Westgate Aged Care Facility

Performance Report

4 William Street   
NEWPORT VIC 3015  
Phone number: 03 9391 9222

**Commission ID:** 4330

**Provider name:** Pannavila Enterprises Pty Ltd

**Site Audit date:** 29 March 2022 to 31 March 2022

**Date of Performance Report:** 13 May 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the Approved Provider’s response to the Site Audit report received 3 May 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

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

The service demonstrated consumers are treated with dignity and respect and their identity, culture, and diversity is valued. Consumers said staff are kind, treat them with dignity and respect and make them feel valued as an individual.

Staff demonstrated respect and an understanding of consumers’ identity, culture and individual values. Staff were familiar with consumers’ backgrounds and explained ways they support particular consumers’ care preferences on a daily basis. Staff explained how communication, consent and reassurance are always provided when delivering care. Staff were observed greeting consumers in a friendly way, knowing and supporting their needs and preferences, and helping them connect with family.

Care planning documentation included information regarding consumers’ background, personal preferences, identity and cultural practices. Sampled consumers’ care plans showed a high degree of detail regarding the consumer’s personal history, lived experiences, preferences and elements of their life that are most important to them. All care plans aligned with consumer and staff interviews.

The service has policies, procedures and staff training that centre around consumers diversity, being treated with dignity and respect and delivering culturally safe care. The Charter of Aged Care Rights and the Elder Rights Advocacy information was included on noticeboards throughout the home.

Consumers from culturally diverse backgrounds said their culture was respected. Most consumers interviewed followed a form of Christianity and enjoyed regular religious services. Staff were able to describe cultural, religious, and personal preferences for consumers and the people and relationships that matter most to them. Care planning documentation recorded all consumers’ religious, spiritual, cultural needs and personal preferences. A priest visits the service regularly, and this is popular with consumers.

The service demonstrated consumers are supported to exercise choice and independence. All consumers interviewed said they are supported to exercise choice, take risks and maintain independence and relationships. During COVID–19 visitor restrictions, consumers were supported to maintain connections with friends and family by staff facilitating phone calls, window-visits and video conference calls.

Staff demonstrated an understanding of consumers’ relationships within and outside the service and could explain various ways in which they provide choice to consumers on a day-to-day basis. Care staff said consumers guide them about their care preferences, for example in relation to shower times.

A number of examples demonstrated the service supports consumers to maintain their independence and take risks, to live the best life they can. Assessment of risk-taking activity occurs in consultation with the consumer, representative and appropriate health professionals, to provide the opportunity for informed decision-making and choice. Care planning documents described areas in which consumers are supported to take risks and staff knew how to support individual consumer’s needs. Consumers confirmed they were supported to be independent and make choices involving risks, to live the best life they could.

The service demonstrated timely, current and accurate information is provided to consumers. Lifestyle staff said information about scheduled activities is updated every month and displayed on the activity noticeboard and throughout the service. The ‘Welcome Pack’ had information about meals, activities, involvement of family, room personalisation and choices around care and services. Menus, activity calendars and other notices were observed throughout each area of the service to communicate current information to consumers/representatives.

Consumers and representatives were satisfied they received timely and accurate information that met consumers’ needs. Representatives advised they were provided with information to assist them in making choices about the consumer’s care and lifestyle, including; current events occurring inside and outside the service, meal selections, and daily activities.

The service demonstrated consumers’ privacy is respected, and information kept confidential. All consumers and representatives were satisfied their privacy was respected. Staff were able to describe practical ways they respect the personal privacy of consumers. Such as; knocking on doors to seek consent before entering and closing doors to provide personal care. Curtains were always drawn when providing care to consumers in shared rooms. Staff asked consumers if they were comfortable with them assisting them when care or assistance appeared necessary.

Management showed how personal information is securely managed on their IT systems and how any private information can be disposed of securely, through the shredding bin in the administration area. Hard copy care documentation for consumers was observed to be kept secure in locked work areas and computers used by staff were password protected.

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

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

The service demonstrated assessment and planning, including consideration of risks to the consumer’s health and well-being informed the delivery of safe and effective care and services. Consumers undergo initial assessments to develop tailored care plans upon entry to the service. The service utilises an electronic clinical information system as well as paper-based charts for clinical care documentation. Consumers and representatives said they felt like partners in the ongoing assessment and planning of their care and services.

Clinical staff are responsible for the completion of initial assessments to identify consumers’ needs, goals and preferences. Consumers and representatives, doctors, and other allied health professionals are involved in the care assessment and planning process. Care planning documentation for most consumers were suitable to inform the delivery of safe and effective care. Two consumers’ care plans did not appear to be updated to reflect their current circumstances.

The service demonstrated assessment and planning identified and addressed the consumer’s current needs, goals and preferences, including advance care planning. Clinical staff were able to describe the care requirements and goals for specific consumers and this matched their care documentation.

The service has policies and procedures in relation to end of life care. Clinical staff explained how advanced care planning would be approached during care planning consultations, or as required. Care planning documentation for most consumers had advanced care planning included along with their preference around resuscitation.

The service was able to demonstrate that assessment and care planning for consumers is based on an ongoing partnership with the consumer, and others that the consumer wished to involve. Consumer files showed the involvement of other individuals and organisations in assessment and planning including; representatives, medical officers, dieticians, geriatricians, speech pathologists, physiotherapists and Dementia Service Australia (DSA). Representatives stated the service always keep them informed of changes in care and they are involved in assessment and planning on an ongoing basis.

The service could demonstrate that outcomes of assessment and care planning are effectively communicated to the consumer and documented in a care plans that were readily available to consumers/representatives. Care plans showed evidence of review and consultation with consumers/representatives and the plan being made readily available to them. For example, one representative confirmed attending care planning conferences and the documentation being provided to them. They advised that staff contact them about any changes and keep them well informed. Clinical staff explained how they communicate the outcomes of assessment and care planning to consumers and representatives through verbal updates and care consultations.

Staff said that all care documentation is readily available on the electronic system. Consumer information is discussed and reviewed daily through progress notes, handover sheets and discussions.

