Performance

Report

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| Name: | West Coast District Hospital - Lyell House |
| Commission ID: | 8046 |
| Address: | 60-64 Orr Street, QUEENSTOWN, Tasmania, 7467 |
| Activity type: | Site Audit |
| Activity date: | 6 February 2024 to 8 February 2024 |
| Performance report date: | 16 March 2024 |
| Service included in this assessment: | Provider: 3543 Tasmanian Health Service  Service: 5019 West Coast District Hospital - Lyell House |

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 West Coast District Hospital - Lyell House (**the service**) has been prepared by Katherine Richards, 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 consumers, representatives, staff, management, and others; and
* the Approved Provider’s response to the assessment team’s report received 12 March 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not 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.

* **Requirement 2(3)(a):** The provider ensures assessment and planning, including consideration of risks relating to diabetes, changed behaviours and application of restrictive practices, is used to inform care and services delivered.
* **Requirement 2(3)(b):** The provider ensures assessment and planning identifies and addresses consumers’ current needs, goals and preferences, and consumers with end of life and advanced care plans are clearly identifiable in care plans. The provider ensures all care planning documentation, included documents used in handovers, is internally consistent, accurate and reflect the current assessed needs of each consumer.
* **Requirement 2(3)(e):** The provider ensures care and services are regularly reviewed for effectiveness, care plans are updated on a routine basis and when consumer needs or circumstances change or incidents occur.
* **Requirement 3(3)(a):** The provider ensures each consumer gets tailored safe and effective personal and/or clinical care to optimise health and wellbeing. Policies, procedures, and training will be reflective of best practice to inform staff in delivery of care, including in relation to wound care, changed behaviour and use of restrictive practice.
* **Requirement 3(3)(b):** The provider ensures there are sufficient staff with skills for identification and management of high impact and high prevalence risks associated with the care of consumers, including in relation to falls, changed behaviour and application of restrictive practices are effectively managed.
* **Requirement 3(3)(e):** The provider ensures information about consumers’ condition, needs, and preferences is clearly and accurately reflected within documentation and handover practices to communicate with staff and others involved in provision of care.
* **Requirement 5(3)(b):** The service ensures consumers can move freely inside and outside the service without requiring staff to unlock doors, where it is safe for them to do so.
* **Requirement 6(3)(a):** The provider ensures workforce planning processes support the number, mix, and skills of staff to meet consumer needs and deliver safe and quality care.
* **Requirement 6(3)(b):** The provider ensures consumers are made aware of and are provided independent and confidential access to advocates, accredited interpreters, and other means of raising concerns.
* **Requirement 6(3)(c):** The provider ensures action is consistently taken in response to complaints and open disclosure practiced when things go wrong. The provider ensures an effective complaints and feedback system is implemented. The provider ensures staff are trained in complaints handling and open disclosure.
* **Requirement 6(3)(d):** The provider ensures complaints and feedback are documented, opportunities for improvement identified and improvement actions implemented. Continuous improvement activities are to be implemented within a timely manner, with review and evaluation of progress.
* **Requirement 7(3)(a):** The provider ensures the number and mix of staff deployed enables the delivery and management of safe and quality care and services, in relation to both personal and clinical care.
* **Requirement 7(3)(d):** The provider ensures staff are required to complete training linked to the Quality Standards. The provider ensures staff are supported with adequate time and resources to complete relevant training and that training completion is monitored by the service.
* **Requirement 7(3)(e):** The provider ensures the workforce performance is assessed, monitored, and reviewed in accordance with its own policies and procedures. Monitoring for completion of formal assessments is to be recorded in a manner to enable clear oversight.
* **Requirement 8(3)(b):** The organisation ensures the governing body implements improvements and oversight to ensure it promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery.
* **Requirement 8(3)(c):** The organisation ensures deficits in systems relating to information management, workforce governance, regulatory compliance, feedback and complaints and continuous improvement are remedied to ensure effective governance and oversight.
* **Requirement 8(3)(d):** The organisation ensures there are effective systems in place for managing high impact, high prevalence risks, dignity of risk and incident management and prevention, as well as recognising and responding to abuse and neglect of consumers. Staff are to be educated about their obligations to identify and report incidents to enable monitoring and responsive actions for current and emerging risks to consumers.
* **Requirement 8(3)(e):** The organisation ensures there is an effective Clinical Governance Framework in place which encompasses up-to-date and best practice policies. The provider ensures staff receive education and training on these topics and develops effective monitoring processes.

