receive copies of appropriate qualifications, registrations and up to date police checks for all staff.

I find this requirement is compliant.

**Requirement 7(3)(d)**

The review audit report identified deficiencies in training at the service.

A dietician review approximately six months before the audit recommended a range of training. The recommendations were adopted however the training has not occurred within the recommended time frames.

Interviewed staff said they complete annual mandatory training and regular competency checks in addition to the service delivering and facilitating in-person training when a skill deficiency is identified. However, staff said they do not feel supported by the service to learn new skills and it was identified that mandatory training had not been completed. The Assessment Team identified gaps in regulatory notifications which it attributed to a lack of training.

The service in its response to the site audit report did not dispute the above findings. The service identified a number of initiatives to develop and extend training.

I find this requirement is not compliant.

**Requirement 7(3)(e)**

The service has not conducted performance reviews in accordance with its own expectations. Approximately half of staff have received formal performance review.

Some staff have not received performance feedback during probation or for more than 12 months.

Prior to this audit the service had itself identified a need for improvement in tracking and performing reviews. The service has undertaken to continue this work.

I find this requirement is not 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. | Not 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. | Not 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

**Requirement 8(3)(a)**

Consumers/representatives said they are engaged in the development, delivery and evaluation of care and services. Management described how consumers are supported to be engaged in the development, delivery and evaluation of care and services through consumer meetings, feedback forms and by providing direct feedback to management.

Consumers/representatives said they can provide feedback and suggestions to management through various mechanisms. For example, consumer/representative meetings, providing feedback formally or informally to management, and consumer advisory meetings.

The service conducts monthly consumer meetings and provides feedback forms throughout the service to encourage consumers in providing feedback. A review of consumer/representative meetings and consumer advisory committee meetings demonstrated an open and transparent approach with consumers and representatives in relation to feedback and complaints and encourage consumers/representatives to provide feedback to the service.

I find this requirement compliant.

**Requirement 8(3)(b)**

The review audit report did not identify any positive contribution the governing body makes to culture or how it is accountable for the delivery of care and services.

The report identifies a number of system failures and, by implication, concludes that the organising body has not appropriately contributed to a culture of safety.

The service in its response to the report does not explain what constitutes the organising body of the service and does not outline any specific actions the organising body makes towards the culture required. The service identifies how it intends to address the system failures identified in the review audit report.

Neither the review audit report nor the service’s response to it demonstrates what the organising body is or how it contributes to a culture of safety or how it is accountable for care. These are the elements of the requirement. In the absence of these elements, I cannot conclude that the organisation demonstrates what is required by its governing body. I find this requirement not compliant for this sole reason.

I find this requirement non-compliant

**Requirement 8(3)(c)**

Effective organisation wide governance systems are required in the six listed areas.

The review audit report does not explicitly identify or explain what governance systems exist either generally or in relation to the six listed areas. However, findings under related requirements usually identify that policies and procedures exist for specified areas. The service response to the site audit report also does not identify or explain what governance systems operate.

The review audit report concludes that this requirement is non-compliant as the area governed has a correlated finding of non-compliance and, therefore, the inference should be drawn that the governance system is not effective.

The service had a site audit in April 2023 at which time all requirements were found compliant.

In August 2023 an assessment contact found four assessed requirements were compliant.

In March 2024 an assessment contact found that the service was not compliant in the two assessed requirements 3(3)(a) and 8(3)(c).

In June 2024 an assessment contact found that the service had returned to compliance in requirement 3(3)(a) however non-compliance emerged in requirements 3(3)(b) and 8(3)(b) and 8(3)(c).

The present performance report identifies non-compliance in sixteen requirements.

Since May 2023 the service has moved from full compliance with the Standards to emerging non-compliance in March 2024 and expanding non compliance in both June 2024 and October 2024.

In that context I cannot conclude that effective risk management systems and practices exists in respect to continuous improvement. For this reason I find this requirement non-compliant.

I make no finding in respect of governance systems that exist for other areas as this information is not in the review audit report or the service’s response to that report.

I find this requirement non-compliant.

**Requirement 8(3)(d)**

The review audit report discloses that the service has policies and procedures to guide staff in incident and risk management. It concludes that the policies are not effective.

The report identified gaps in two areas: identifying risks and incident management.

The report identifies, in relation to identifying risk, that a number of sound procedures were not fully implemented because of insufficient staff to conduct the requisite activities. Examples from different perspectives were given.

The report identified, in relation to incident management, a number of factors that contributed to gaps in effectiveness. Amongst these were staffing resource pressures.

Risk management systems were not explicitly explained in the review audit report but the presence of policies and procedures, as noted above, was noted. Flaws in the systems were not noted and there was a strong, multi-exampled contribution of staffing pressures. In that context I consider the root cause deficiency or non-compliance is better recognised and this has been considered under requirement 7(3)(a). I cannot conclude on the available evidence that this requirement is not-complaint.

I find this requirement compliant.

**Requirement 8(3)(e)**

The review audit report states that the service has a clinical governance framework. It does not provide any information about what constitutes that framework or how it operates.

The report identifies that deficiencies in requirements 2(3)(a), 3(3)(a) and 3(3)(e) are observed elsewhere in the report and that, by implication, clinical governance processes (and hence the framework) must not be effective.

The requirement specifically identifies antimicrobial stewardship, minimising the use of restraint and open disclosure. It identifies these in an inclusionary way, meaning that they are not the only areas that should be caught by the governance framework. I place greater weight on these areas however as they are listed. Importantly, the review audit did not identify deficiencies in these areas.

The audit did identify, and I have agreed, that there are deficiencies in requirements 3(3)(a) and 3(3)(b), both of which are centrally clinical. I cannot conclude by inference however that the failures in those areas are due to a lack of clinical oversight or governance as resourcing was commonly cited by staff as a causative factor.

In the absence of information on the clinical framework and in the context of positive findings across antimicrobial stewardship, minimising the use of restraint and open disclosure, I find that this requirement is compliant.

1. The preparation of the performance report is in accordance with section 76A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)