The service demonstrated assessment and care planning are regularly reviewed for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Care documentation recorded incidents and changes such as; medication changes, infections, falls, behavioural episodes and pressure wounds. Management plans were also revised and put in place. Clinical staff review the care plans monthly through a Resident of the Day (ROD) schedule and a 3 monthly review. The service has policies and procedures to support regular and incident driven care reviews. Key clinical indicators, incidents and trends are reported monthly.

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirement (3)(a). Reasons for the finding are detailed in the relevant Requirements below.

The service was able to demonstrate high prevalence and high impact risks to consumers were effectively managed. Management advised the high impact and high prevalent risks to consumers included; pressure injuries, falls risks, weight loss and behaviour. Strategies to manage these risks were also described such as; regular repositioning, use of pressure relieving devices, hip protectors, and crash mats. Care planning documentation identified individual risks and the associated care interventions.

Staff were able to identify and describe consumers receiving pressure area care and this was in line with care planning information. Clinical staff described indications for reporting medication incidents such as medication omissions. If there was a missing signature, then the staff member identifying it has to report to the management as soon as possible followed with a medication incident report.

Weight loss was monitored and reviewed each month during the clinical indicator review. Referrals were made to specialists such as a dietician and speech pathologist, where indicated. For example, two consumers prescribed diuretics had their medications reviewed by the medical officer during the audit.

The service was able to demonstrate needs, goals and preferences for consumers nearing the end of life are recognised and addressed, their comfort maximised, and dignity preserved. The service had policies and procedures in relation to the end of life pathway with maximising comfort and dignity central. While there were no consumers receiving active palliative care, staff were able to describe how end of life care needs were met, maximising consumer comfort and providing emotional support. Staff advised that advance care planning information with resuscitation orders is included in consumers’ care plans. Care planning documents for sampled consumers reflected their end of life needs with resuscitation orders included in their care plans. One representative interviewed said that end-of-life care planning had been discussed by the service.

Changes in consumer’s clinical care needs were recognised and responded to in a timely manner. Consumer representatives interviewed were satisfied with the delivery of care where there was deterioration or changes to a consumer’s condition. Care planning documentation showed changes in consumers’ condition were identified and timely interventions and referrals occurred.

Staff provided examples of identifying and responding to changes in consumers’ condition such as; consumers with weight loss were referred to a dietician for a weight management plan, consumers with behavioural issues were referred to other health specialists such as Dementia Services Australia (DSA), medical officer and geriatrician. Care staff could describe signs and symptoms of pain and behavioural triggers and interventions for specific consumers.

Care documentation such as handover notes, care plans and progress notes provided adequate information about the consumer’s condition, needs and preferences and were communicated to others involved in the care. Staff advised that progress notes were used to communicate information about consumers’ condition and needs during shift handover. Representatives confirmed the service communicated effectively when there have been changes in clinical care.

Care planning documentation along with staff and consumer interviews confirmed the timely and appropriate referral of consumers to individuals, and other health professionals. Emails and progress notes evidenced the referral of consumers to other health professionals such as; medical officers, physiotherapists, dieticians, geriatricians, speech pathologists.

The service has policies and procedures in relation to infection control, COVID-19 and practices to reduce the risk of resistance to antibiotics. Monthly clinical indicator reports analyse and trend infection data which are presented in monthly meetings.

Consumers said staff wear gloves and practice hand hygiene when they assist with care. Staff advised they received infection prevention and control training and described antimicrobial stewardship practices to reduce antibiotic use. For example, sending urine for pathology testing, case review by medical officer and prescribing of medications only where indicated.

Management described infection prevention and control practices at the service during the COVID-19 outbreak in February 2022. The service was in consultation with the public health unit who guided them with advice throughout the outbreak. Whilst most consumers were asymptomatic, some consumers were identified with symptoms such as hoarse voice and were confirmed positive through testing.

Management stated all staff and 99% of consumers have received COVID-19 vaccinations. One consumer declined vaccination and they have this documented in the register.

Ample supplies of personal protective equipment were seen stored at the service. Staff and visitors were screened for COVID-19 prior to entry to the service including; answering questions, temperature checking and completion of a rapid antigen test.

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found most consumers get safe and effective personal and clinical care however, pain management and administration of medication was not always safe and effective care and in line with best practice. Evidence relevant to the finding included:

* The Assessment Team identified multiple instances where medication charts were missing required signatures making it unclear whether essential medication (including insulin) was being administered in accordance with prescribing medical officers’ directions.
* There were no corresponding medication incident reports for the incidents when medication charts were unsigned. The medication management policy states any discrepancies in medication are to be reported to the manager verbally and followed with a medication error incident report, as soon as possible thereafter.
* The monthly clinical indicator report reviewed for the December 2021 - February 2022 quarter showed only one medication incident was reported. An expired insulin administered to a diabetic consumer.
* Management advised in response to the feedback that a medication chart audit will be completed, and missing medication administration signatures will be followed up with incident reports.
* Medication administration charts did not always show a diagnosis to support safe medication administration. The clinical manager acknowledged that the medication charting did not have a section for recording consumers’ diagnosis.
* The medication care plan for one consumer requiring their medications to be crushed did not specify the puree thickness for the medication mixture.
* Some consumer files showed inadequate pain assessment, pain monitoring and no pain management review.
* Other sampled consumers’ care documentation reflected individualised care that is safe, effective and tailored to the specific needs and preferences of the consumer.
* Four of five consumers and representatives sampled said they received the personal and clinical care that they need. Most care and clinical staff interviewed were able to describe the sampled consumers’ individual care needs, goals, and preferences.
* Two consumers said they wait for a long time to be assisted with their toileting care needs. The Assessment Team observed staff walking past a consumer’s room when they were calling for assistance without acknowledging them.
* Call bell records for one consumer showed that from 28 February 2022 to 29 March 2022, there were 15 occasions when call bell responses had exceeded 20 minutes. Call bell records reviewed for the entire upstairs wing (Daffodil) had a trend of excessive wait times.
* Progress notes reviewed showed the service did not always record the trial of non-pharmacological strategies prior to medication being given.
* Staff confirmed there was only one care staff allocated to the upstairs wing.
* The Clinical Care Coordinator (CCC) said they monitor and review daily progress notes of all consumers at the service and follow up with the clinical staff accordingly. Care staff said they would report to the nurse any concerns they had in relation to a consumer’s personal or clinical care.
* The service has policies and procedures in place to support and guide the staff about best practice care delivery such as; pain management, restrictive practices, falls management, nutrition and hydration management, medication management.
* Clinical indicators are collected, trended, and analysed monthly and discussed at monthly meetings. The service has an internal clinical audit system in place to ensure consumers get safe and effective personal and clinical care.
* An education and learning program is in place to ensure staff are receiving knowledge on best practice care delivery.