# 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

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been assessed as Compliant.

Consumers said staff value their identity, understand their backgrounds and values, and treat them with dignity and respect. Management and staff spoke about consumers respectfully and were able to describe the measures taken to uphold this respect when providing care such as asking for consent. Care plans captured consumer backgrounds and life history, and consistently used respectful language.

Staff described how they ensured provision of culturally safe care, considering consumers’ identities, choices, and needs. Care plans sampled evidenced that the service recognises and respects the consumer’s cultural background and provides services that are consistent with their needs and preferences. Staff practice was informed through the cultural and spiritual support policy.

Consumers and representatives detailed how consumers were supported to exercise independence and choice regarding care, involvement of others, and maintaining important relationships. Management and staff described how each consumer was supported to make informed choices about their care and services and gave examples of actions to support consumers to maintain relationships. Care planning documentation captured consumer choices around care delivery and who was involved, in line with the Consumer choice policy, with staff saying they reconfirmed choices and respected consumer decisions to refuse care.

Staff demonstrated an awareness of informed risks taken by consumers, outlining consultation and assessment processes to communicate risks and associated strategies. Care planning documentation included Dignity of risk forms for consumers supported in risk taking activities, outlining the risks and strategies.

Consumers described how information was communicated to them in a clear and appropriate manner to enable choice, for example, hospitality staff assisted consumers complete menu forms identifying meal choices. Staff described different ways information was provided and how it was adapted to meet documented communication needs for individuals. Documented meeting minutes were available, demonstrating the consumer meeting was used to inform consumers and representatives of developments. Whilst activities calendars were not made available in advance, with staff saying activities were ad-hoc, consumers did not raise concerns, and management outlined improvements to be implemented.

Consumers and staff explained measures taken by staff to respect privacy, such as knocking on doors before entering consumer rooms, and closing doors and blinds during personal care. Policies and procedures outline procedures on collection and use of personal information to ensure confidentiality was maintained.

# 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. | Not Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

This Quality Standard is assessed as Non-compliant, as 3 of the 5 Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements 2(3)(a) and 2(3)(e) Not Met.

Requirement 2(3)(a) was recommended Not Met as assessment and planning processes did not identify risks relating to diabetes management, use of chemical restraint, or management of changed behaviours. This resulted in an absence of tailored diabetes management plans or behaviour support plans to manage risks and inform care. In response to the lack of directives for management of diabetes, a clinical staff member said they would search the internet for directives if required.

Despite the service identifying multiple consumers subject to various forms of restrictive practices, only one consumer in the service had a behaviour support plan, and this did not include current changed behaviours, tailored strategies for management, or inform staff when to use restrictive practices. A representative for a named consumer said they had not provided consent for use of a psychotropic medication used as chemical restraint, however, was aware of use. Staff confirmed the medication was used frequently, however, documentation did not demonstrate use of non-pharmacological strategies prior to administration.

Management acknowledged deficiencies, identified prior to the Site Audit linked to workforce challenges, and explained remedial actions being undertaken, evidenced within the Plan for continuous improvement (PCI)

The Assessment Team recommended Requirement 2(3)(e) Not Met, as care and services plans were not reviewed for effectiveness in line with routine scheduled reviews or following changes in health. Clinical staff were either unsure of the process or said there was insufficient time to attend this. Consumers prescribed psychotropic medication were not regularly reviewed by the Medical officer in line with policies and procedures. One consumer identified as experiencing decline in health did not have timely review of risks or strategies, and advance care directives and end-of-life wishes had not been reviewed after initial creation for 3 consumers. Management and staff advised the review process was impacted by staffing deficits and use of agency staff, with management outlining actions within the PCI to address this, including developing a new review schedule and providing training.