The Approved Provider’s response corrected some of the statements in the Assessment Report and provided additional information and evidence in support of safe and effective personal and clinical care being delivered by the service. The Approved Provider advised:

* Incident reports have been completed for all medications non-signed. Registered nurses responsible have completed an explanation form and have also received education regarding the importance of signing all medication administrations.
* A message was sent to all registered nurses regarding non-signing of medication and the protocol in the event of this happening.
* Medication chart audit schedule has been changed from weekly to daily to identify gaps as soon as possible and investigate and follow up on omissions.
* An additional care staff member has been rostered on to the upstairs wing.
* The compact paper medication charts in use by the service do not provide a space for diagnosis however, staff use the clinical software system that highlights the resident’s diagnosis on the front page.
* The clinical indicator report did not include incident reports pertaining to non-signing of medications. Future reports will include this information and will be discussed in meetings and published in a memo for all registered nurses to note. The analysis of statistical data will be included in a report for staff to note.
* Registered nurses that are non-compliant with the requirements of signing administration of medications will be educated and/or performance managed.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I note the service took a number of immediate steps after issues were raised by the Assessment Team and has taken additional actions since the audit. The deficits identified by the Assessment Team in relation to care delivery, medication administration and pain management had the potential to impact consumer well-being and safety and I am uncertain they would have been identified by the service. The difficulty verifying whether medication was administered (but not signed off) demonstrates why clinical record keeping is integral to best practice clinical care. While I am satisfied that consumer’s in the service are generally receiving safe and effective care, tailored to their needs, I am not satisfied it always reflected best practice clinical care, at the time of the audit.

Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

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

The Assessment Team recommended Requirements (3)(b), (3)(c) as not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Overall, consumers felt the service provided safe and effective supports and services to meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life. Consumers and representatives expressed satisfaction with the care and services provided and indicated they were well looked after. Care plans included information about what is important to them, and the supports needed to help them do the things they wished to. Staff were able to describe how care is provided to consumers to support their individual needs for daily living. Staff were seen being careful, considerate and patient with consumers.

Consumers were observed engaging various activities during the site audit, namely bingo and a cooking class. Some residents were asleep and disengaged with bingo however, care staff assisted these consumers as best as possible.

There was evidence that information about the consumer’s condition, needs and preferences was communicated within the organisation, and with others, where responsibility for care is shared. Consumers/representatives felt information about their choices and preferences was effectively communicated and staff who provide daily support understood their needs and preferences. Care documents provided adequate information to support the delivery of effective and safe care and services. Staff were able to describe a variety of ways in which they share information and are kept informed of the changing condition, needs and preferences for each consumer.

The service demonstrated timely and appropriate referrals were made to individuals, other organisations and providers of care and services. For example, consumers can visit the hairdresser throughout the week and one consumer has regular visits from the physiotherapist for leg care. Care planning documents included information about individuals and external services who support consumers to maintain their interests and participate in the community outside the service. Staff demonstrated an understanding of what organisations, services and supports were available in the community to support a consumer. The lifestyle manager described how they were working within the COVID-19 restrictions to deliver the lifestyle program. The service had paused all visits from musicians and performers however, the priest still visited consumers throughout February. External bus trips will be reintroduced to take consumers to various rural locations. A variety of brochures and resources were available around the service to support referral to external organisations.

The service demonstrated the meals are varied and of suitable quality and quantity*.* Most consumers expressed satisfaction with the variety, quality and quantity of food at the service. Consumers confirmed special dietary options such as; vegetarian, gluten or lactose free diets, were available. Care planning documentation confirmed consumers’ dietary requirements and preferences were captured and their information is available to guide catering staff. Catering and care staff were aware of dietary needs and preferences for consumers such as; allergies, texture modified diets and preferences. Clinical staff were responsible for advising the kitchen of any changes in a consumer’s dietary needs and would provide them with an updated report generated via the service’s electronic care system. Any feedback from consumers is also taken on board and discussed with clinical staff to update care plans.

The kitchen was observed to be clean and tidy with staff observing general food safety and work health and safety protocols. A copy of a current Food Business License was displayed at the service.

The service demonstrated the equipment provided, was safe, suitable, clean and well maintained. The service provides equipment such as mobility aids, as well as a wide range of lifestyle activity products which appeared fit for purpose, clean and well maintained. All consumers were happy with the equipment provided and no issues were raised.

Staff could describe the process to document and report when equipment is faulty. Maintenance staff advised equipment is cleaned and maintained regularly and they clean and sanitise equipment as necessary following use. The service conducts regular inspections on all equipment to ensure operational integrity and safety. Maintenance documentation identified when scheduled preventative maintenance, had been completed. Auditing activities monitor cleanliness and condition of equipment used at the service and where deficits are identified equipment is replaced or repaired as required.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team found the service demonstrated services and supports provided promote each consumer’s emotional, spiritual and psychological well-being. However, the service was unable to describe how days of cultural and religious significance were celebrated. Evidence relevant to the finding included:

* Most consumers said their emotional, spiritual and psychological well-being needs, goals and preferences were well supported within and outside of the service.
* Two representatives for different consumers said their relative is supported by the service and the visiting priest to practice their Catholic faith, which is important to them.
* One consumer stated they lacked intellectual stimulation and that all the residents and activities within the service are of no interest to them as neither “exercise” their brain. They felt like “a fish out of water” and this sometimes impacts their self-esteem. Care documentation for the consumer indicated they received emotional support from conversations with staff and engagement with other humans.
* Care planning documentation for consumers sampled contained information about their emotional and spiritual or psychological well-being and how staff can support them, and this was in-line with feedback provided by consumers.
* Staff said that they know the consumers well and what is usual for them. If a consumer is feeling unwell or agitated, they usually know why and provide necessary emotional support to them.
* Lifestyle staff were unable to describe how they facilitate celebrations for consumers’ various days of cultural and religious significance. Staff were unable to explain how they were supporting consumers to celebrate the upcoming Easter period. The lifestyle calendar indicated there were no planned activities to celebrate the Easter holidays despite the large number of consumers who practiced Christianity.
* Management or lifestyle staff could not provide an explanation as to why the service was not acknowledging this important cultural and religious festival.
* All Care Plans observed by the Assessment Team found that all consumers had their religious and spiritual preferences listed.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of care information being documented and communicated within the service. The Approved Provider advised:

* The service planned and ran a number of Easter themed activities over the Easter period. For example, a special morning tea on Good Friday with hot cross buns, traditional fish meal on good Friday, all residents served a chocolate easter egg on their breakfast tray. Activities included painting Easter eggs and making decorations with eggs and bunnies. The Catholic priest also visited all residents of Catholic denomination.
* The lifestyle calendar did not display the information as there were difficulties planning for the previous two months due to the COVID-19 outbreak. Staff were unable to plan in detail due to uncertainty around the outbreak finishing and what government directives would apply.
* Residents had their favourite activity on Easter Saturday and staff were rostered and able to facilitate these activities.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I note that most consumers indicated their emotional, spiritual and psychological well-being was being supported by the service. I agree that the recognition of significant religious and cultural events is important however, I accept that there had been some disruption due to the recent COVID-19 outbreak in the service. While the relevant lifestyle calendar did not display planned activities, I accept that the service ultimately did undertake a number of activities in recognition of the Easter period. I find that the service has provided services and supports for daily living that promote each consumer’s emotional, spiritual and psychological well-being.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### Requirement 4(3)(c) Compliant

*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.*

The Assessment Team found overall, the service did not show how the lifestyle program adequately supports consumers to participate and engage with things of interest to them. The service was able to show how social and personal relationships were maintained and consumers do things of interest to them. Lifestyle staff were unable to adequately demonstrate how services have developed and evolved in the wake of the service’s COVID-19 lockdown restrictions being lifted. Evidence relevant to the finding included:

* Most consumers and representatives said they enjoyed the lifestyle program and it supported their lifestyle needs.
* One representative said that staff will come to the consumer’s room when they are unable to attend activities of interest in the common areas.
* One consumer said the activities offered by the service are not stimulating enough. Bingo was repeatedly offered but they had no interest in it and they found the happy hours dull. This consumer did enjoy talking to family and staff and going outside the service for lunch.
* Consumers could not cite any recent efforts by the service to formally provide feedback and review the lifestyle services in relation to consumer preferences and activities. Some consumers/representatives stated that relative/resident meetings have yet to be held in 2022 and are held during the week, a time when most representatives are unable to visit.
* There had been no Resident and Relative or Food Focus Meetings yet in 2022. There had been no Lifestyle Meeting held since 15 September 2021.
* The Assessment Team observed the activity calendar for April 2022 remained largely unchanged from March despite the service exiting their lockdown restrictions.
* All sampled consumers stated they were very excited for the service’s COVID-19 outbreak restrictions to lift so they can attend activities outside of the service. Consumers particularly mentioned bus trips were an activity they looked forward to returning.
* Consumers described ways in which they were supported to do things within and outside the service prior to the COVID-19 restrictions and how they keep in touch with people important to them. For example, staff assisted with video calls, visits and window visits during the lockdown.
* Some consumers/representatives expressed the desire for external outings such as visiting the RSL for lunch to resume.
* The care planning documentation for sampled consumers contained detailed information outlining activities of interest, evidence of participation in those activities as well information about relationships they wish to maintain.
* Staff advised they regularly seek feedback about activities from consumers/representatives and this information is used to develop future activity calendars and events.
* Lifestyle staff described how they regularly attend consumers’ rooms who spend large portions of their days in their rooms, alone. Staff said they regularly visit and provide one-on-one care to these consumers, including hand massages, painting consumers’ nails and providing them with conversation.
* All lifestyle staff could provide examples of how they supported consumers to keep in touch with the people important to them during COVID-19 restrictions. For example, assisting with phone and video calls, computer access or window visits.
* The activity calendar is displayed throughout the service and offered to consumers and their representatives to inform them of the activities available.
* The Assessment Team noticed that across the Easter long weekend, no activities were scheduled for the consumers for four consecutive days. Lifestyle staff didn’t offer an explanation.
* Management cited the consequences of the service’s recent COVID-19 outbreak and staff shortages as being the cause for restricted activities.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of the lifestyle supports provided by the service. The Approved Provider advised:

* The service planned and ran a number of Easter themed activities over the Easter period. For example, a special morning tea on Good Friday with hot cross buns, traditional fish meal on good Friday, all residents served a chocolate Easter egg on their breakfast tray. Activities included painting Easter eggs and making decorations with eggs and bunnies. The Catholic priest also visited all residents of Catholic denomination.
* The lifestyle calendar did not display the information as there were difficulties planning for the previous two months due to the COVID-19 outbreak. Staff were unable to plan in detail due to uncertainty around the outbreak finishing and what government directives would apply.
* The service supported family visits even during COVID-19.
* Bus outings are planned to recommence early next month as one driver was injured and the other driver is away. A newly recruited lifestyle coordinator will also be able to drive the bus once they commence.
* More independent consumers had already been notified in writing they were able to leave the service following the lockdown.
* At the 13 April 2022 Resident and Relative meeting, they discussed holding some meetings on Saturdays or after hours to enable more representatives to attend.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I acknowledge the service was found to support consumer’s social and personal relationships. I am satisfied the service’s lifestyle program was generally supportive of consumers’ needs and there were processes in place to seek consumers/representatives feedback and amend the program to reflect their preferences. I accept that the recent month long lockdown disrupted operations at the service and some of the lifestyle program activities and consumer meetings could not proceed. I note the service was moving to resume these activities, albeit slower than some consumers wished. I accept the popular external outings were to resume as soon as the bus drivers were available. I therefore find the service demonstrated each consumer is supported to; participate in their community (within and outside the service), have social and personal relationships and do the things of interest to them.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

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

The Assessment Team recommended Requirement (3)(b) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the findings are detailed in the relevant Requirements below.

The environment was welcoming and easy to understand, and optimised each consumer’s sense of belonging, independence, interaction and function. The service has a main entrance where visitors sign in and undergo COVID-19 screening. This includes; completing a declaration, rapid-antigen testing, temperature check and issue of personal protective equipment.

The service is large, with many medium-sized communal indoor areas where consumers congregate to participate in activities, socialise and sit quietly. The indoor facilities provide a safe environment where consumers can move from their rooms, along wide corridors, with handrails and clear signage. Among the several courtyards and gardens, there are shaded areas and outdoor furniture. There is signage to direct consumers and visitors to the various areas of the home. Consumers were seen having morning tea and participating in activities in one of the main common areas.

Some consumers’ rooms appeared to lack personalisation, with no photographs or artwork. As few rooms had photographs and name placards outside each room, many rooms were indistinguishable from one another. Some rooms within the service are shared rooms. Staff described how the layout works with various courtyards, gardens and plenty of common areas for consumers and visitors to socialise and relax. Consumers were seen moving freely between the different areas of the service to visit other consumers or participate in activities.

Consumers said they felt at home in the service, and it was an enjoyable place to live. One representative said they were very pleased with their parent’s room as it had everything they need and suits them well. Another representative says the rooms within the service appear “clinical” and “impersonal”, stating that the service sometimes feels bleak and boring. In response to the service appearing “impersonal”, management acknowledged the comment and said they would consider making changes to improve this. It was suggested that photos and names be put out the front of each consumer’s room.

The furniture, fittings and equipment in the service were safe, clean, well maintained and suitable for consumers to use. Consumers were satisfied the furniture, fittings and equipment were clean, well maintained and suitable for them. Consumers said they felt safe when staff were using mobility or other equipment with them. The call bell system was observed to be operating effectively

Furniture, fittings and equipment are assessed for suitability prior to purchase to ensure they meet consumers’ personal and clinical needs. The service’s maintenance program included planned, periodic and ad hoc maintenance in response to maintenance requests. Lifting equipment was maintained and cleaned between use. Disinfectant wipes were available where equipment was shared.

The service has a fire detection and alarm system. Documentation confirmed fire systems and equipment were part of the preventative maintenance schedule and there were multiple fire emergency plans with instructions throughout the service and all emergency lighting was working.

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The Assessment Team found the service environment was clean and well maintained however, they did not find the environment allowed consumers to move freely and safely both indoors and outdoors. Evidence relevant to the finding included:

* Most consumers said they were able to move freely and independently both indoors and outdoors. Consumers from the upstairs area said they needed assistance from staff or family to take them downstairs or outside.
* Some consumer movements were restricted as ten out of twelve upstairs residents were required to get staff assistance to use the lift, as they did not have the access code. Management was comfortable with the current management of consumers in the upstairs area whereby staff escorted them down the lift safely.
* Corridors were observed to allow clear and safe movement for consumers and representatives. Staff were observed moving care equipment throughout the service, without impacting the safe movement of others in the corridors.
* External pathways were level, well-maintained and free from trip hazards.
* Various doors leading outside were locked and required staff to unlock them to exit the building. One fire escape door was padlocked and when asked, management was unsure it was part of the required fire egress route.
* There were unlocked waste bins in common gardens areas and there was access via an unlocked gate to an unlocked tool shed where tools, equipment and electrical goods were stored.
* There was no “Assembly Meeting Point” sign visible for consumers and staff to see when exiting the fire exits.
* After raising the above issues management immediately updated the Continuous Improvement Plan with actions to mitigate the unlocked waste bins and access to the tool shed access. These actions were completed that day.
* The Continuous Improvement Plan was also updated to install an “Assembly Access Point” sign to direct everyone in the event of an emergency. This request is pending with the maintenance officer.

The Approved Provider’s response disputed that the padlocked door was the fire egress route and provided additional information and evidence in support of the safety of the service environment. The Approved Provider advised:

* The issues raised by the Assessment Team were addressed immediately. Waste bins were moved into the locked area accessible to staff only via key card. The garden shed was locked and photos provided 10 minutes later to the Assessment Team, who indicated the solution was satisfactory.
* An email to source a suitable sign was immediately sent and the Continuous Improvement Plan was updated to reflect the action.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I note the service has acknowledged and addressed most of the issues raised by the Assessment Team at the time of the audit. The service has undertaken to acquire an assembly point sign and secure the garden shed. Rubbish bins may be rendered safe by being closed (not necessarily locked) and placed away from consumer access and thoroughfares. As these issues were individual cases which were resolved at the time of the audit, I find the service environment is safe, clean, well maintained and comfortable; and that it enables consumers to move freely, both indoors and outdoors.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

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

The Assessment Team recommended Requirement (3)(c) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirements below.

The service demonstrated that it encourages and supports consumers and others to provide feedback and make complaints. Consumers/representatives said they are encouraged and supported to provide feedback regarding care and services and would feel comfortable in raising concerns should the need arise. For example, one representative said management have an ‘open door’ policy with regards to feedback and they feel comfortable approaching management with any concerns.

Consumers/representatives were aware of various ways in which feedback or complaints can be provided at the service such as; speaking directly to staff or management, through ‘feedback forms’, at forums such as consumer/representative meetings. Consumers/representatives were made aware of advocacy and language services and other avenues for making complaints. Minutes of consumer/representative meetings captured compliments and complaints demonstrating consumers were comfortable raising any issues or concerns.

Staff could describe the processes available to consumers should they wish to provide feedback or raise a complaint including; via feedback forms, case conferences or consumer meetings. Staff described how they act as advocates for consumers by communicating concerns to management on their behalf, encouraging them to provide feedback and assisting consumers to complete feedback forms as required.