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Undertaking review of care planning documentation and strategies for all consumers, prioritising consumers named within the Site Audit report.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. However, based on the evidence before me, I consider the service did not demonstrate assessment and planning processes were used to identify risk and inform delivery of safe and effective care, nor did they demonstrate that care and services were reviewed for effectiveness regularly and following incident or change of consumer circumstances. Once improvement activities are finalised and enacted I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the service Non-compliant in Requirements 2(3)(a) and 2(3)(e).

The Assessment Team recommended Requirement 2(3)(b) as Met, however, based on the evidence before me I have come to a different conclusion. Whilst staff could describe approaches to assessment and planning to ensure consumer preferences were captured, care planning documentation did not include tailored information about consumer needs and preferences, resulting in findings of Non-compliance in Standard 3 Requirement (3)(e). Advance care planning was observed to be generic, however, processes ensured this was reviewed with representatives following consumer deterioration to prepare for end-of-life care. Feedback from one consumer about preferred leisure activities did not align with documentation. Management acknowledged care planning documentation did not always reflect changes to consumer preferences, with many out of date and in need of review but this had not been attended due to staffing constraints and prioritisation of care delivery. The policy on palliative care had expired and was undergoing review as it was identified as insufficient to support staff through assessment and planning processes relating to end-of-life. Whilst the issues had been identified, and corrective actions commenced, these had not been timely. Given the reported volume of new and agency staff, dependent upon documentation to familiarise themselves with consumer needs, goals, and preferences, I find the service Non-compliant with Requirement 2(3)(b).

I am satisfied the other Requirements in this Standard are Compliant.

Overall, consumers and representatives described their involvement in care planning. Staff explained how they partnered with consumers, representatives, and others involved in consumer care to undertake assessment and planning. Care planning documentation evidenced input from a range of providers.

Management advised care and services plans were offered to consumers and representatives during case conferences or following requests, although there was variability in the frequency this occurred, as outlined above. Consumers and representatives overall reported good communication, although one representative raised concerns on the timeliness of sharing changes to consumer condition.

# 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

This Quality Standard is assessed as Non-compliant, as 3 of the 7 Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements 3(3)(a) 3(3)(b) and 3(3)(e) Not Met.

Requirement 3(3)(a) was recommended Not Met, as consumers did not have tailored care in relation to wound care and use of restrictive practices, and staff could not outline best practice management. Documentation within wound charting did not include clear and regular photographs to show progress in line with policies and procedures, and records were not always updated following each dressing change nor recorded in consecutive date order making monitoring and oversight difficult. Management were not familiar with how many consumers were subjected to restrictive practices, and documentation within the register did not align with other records or observations of the Assessment Team. Management advised only consumers with exit seeking behaviours were considered environmentally restrained, however, the entrance door was secured and no consumers were able to leave independently (refer to Standard 5 Requirement (3)(b) for further information). Consumers subject to restrictive practices did not always have consent, and behaviour support plans with tailored strategies had not been developed in line with legislative requirements.

The Assessment Team recommended Requirement 3(3)(b) Not Met as care planning documentation did not effectively identify risks to develop mitigating strategies, as outlined within Standard 2 Requirement 2(3)(a). Staff outlined how consumer safety was compromised due to staffing deficits, increasing risk of falls for at least one identified consumer who would try to mobilise independently rather than wait for assistance. Strategies for management for the changed behaviours of a named consumer were ineffective, not reflected within the behaviour support plan, and consent had not been obtained for the use of a medication used regularly as chemical restraint for at least 5 weeks. Documentation for the consumer did not demonstrate chemical restraint was used as a last resort, and when it was administered associated risks were not considered or monitored, although staff demonstrated awareness of monitoring for effectiveness against the changed behaviour. Furthermore, the service did not demonstrate consideration of risks to other consumers arising from the changed behaviours, including psychological impact, despite management explaining other consumers required supportive conversations following incidents, and incidents were not considered for reporting through Serious Incident Response Scheme (SIRS) in line with legislation.

Medication administration systems were not in line with best practice, administration times were not recorded despite this being a requirement, and consumers gave feedback on the variability of provision of medications. Although reported medication incidents were low, management suggested based on anecdotal evidence this may be under reported. Deficiencies in incident reporting processes and oversight have been further considered within Standard 8 Requirement 8(3)(d), as incidents outlined within progress notes were not consistently reported through the incident management system.

Deficiencies within assessment and planning processes, outlined in Standard 2, combined with heavy reliance on agency unfamiliar with consumers’ needs and preferences resulted in a recommendation of Not Met in Requirement 3(3)(e). Management explained communication of consumer needs and conditions was through verbal and written handovers, staff meetings, and care planning documentation. However, care planning documentation did not effectively capture this information and staff outlined challenges working with agency staff who did not know consumers or processes well. Staff were unable to identify consumers subject to restrictive practices during interviews, and only one consumer had a behaviour support plan and this did not contain current or tailored strategies.

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Undertaking review of care planning documentation and strategies for all consumers, prioritising consumers named within the Site Audit report, including reviewing behaviour support strategies with specialist input for the named consumers with changed behaviours.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.
* Development of a risk register identifying consumers with high impact or high prevalence risks.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. Based on the evidence before me, I consider the service did not demonstrate each consumer received safe and effective care, tailored to needs and identified risks or reflective of best practice. Information about consumers was not always reflective within care planning documentation, placing heavy reliance on verbal handover processes through a workforce with significant variance in knowledge of the consumers. I also am not satisfied the that the Approved Provider’s response identifies reporting obligations within SIRS relating to the unauthorised use of restrictive practice for consumers.

Once improvement activities are finalised and enacted, I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the service Non-compliant in Requirements 3(3)(a) 3(3)(b) and 3(3)(e).

I am satisfied the other Requirements in this Standard are Compliant.

Whilst policies and procedures were being reviewed, as guidance was not sufficient to inform best practice palliative care, staff outlined how they recognised consumers nearing end-of-life and adjusted care to maximise comfort. A representatives explained how staff effectively managed pain for consumer comfort, reflected within care planning documentation along with hygiene measures and repositioning to maintain comfort and dignity.

Staff identified how they identified deterioration, explaining common signs monitored for change, and commenced assessment and monitoring processes with escalation where appropriate. Care planning documentation demonstrated change in consumer condition was identified in a timely manner and managed in line with policies and procedures, including review by Allied health staff, Medical officers, or specialists. Whilst the Site Audit report referenced deterioration of one consumer’s condition was not recognised or responded to in a timely manner, evidence demonstrated issues had been identified some weeks before the Site Audit, with referrals made efforts to understand and develop responsive management strategies.

Care planning documentation evidenced referrals to Allied health staff and specialist providers, and consumers and representatives said referrals were promptly attended. Staff explained pathways for referral for various providers, acknowledging challenges due to the rural location, with use of alternate strategies or telehealth services to avoid delays.

Staff were observed following infection control procedures, including screening all visitors and staff entering the service and using personal protective equipment. Policies, procedures, and an outbreak management plan supported staff in reduction or management of infection related risks. A staff member was undertaking study to become an Infection prevention and control (IPC) lead, and the previous IPC Lead was still providing support. Staff outlined principles of antimicrobial stewardship, and how antibiotics were used following pathology results.

# Standard 4

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

Findings

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements have been assessed as Compliant.

Staff outlined how preferences, interests, likes, and dislikes were captured within assessment and planning processes, and then used to identify services and supports required to optimise quality of life. Activities and equipment were adaptive to meet cognitive and sensorineural needs of consumers.

Staff explained how they identified and supported consumers’ experiencing low mood, providing relevant examples. Spiritual and emotional needs were captured within care planning documentation, and used to inform care and services, such as religious services and visits, referral for psychological support, or spending one-on-one time with consumers. As outlined within Standard 8 findings, the service did not demonstrate consideration of the psychological welfare of consumers impacted by changed behaviours of a named consumer, despite management acknowledging some consumers needed ‘supportive conversations’ after incidents. Whilst staff said they would provide support through conversations and/or offering counselling, I would strongly encourage the service to develop processes to assess and monitor consumers impacted by these incidents to ensure emotional well-being is considered and supported.