The resident information book, feedback forms, posters and brochures about advocates, language services and making complaints were displayed and readily available at the service’s front reception. Hard copy feedback forms and a secured suggestion box were observed around the service.

The service uses complaints and feedback to inform improvements. For example, one consumer who had complained about the lack of breakfast options, said action was taken to resolve the issue.

The service has a plan for continuous improvement which reflected the consumer feedback provided. All complaints and feedback requiring actions are recorded in an electronic management system.

Management advised they have reviewed complaints in relation to staff training and have added additional education for care staff regarding wound management, correctly updating care plans, monitoring and recognising deterioration in consumer health status, communication and open disclosure. The service has also moved to holding food focus groups every two months following complaints about food.

Whilst feedback and complaints from consumers and representatives had been recorded in the register, not all items had been incorporated into the continuous improvement plan to prevent similar instances in the future.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team found the service did not demonstrate appropriate action is taken in response to complaints and an open disclosure process is consistently utilised when things go wrong. Some consumers/representatives were not satisfied that concerns raised were promptly addressed by the service and an open disclosure process utilised to resolve the complaint. Staff did not have a consistent understanding of open disclosure and how they should use it. Evidence relevant to the finding included:

* One representative said they had raised several complaints regarding excessive call bell waiting times. They said although management seem responsive when they are informed of this ongoing issue, no further updates or explanation are given as to the reasons for the delays or what will be done to prevent future occurrences.
* One representative expressed concern regarding the service’s application of open disclosure. The representative said open disclosure was not used when they had identified instances of incorrect manual handling and failure to promptly identify a deterioration in health status.
* Some consumers/representatives said they were satisfied with the management’s responsiveness when concerns were raised and felt confident that any issues would be resolved by the service.
* Staff, including registered staff, were unable to demonstrate a shared understanding of open disclosure and how this related to complaints resolution.
* Staff interviewed said they had received training on open disclosure but could not recall how long ago this was conducted.
* Management acknowledged they were aware of consumers and representatives raising concerns regarding call bell response times.
* The service’s ‘compliments and complaints register’ showed all items were addressed and contained status updates along with correspondence where necessary. All known complaints were registered.
* The facility manager demonstrated an understanding of open disclosure, however, was unable to describe examples and provide evidence of an open disclosure process being utilised in response to recent complaints.
* The service did not have a finalised open disclosure policy however, open disclosure was referenced in the feedback management policy and a draft open disclosure policy was sighted.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of complaints being responded to appropriately and open disclosure being practised within the service. The Approved Provider advised:

* Each complaint received by the service is recorded, acknowledged and answered promptly, until the customer satisfaction is achieved.
* The complaints folder and electronic complaint register which was sighted by the auditors provides evidence of an effective complaints process.
* Policy regarding open disclosure was incorporated in relevant policies on the day of the audit.
* The circumstances around one representative complaint were disputed, although the service acknowledged that the communication with the representative was less than desired. The complaint was made externally and staff at the service had been routinely communicating with the consumer’s spouse and there had been challenges communicating with another representative.
* This complaint was handled in accordance with the service policy and all documentation was made available.
* A separate open disclosure policy has been finalised and promulgated to staff.
* The service has provided education to staff on open disclosure and will continue to educate new staff.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I accept the service had systems in place to record and track the resolution of complaints. While one complainant appears dissatisfied with the response generally, consumers were comfortable to complain and felt the service responded appropriately. I accept the service referred to open disclosure in policies and that it has issued a seperate open disclosure policy to all staff. While there may be scope for some improvement, I find that the service demonstrated that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a) and (3)(c). Reasons for the finding are detailed in the relevant Requirements below.

The service was able to demonstrate the workforce interacts with consumers in a kind and caring manner, and that staff are respectful of each consumer’s identity, culture and diversity.

Consumers/representatives confirmed staff engage with consumers in a respectful, kind and caring manner, and are gentle when providing care. Consumers commented, “staff do what they can to ensure I’m happy” and “the staff are kind to me”. However, some consumers reported being rushed and said some staff do not speak good enough English or don’t use English when they converse with other staff.

Interactions between staff and consumers were generally observed to be kind, caring and respectful of the consumer’s identity, culture and diversity. However, poor interactions were observed when consumers were requesting assistance but were ignored by nearby busy staff.

The service was able to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards.

Most consumers sampled said they did not think there were any areas where staff required more training. However, one representative said staff lacked sufficient training in manual handling, wound management and open disclosure.

There is mandatory training for all staff and role specific training. Staff were able to describe the training, support, professional development and supervision they received during orientation and on an ongoing basis. The annual performance review also gives staff the opportunity to identify further education to improve their professional knowledge and skills. Staff interviewed had not utilised this opportunity yet as the mandatory and optional training and support provided by the service was good.

The ‘Recruitment, Induction and Promotions’ policy identifies the process followed by management and key personnel to ensure that new staff are recruited, trained, equipped and supported in their role. The service has an electronic system to monitor training completed.

The service was able to demonstrate that the performance of the workforce is regularly assessed, monitored and reviewed. The service has a staff performance framework that staff are required to complete annually. Management advised that staff performance is monitored primarily through observations. Examples of performance assessments and the training matrix indicated the program was effective and up to date.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

The Assessment Team found the service was not able to demonstrate that the workforce is planned and adequate in number to enable the delivery and management of safe and quality care. Overall, consumers and representatives did not think there was adequate care staff and they reported delays in care delivery, delays in call bell responses and care being rushed and not in accordance with their care and service plan. Evidence relevant to the finding included:

* One consumer that required assistance with toileting said call bell wait times have progressively increased due to the recent high turnover of staff. They also had to repeatedly explain their care needs and preferences to different staff.
* One representative stated that the service is “heavily understaffed,” and they had observed on occasion “one registered nurse assigned to more than 30 residents.”
* One representative said they have noticed staff being more rushed as of late.
* One representative said there are “excessively long call bell wait times, often exceeding 20 minutes. They said no regular staff are rostered in the Daffodil sector located upstairs.
* Four consumers residing in the Daffodil wing expressed concerns regarding excessively long call bell waiting times which mostly impacted them when they required toileting. Two of these consumers said the call bell wait times were worse on weekends. They both said they raised these concerns with care staff but were unclear if this has been escalated to management.
* Most staff did not express concerns regarding the staffing levels. Some staff did acknowledge that the high levels of new staff presented some “challenges” with regards to them getting settled at the service.
* Staff were aware of the long call bell wait times but alluded to the fact that the challenging behaviours of consumers attributed to this as some consumers can be “very demanding”, and “press call bells often” said one nurse.
* The service’s complaints documentation for the period of September 2021 to March 2022 showed there were multiple complaints made in relation to staffing inadequacies and delays in care delivery. One complaint was made to the Aged Care Quality and Safety Commission.
* The call bell response time report for the period of 28 February to 29 March 2022 identifies there were 765 call bell responses over 10 minutes with approximately 20 of those being over one hour. Management was not able to provide explanations for the excessive wait times due to the fact no review or analysis is conducted on call bell response time reports.
* Management advised they would put the regular analysis and review of call bell response times on the continuous improvement plan.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of care information being documented and communicated within the service. The Approved Provider advised:

* The service added actions on the Continuous Improvement Plan as soon as this issue was raised.
* In response to the issue of call bell response times upstairs, the service immediately provided another staff member to Daffodil wing at “peak” times (3-8 pm, seven days a week) to promptly assist the relevant consumers. One of the registered nurses is stationed to work from Daffodil wing and also assist with call bells.
* A staff message was issued reminding staff of the expectation of timely responses to all call bells.
* The call bell report is now provided to management at the beginning of every month and it is formally analysed for any required actions.
* While the service’s occupancy ranges from 52-57 residents at any given time, they continue to employ two registered nurses on every morning and afternoon shift and one registered nurse on night duty.
* The service covers planned and unplanned leave with casual staff. Due to COVID-19 and single site requirements, some staff had to leave and our recruitment processes were used to ensure we addressed this.
* The service does not use agency staff, (this was not possible this past two years due to COVID restrictions).
* The service was proud that they did not have staff shortages even in the outbreak times and that the relevant government public health unit had stated that the service “had set the golden standard in COVID management”.
* The call bell report for April shows a significant reduction in call bell response times of over 10 minutes compared to March (519 vs 788). In April there were 56 calls with a response time over 20 minutes vs 264 in March.
* The service acknowledges the results are still not ideal, but there is significant improvement as a result of the education and emphasis to staff on the importance of answering call bells promptly.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I accept the aged care sector has faced significant challenges maintaining staffing during the pandemic. The lack of analysis and investigation of call bell data and longer response times by the services makes it difficult to assess whether staffing levels are adequate. Call bell responses are an important metric in determining whether care needs are generally being met and whether complaints about wait times are warranted. I note some consumers expressed dissatisfaction with wait times for assistance and the service has undertaken actions to improve staff responsiveness to call bells. While these actions are showing a substantial improvement in the management of call bell responses, I find at the time of the audit the workforce was not planned and sufficient to enable the delivery and management of safe and quality care and services.

Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Non-compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team found the service did not demonstrate that its workforce was competent and had the qualifications and knowledge to effectively perform their roles. Consumers/representatives sampled said that staff did not know their care preferences and needs. Staff sampled were not able to consistently relay the care needs of two consumers in relation to their diagnosis, toileting needs and meal needs. Poor information management practices were also observed by the assessment team on two separate occasions. Evidence relevant to the finding included:

* A number of consumers/representatives sampled expressed concerns with the knowledgeability of staff in meeting their care needs. One representative said they had observed “exceptionally high staff turnover rates,” which attributed to a lack of staff competency, particularly in relation to wound management, manual handling and open disclosure. The representative also stated that many staff members cannot speak English at a reasonable level.
* One representative expressed concern about the impact of noticeable staff turnover on knowledge of care needs and preferences.
* One representative said there was a significant communication barrier with nurses due to their comprehension of English. They also were concerned with “staff not knowing their care needs.”
* One representative, who elected to remain anonymous, said they were aware of consumers often having to instruct and educate staff on their care needs and preferences.
* One consumer stated new staff do not know their care needs, in particular with toileting and showering needs and preferences and as a result they often have to explain these to staff. They also said many new staff do not speak English well and this has created a significant communication barrier.
* Management described how the service ensures staff are competent and capable in their role. All recruited staff must meet the minimum qualification and registration requirements. Position descriptions set out the expectations for each role.
* The service checks criminal history certificates and professional registrations (where required), and annual influenza and COVID-19 vaccination records are maintained.
* New staff undergo a robust orientation and onboarding process, which includes a minimum of five buddy shifts with experienced staff in their role, site orientation, mandatory training and core competency checks.
* Staff performance is monitored through self-reflection processes, annual performance appraisals, feedback from consumers/representatives and input from other staff members.
* When the Assessment Team informed management of the concerns regarding staff knowledge they responded by acknowledging the finding and stating that “it was not acceptable.”
* Review of education and training records identify that training is provided regularly, via online modules and in-person training sessions. The service tracks and monitors completion of the online mandatory training modules and competencies for all staff and sends electronic reminders to staff and management if staff have failed to complete the required training.
* The Assessment Team observed on two occasions (both on 31 March 2022) where staff left the computer at the nurses’ station in the Banksia wing unlocked. Numerous wound photos of consumers were displayed on the home screen of the desktop breaching that consumer’s privacy and confidentiality.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of care information being documented and communicated within the service. The service also provided a copy of amendments to their Continuous Improvement Plan. The Approved Provider advised:

* One of the representatives was not well placed to comment on staffing patterns and competencies as they had only visited the service on a few occasions.
* Another representative was not accurately quoted by the Assessment Team as they had provided very favourable comments about the service.
* The service has very robust staff recruitment processes to replace staff that move on.
* Numerous staff are from a culturally and linguistically diverse backgrounds, as is the case in most aged care facilities in Australia, especially in Melbourne West. English is often their second language and it is understandable that it may be perceived they speak poor English. However, all are qualified and registered in Australia and have to demonstrate their proficiency in English.
* Ongoing education is also provided from various professional sources.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. I acknowledge the difficulties in recruitment and turnover of staff during the Covid-19 pandemic and the impact of ongoing new staff at the service. I note that the service has recruitment and training practices which are consistent with industry wide practices. Roles which require minimum qualifications and registration are independently certified and the service should be able to rely on these external recognitions. Nonetheless, some consumers have expressed concerns new staff and staff with English as a second language are not competent in performing their role including in relation to provision of personal and clinical care which is adversely impacting their care experience. The service has not identified actions on their Continuous Improvement Plan to investigate or assess the effectiveness of their processes to ensure all staff, including new staff are competent in their roles, including in their communication with consumers to ensure consumers receive safe and effective care in line with these Standards. I have also considered outcomes in Standard 3 Requirement (3)(a) which demonstrate staff administering medications are not always competently completing the required documentation.

I find the service has not demonstrated the workforce is competent and the members of the workforce have the knowledge to effectively perform their roles.

Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

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

The Assessment Team also recommended Requirement 8(3)(e) as not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirement below.

The service supported consumers’ engagement in the development, delivery and evaluation of care and services. Management advised that consumers are consulted through consumer and representative meetings, regular care reviews, feedback and complaints processes. Consumers were confident they are engaged in the development, delivery and evaluation of care and services at the service.

The minutes from the two most recent ‘Resident and Representative meetings’ showed some concerns raised from prior meetings were not addressed in the relevant minutes. The Assessment Team also noted meetings have not been convened for 2022, due to COVID-19 lockdowns.

The service was able to demonstrate that the governing body is accountable for the delivery of care and services, and promotes a culture of safe, inclusive and quality driven culture.

The Board corresponds regularly with the service management, staff, consumers and representatives via email and memoranda. The Board was closely engaged in the response to the COVID-19 pandemic over the past year. The Board satisfies itself that the Quality Standards are being met through management reports at meetings, regular communications and outcomes of Aged Care Quality and Safety Commission audits.

The Board drove the creation of food focus groups to facilitate consumer input into the menu and general catering arrangements. The Board has also overseen amendments to the service’s systems and processes for incident reporting following the implementation of the Serious Incident Reporting Scheme (SIRS). These changes included revision of the service’s policies, procedures and the upcoming rollout of an electronic systems to record, analyse, respond to and notify incidents within legislated timeframes.

The service was able to demonstrate there are effective organisation wide governance systems in place which guide information management, continuous improvement, financial governance, the workforce, regulatory and legislative compliance, and feedback and complaints. The governing body has access to relevant information about the performance of the service and oversight of the governance arrangements. Management and staff have access to the suite of frameworks, policies and procedures relating to; information management, continuous improvement, financial governance, the workforce, regulatory and legislative compliance, and feedback and complaints.

The service provided a documented risk management framework, including policies describing how:

* high impact or high prevalence risks associated with the care of consumers is managed
* the abuse and neglect of consumers is identified and responded to
* consumers are supported to live the best life they can

Staff demonstrated a shared understanding of what constitutes elder abuse and neglect and its inclusion within the SIRS. Staff were able to describe their reporting responsibilities when they become aware, or have a suspicion, of an instance of abuse and neglect.

Management and staff were able to describe how incidents are identified, responded to and reported in accordance with legislation, including serious incident reporting. Staff had been educated about the policies and were able to provide examples of their relevance to their work. For example, one consumer is supported to live the best life they can, by staff aiding them to smoke in a designated smoking area which complies with smoking legislation.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

The Assessment Team found that although the service has a clinical governance framework that includes reference to open disclosure, the service could not demonstrate an open disclosure policy or how it is used to address complaints in relation to care. The service provided:

* a documented clinical governance framework
* a policy relating to antimicrobial stewardship
* a policy relating to minimising the use of restraint

Staff said they had been educated about the policies but were not able to provide examples of how they used them in their work. Management was able to provide examples of how antimicrobial stewardship is applied at the service with regards to the provision of antibiotics and whether chemical restraint has been reviewed or reduced. Evidence relevant to the finding included:

* Clinical staff could not adequately describe open disclosure, nor could they provide examples of where they have utilised the principles of open disclosure.
* Open disclosure is referenced within the service’s feedback management policy, and a draft open disclosure policy was produced by the service management.

The Approved Provider’s response disputed some of the statements in the Assessment Report and provided additional information and evidence in support of their clinical governance framework. The Approved Provider advised:

* Management had outlined principles of open disclosure to the Assessment Team during the interview.
* Open disclosure was referenced in policies and open
* Staff training covering open disclosure was, and is, provided.
* A separate policy on open disclosure has been finalised.

Having considered the evidence in the Assessment Report and the Approved Provider’s response. While staff could not recite specific examples of when they practised open disclosure when put on the spot, this appears more related to staff knowledge and recall than the service’s clinical governance framework failing to encompass open disclosure. I note that a draft open disclosure policy was available at the time of the audit and the existing feedback management policy referenced open disclosure. I also note that all consumers sampled indicated they were comfortable and confident to raise complaints within the service and the feedback and complaints processes were operating and documenting complaints. The Assessment Team have identified there is scope for improvement in staff implementation of open disclosure however, I find that the service has a clinical governance framework which includes; antimicrobial stewardship, minimising the use of restraint and open disclosure.

Based on the evidence (summarised above), I find the service Compliant with this Requirement.

# Areas for improvement

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

* Standard 3 Requirement (3)(a): Ensure each consumer gets safe and effective personal and clinical care is best practice, tailored to their needs and optimises their health and well-being.
* Standard 7 Requirement (3)(a): Ensure the workforce is planned and sufficient to enable the delivery and management of safe and quality care and services. Trending objective measures of care delivery would support determining workforce adequacy.
* Standard 7 Requirement (3)(c): Ensure the workforce is competent and members of the workforce have the knowledge to effectively perform their roles. Ensure consumer feedback around barriers to staff competently performing their roles is assessed in the context of continuous improvement.