Consumers explained how they were supported to do things of interest, both within the service and greater community, and made new friends through social activities. Staff explained social activities to connect consumers to the broader community, including through the local Returned Services League, and supported relationships through visiting processes. Consumers were observed entertaining visitors and leaving to participate in activities in the local day centre.

Consumers said staff were updated on changes to condition, needs, and preferences. Staff described methods to share information in a timely manner, with kitchen staff informed of dietary changes through care planning documentation, and information shared with support workers through regular communication and meetings. Overall, care planning documentation included sufficient information to inform staff of needs, goals, and preferences, however, one consumer’s interests were not reflected in documentation with management advising the review was undertaken annually and not yet scheduled (considered further within my findings for Standard 2 Requirement (3)(b)).

Consumers and representatives identified referrals as appropriate and timely. Staff explained the rural location limited access to some services but gave examples of engaging with Advocacy Tasmania for financial affairs support, mental health services, and religious providers.

Consumers and representatives expressed satisfaction with the quality, quantity, and variety of meals, describing food as fresh, with appropriate size portions and snacks in between. Consumers reported they gave input into the menu and could also for alternates. Staff explained how they catered meals in line with consumer likes and dislikes, and assisted consumers make selections from menu items or alternates coordinated. Feedback on meals and improvements were actively sought.

Consumers and representatives said equipment was safe and suitable for individual needs, and it was observed to be clean and in good condition. Whilst staff said they would benefit from additional equipment for leisure activities, they had sufficient equipment for personal care and detailed their responsibilities to ensure it remained clean and well-maintained.

# 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. | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard is assessed as Non-compliant, as one of the 3 Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement 5(3)(b) Not Met as consumers’ free movement was restricted through doors secured with a code or swipe pendant not available to consumers. Management explained this decision was made as all secured doors within the greater location, including the hospital and nurses’ stations, would be accessible if provided to consumers, and they had not considered it environmental restraint as consumers were not demonstrating exit seeking behaviours. Consumers explained they needed to wait at the door to be let out or in of the service, and there could be delays if staff were busy. Furthermore, the safety and cleanliness of the service environment was affected by changed behaviours of a consumer, causing distress to consumers.

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Undertaking review of care planning documentation and strategies for all consumers, prioritising consumers named within the Site Audit report.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.
* Reinstated code access to the main door to facilitate free movements of mobile consumers who can manage their own safety.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. However, based on the evidence before me, I consider the service did not demonstrate the service environment was safe, clean, comfortable, or enabling for consumers to move freely indoors and outdoors. Once improvement activities are finalised and enacted I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the service Non-compliant in Requirement 5(3)(b).

I am satisfied the other Requirements in this Standard are Compliant.

Consumers and representatives said they found the environment home-like and were supported to personalise their space. Management described actions and designs to support consumers feel at home, such as orientating new consumers, and dementia friendly principles had been incorporated into the design to enable independent movement and wayfinding.

Furniture, fittings, and equipment were observed to be safe, clean, and well-maintained, with staff outlining cleaning and maintenance processes. Documentation demonstrated reactive and preventative maintenance was logged, and monitoring for the environment, furniture, fittings, and equipment to ensure safe and suitable for use. Consumers were observed using equipment or furniture, and confirmed actions were in place to ensure cleanliness and safety.

# 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. | Not 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. | Not 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. | Not Compliant |

Findings

This Quality Standard is assessed as Non-compliant as 4 out of 4 Requirements have been assessed as Non-Compliant.

The Assessment Team recommended Requirements 6(3)(a), 6(3)(c) and 6(3)(d) Not Met.

Requirement 6(3)(a) was recommended Not Met as feedback forms were not readily available, and the feedback box located in an area outside the service doors that was inaccessible to consumers. Whilst feedback forms could be requested from staff, this did not support anonymous feedback and was contrary to supports for confidentiality outlined in policies and procedures. Alternate opportunities for feedback were not reliable, with sporadic consumer meetings not prioritised by previous managers and whilst surveys were undertaken, the inability to access specific results impacted insight and understanding of responses.

Consumers and representatives described having longstanding complaints that were not resolved and were not lodged within the complaint system. Although staff interviewed were unfamiliar with the term ‘open disclosure’, management and staff could outline steps taken in response to a complaint in line with the principle. However, verbal complaints made to staff were not always recorded in line with policies and procedures, and consumers and representatives expressed frustration that appropriate action was not taken leaving them to repeatedly raise concerns and/or find their own solutions. Despite management advising trended complaints around food and service environment, only one complaint was lodged within a 6-month period just prior to the Site Audit. Furthermore, management advised they only enter items into the complaint register where there was a safety or reputational risk. The service was unable to provide any evidence of how feedback and complaints specifically were used to develop improvement activities on the PCI. This evidence resulted in the Assessment Team’s recommendation of Not Met for Requirements 6(3)(c) and 6(3)(d).

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.
* Established a feedback box, with brochures and forms and contact details, including email and phone options, for the regional consumer feedback team.
* Sought consumer input into the Lifestyle program, with training and support systems for the coordinating team.
* Increased frequency of consumer and representative meetings to support communication.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. However, based on the evidence before me, I consider the service did not demonstrate consumers were encouraged and supported to provide feedback or make complaints. Furthermore, the service did not demonstrate appropriate action was taken in a timely manner to address complaints. The failure to record all complaints resulted in management being unable to demonstrate how complaints were analysed for trends and used to inform continuous improvement activities in the PCI to improve the quality of care and services. Once improvement activities are finalised and enacted I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the service Non-compliant in Requirements 6(3)(a), 6(3)(c), and 6(3)(d).

The Assessment Team recommended Requirement 6(3)(b) as Met, however, I have come to a different conclusion. Staff said they could access language services for translation and interpreting services, and gave examples of how consumers were visited by, and referred to, advocacy groups. However, consumers did not have the means to independently and confidentially access details or make contact with external supports for advocacy or complaints. Brochures displayed external to the service and only available upon request, and consumers reported they could not access Wi-fi to enable sending emails. The one consumer who referenced using advocacy services had been referred by staff for support managing affairs. The consumer handbook included information about complaints but did not educate consumers of external supports and complaint services. As consumers were not reliably informed or enabled to access external supports, I find the Service Non-compliant in Requirement 6(3)(b).

# 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. | 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

This Quality Standard is assessed Non-Compliant as 3 out of the 5 Requirements have been assessed as Non-Compliant.

The Assessment Team recommended Requirements 7(3)(a), 7(3)(d) and 7(3)(e) Not Met.

Requirement 7(3)(a) was recommended Not Met as whilst care was not reported to be impacted for most consumers, it was generally acknowledged by consumers, representatives, staff, and management that the service had ongoing struggles due to being short-staffed. Rostering evidenced shifts could not be filled, with reliance on overtime and agency staff, and staff expressed concern at the quality of care from agency staff unfamiliar with consumers and processes. Clinical staff cover the service and the co-located hospital, and consumers and staff reported delays in provision of personal and clinical care, with one representative reporting the level of emotional distress this had caused a consumer. Clinical staff said some consumers required assistance of 2 or 3 staff but tried to mobilise independently because there are not enough staff, and they believed this could contribute to experienced falls. Management described the staffing shortage as severe, relying every day on overtime and inexperienced agency staff requiring guidance and support, reporting recruitment was impacted through rural location and funding constraints.

The Assessment Team recommended 7(3)(d) as Not Met because onboarding processes were not effectively organised with staff saying they felt unequipped to work with consumers as orientation programs were not structured, saying they learned on the job rather than through formal processes. Training in relation to restrictive practice, mandatory incident reporting, and infection control was ineffective, and not all staff were aware of SIRS reporting obligations. Furthermore, staff could not explain strategies used in response to a consumer’s changed behaviours or demonstrate understanding of best practice principles for application of restrictive practices. A representative said staff did not have sufficient training to provide best practice care for the needs of a named consumer. Mandatory training records for SIRS and application for restrictive practice demonstrated completion rates of under 10% for care staff, and no clinical staff had undertaken the training, and infection control training was under 50% for all staff. Agency staff training and knowledge was not monitored by the service. Other mandatory training modules also demonstrated low level of compliance. Management advised whilst they had identified areas for training and development, training had not been possible due to staffing deficiencies, and inability to fill the Nurse educator role.

Workforce performance had not been assessed, monitored, or reviewed, resulting in a recommendation of Not Met in Requirement 7(3)(e). Records demonstrated low completion rate (22%) of the formal performance review process, some staff were unaware it existed, and management were unable to locate any of the completed review documents. Management explained formal and informal processes, and advised identified performance issues usually resulted from fatigue, competing priorities, and/or lack of education. Improvement actions were outlined by management, with intention to complete the annual appraisal process in coming months.

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Undertaking review of care planning documentation and strategies for all consumers, prioritising consumers named within the Site Audit report.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.
* Provided support for Infection Prevention and Control support for initial period.
* Provided Basic Life Support training for all staff and developed plan for ongoing compliance with mandatory training.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. However, based on the evidence before me, I consider the service did not demonstrate the number and mix of workforce members supported safe and effective care delivery and management with regular assessment, monitoring, and review of staff performance. Furthermore, staffing levels and training processes were not sufficient to deliver outcomes required by the Quality Standards, evidenced within my findings of Non-compliance in 6 of the 8 Quality Standards.

Deficiencies within assessment and planning processes, outlined within Standard 2 findings, were reported by management as resulting from not having a core of experienced clinical staff. Lifestyle programs were not scheduled in advance and delivered on an ad hoc basis, and staff reported a lack of activities and diversional therapy particularly after 11:00am. Training and onboarding procedures did not ensure staff had sufficient knowledge to provide safe and effective care for consumers, with poor adherence to mandatory training, and performance was not regularly evaluated to identify improvements or training opportunities.

Once improvement activities are finalised and enacted I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the service Non-compliant in Requirements 7(3)(a), 7(3)(d) and 7(3)(e).

I am satisfied the other Requirements in this Standard are Compliant.

Consumers and representatives described staff as kind, caring, respectful, and gentle, and this was observed within interactions between staff and consumers. Management said staff interactions were monitored with action taken if it is not to standards and expectations. Policies, procedures, and staff guidelines inform staff practice and behaviours.

Management explained processes to determine competency of staff, through assessment of qualifications and knowledge in recruitment processes. Documentation showed monitoring of registration with professional bodies, however, oversight practices were unable to be viewed in relation to other qualifications, and records such as police checks or vaccination status (I have considered this further in my findings in Standard 8 Requirement 8(3)(c)). Position descriptions included qualifications and competency requirements, and staff could outline training and competencies in line with their roles.

# 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. | Not 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. | Not Compliant |

Findings

This Quality Standard is assessed Non-Compliant as 4 out of the 5 Requirements have been assessed as Non-Compliant.

The Assessment Team recommended Requirements 8(3)(c), 8(3)(d) and 8(3)(e) Not Met.

Requirement 8(3)(c) was recommended Not Met due to identified deficiencies within governance systems relating to information management, workforce governance, regulatory compliance, and feedback and complaints. Although staff said they could access information to perform their roles, information within the paper-based care planning documentation did not adequately reflect information about consumers, and records were not always in date sequence; management were unable to easily access documentation relating to workforce management resulting in deficiencies in monitoring of staff compliance with mandatory training or competencies, and requirements of their roles, including police clearances.

Systems in relation to feedback and complaints did not identify consumers could not access feedback processes, complaints were not being consistently captured or recorded, impairing oversight, and resulting in inability to determine current or emerging trends. Ineffective workforce governance practices resulted in a lack of suitably skilled staff familiar with consumers’ care, with heavy reliance on agency staff and overtime to prevent shift shortages. Staff had not completed mandatory training essential to understand their roles and responsibilities under legislation and the Quality Standards.

Deficiencies in compliance with regulatory compliance included failure to understand, identify, and develop behaviour support plans for consumers subject to restrictive practices or ensure staff were aware of mandatory reporting obligations through SIRS. Whilst the Site Audit report reflected the PCI included improvement actions, evidence brought forward did not demonstrate timely action, for example, activities around training had not been progressed the Nurse educator position being unfilled for over 4 months.

The Assessment Team recommended Requirement 8(3)(d) Not Met as the service did not demonstrate a comprehensive risk and incident management framework. Policies and procedures did not inform staff of legislated reporting requirements under SIRS, staff were unaware of their reporting obligations, and there was no system to assess the psychological impact on consumers. Incidents reflected within consumer care planning documentation were not always reported as incidents, and when reported, timely review and investigation in line with documented protocols was inconsistent, with staff explaining this was due to lack of time due to staffing shortages.

The clinical governance framework did not support management and oversight of clinical care delivery, with deficiencies relating to recognising, reporting, and minimising use of restrictive practices. Further risks raised within the Site Audit report included medication management and administration, wound care monitoring, diabetes management, and falls prevention. This resulted in the Assessment Team recommending Requirement 8(3)(e) as Not Met.

The Approved Provider’s response acknowledges the feedback, and explains strategies being implemented to address deficiencies, included but not limited to:

* Increasing onsite management and clinical leadership support.
* Commissioning a Steering Group with aged care, clinical governance, and risk management to track progress in addressing deficiencies, develop PCI activities, identify learning needs and create a training plan, implement a Risk Register, and develop a workforce strategy.
* Communicating identified issues and responsive actions to staff, consumers, and representatives.
* Sought approval to review and develop clinical risk management, SIRS and incident reporting, medication management, behaviour support planning, minimising use of restrictive practices, and management of pain, to drive system improvements.
* Review incidents and submit SIRS reports for all consumers identified as experiencing psychological impact resulting from changed behaviour of an identified consumer.
* Commence SIRS training with management and staff.
* Appointed Consultant Pharmacy Service to undertake medication review for all consumers and ensure medical review of psychotropic medications and accurate psychotropic and restrictive practices registers maintained.

A copy of the PCI has not been submitted to verify status or previous actions referenced as added during the Site Audit, however, the Approved Provider notes activities are still being developed.

I acknowledge the Approved Provider’s response, actions, and documented commitment to ensure the safety and well-being of consumers. However, based on the evidence before me, I consider the organisation did not demonstrate effective governance systems, risk management frameworks, incident management systems, and clinical governance frameworks. The deficiencies are reflected within the significant findings of Non-compliance within 6 of the 8 Quality Standards, outlined within this report. Workforce governance and information management deficiencies directly impacted the quality of care and services through assessment and planning processes, deliverance of care, and effective management of complaints. Incidents were not reported, risks were not effectively identified for monitoring and management, and the clinical governance framework did not support management to address identified deficiencies within a timely manner. I also am not satisfied the that the Approved Provider’s response identifies reporting obligations relating to the unauthorised use of restrictive practice for consumers within SIRS.

Once improvement activities are finalised and enacted I consider actions will require time to implement, evaluate, and embed into ongoing practice. For these reasons, I find the organisation Non-compliant in Requirements 8(3)(c), 8(3)(d) and 8(3)(e).

The Assessment Team have recommended Requirement 8(3)(b) as Met, however, I have come to a different conclusion. Management described the role of the governing body, maintaining oversight through reporting processes and escalation pathways, however, I consider deficiencies within information management practices impacted the accuracy of these reports. Monitoring of staff compliance with mandatory training relating to expectations within the Quality Standards was not accurate, and policies and procedures did not always reflect current legislative requirements, and these had not been recognised or addressed by the governing body. Given the extent of the deficiencies leading to findings of Non-compliance in 6 of the 8 Quality Standards, I find the monitoring processes of the governing body were ineffective to identify risks to consumers and did not ensure care and services were safe and of quality. For these reasons, I find the organisation Non-compliant with Requirement 8(3)(b).

I consider Requirement 8(3)(a) Compliant. Whilst deficiencies relating to the complaint management system were identified within Standard 6 of this report, overall consumers and representatives reported improvements following the appointment of the new manager, and I have placed weight on this in making a finding of compliance. Consumers and representatives described their engagement within the service. Management advised feedback was sought through meetings, surveys, conversations and during care plan reviews.

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