Performance

Report

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| Name of service: | Performance report date: |
| Westminster Village Aged Care Facility | 14 October 2022 |
| Commission ID: | Activity type: |
| 6941 | Site audit |
| Approved provider: | Activity date: |
| Uniting SA Ltd | 16 August 2022 to 18 August 2022 |

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

**This performance report**

This performance report for Westminster Village Aged Care Facility (**the service**) has been considered by Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the assessment team’s report for the Site audit, the Site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* the provider’s response to the assessment team’s report received 29 September 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* **Requirement 2(3)(b)** – The Approved Provider ensures assessment and planning identifies and addresses the consumer’s current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wishes.
* **Requirement 3(3)(a)** – The Approved Provider ensures each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

(i) is best practice; and

(ii) is tailored to their needs; and

(iii) optimises their health and well-being

* **Requirement 3(3)(c)** – The Approved Provider ensures the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.
* **Requirement 4(3)(f)** – The Approved Provider ensures where meals are provided, they are varied and of suitable quality and quantity.
* **Requirement 5(3)(b)** - The Approved Provider ensures the environment:

(i) is safe, clean, well maintained, and comfortable; and

(ii) enables consumers to move freely, both indoors and outdoors

* **Requirement 7(3)(a)** – The Approved Provider ensures the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services
* **Requirement 8(3)(a)** – The Approved Provider ensures consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement

# 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

Consumers considered they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services, and live the life they choose. The Assessment Team spoke to consumers who said their culture and diversity are valued, and their privacy is respected. Staff were observed, demonstrating respect towards consumers and understood their individual care preferences. A culturally appropriate care procedure was sighted, the procedure also details how resident care, lifestyle, dietary customs, emotional support, and participation are to be delivered by the staff. The staff had in-depth knowledge of each consumer’s identity and were able to articulate how they meet the individual needs of consumers.

Consumers feel they are supported to make decisions about their care and when others participate in their care and said they are supported to make and maintain connections and relationships, including intimate relationships. The Care Manager and lifestyle coordinator provided an overview of care planning and resident meetings for consumers to ensure they can exercise choice and independence.

Consumers said they are supported to take risks to enable them to live the best life they can. Consumers and representatives were very satisfied that they receive timely and accurate information, and they are provided with information to assist them in making choices about their care, lifestyle activities, and menus. Staff were able to describe how often they review the information provided to consumers to ensure it is current and relevant.

Consumers said staff respect their privacy, knock on the door before entering and seek permission to enter the room before entering. A privacy policy was cited outlining how the service maintains and respects the privacy of personal and health information for consumers.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identify and addresses the consumer’s current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | 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)(f) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* Assessment and planning identify and addresses the consumer’s current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wishes.

The Assessment Team identified two named consumers for who the service had not discussed end of life wishes and preferences with and for who care planning documentation did not include advance care planning and end of life care wishes. The Assessment Team identified staff directly providing palliative care to a consumer without knowledge of the existence of any end-of-life plan for that consumer.

The Approved Provider’s written response of 29 September 2022 acknowledged the deficiencies identified by the Assessment Team and advised that the limited opportunity to commence end of life discussions with one identified consumer was due to their recent admission. While an Advance Care Directive with limited information had been uploaded to their electronic care management system for the other named consumer, the Approved Provider acknowledged this should have led further discussion with the clinical team. The Approved Provider undertook to commit to reviewing all recently admitted consumers within the last six months to determine which consumers and family have had adequate discussions surrounding their end of life wishes to ensure this vital information is captured in a timely manner. The service has since commenced a palliative care approach to care quality improvement project to increase staff awareness as to the importance of end-of-life discussions, and early identification of palliative trajectories.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, and I acknowledge the actions taken since the Site audit, however, I am of the view the service did not demonstrate care planning documents detailed advance care planning information, including choices and end of life preferences. I find Requirement 2(3)(b) is non-compliant.

The Assessment Team recommended the following Requirement was non-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.

The Assessment Team found the service was unable to demonstrate care and services are reviewed regularly or when circumstances change despite having systems and processes in place to review care and services for consumers. The Assessment Team identified three named consumers for whom they stated care plans had not been reviewed according to policy and one consumer who had not been reviewed since 2019.

The Approved Provider’s written response of 29 September 2022 further confirmed the organisation’s care plan management procedure and stated care plan reviews are undertaken on a 6 monthly basis and as required with any change to the resident’s care needs. The service maintains an electronic care management system to assist staff to know when reviews are due for competition.

The Approved Provider put forward the care planning documents of each of the named consumers identified by the Assessment Team to demonstrate each consumer had in fact undergone regular reviews at least every six months or when circumstances change and confirmed that reviews are occurring consistently at the service.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, including care plan documents presented which do show appropriate reviews have been made of identified consumers care plans. I am satisfied the service has ensured care and services are reviewed regularly or when circumstances change and has systems and processes in place to review care and services for consumers. I find Requirement 2(3)(e) is compliant.

I am satisfied the remaining three requirements of Quality Standard 2 are compliant.

The service demonstrated assessments and care planning include risks to the consumer’s health and well-being and inform the delivery of safe and effective care and services. Staff said assessment outcomes are reflected in the care plans which guides them in the safe and effective care of consumers. Consumers and representatives said they are satisfied with the care they receive, and risks are identified and managed to promote their independence and safe care. Consumer documentation and care plans identified key high impact and high prevalence risks such as falls, pressure injury development, weight loss, and swallowing difficulties.

Consumers and representatives said they are satisfied with the quality of care and services they receive. Assessments and care planning are based on partnership with them and include others they choose to involve in their care, and this is documented on the services electronic system. Registered and care staff could describe the process of referring consumers to relevant allied health professionals such as physiotherapists, podiatrists, and other allied health services.

Care planning documentation on the service’s electronic care management system identifies when care plans are reviewed and who participated in the consultation process. Staff confirmed the care plans are reviewed with the consumer and their representative was regularly involved. Consumers and representatives sampled confirmed they participated in care plan reviews, were happy with their care and could request a copy if they wanted.

# Standard 3

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

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirements are 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 needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

Consumers gave generally positive feedback about the care and services they received from the service. However, the service was unable to correctly identify how many consumers within the service were subject to restrictive practices. On two separate occasions during the Site Audit the service presented different numbers of consumers subject to environmental and chemical restraint, verbally and through physical documents, to the Assessment Team. The service was unable to identify how many consumers at the service were subject to chemical restraint by the end of the Site Audit. The Assessment Team found deficiencies in the availability of consent authorisations for consumers subject to restrictive practices and identified two named consumers for whom they could not locate a behavioural support plan.

In addition, two consumers reported their wound management was poor, advising they had self-identified their wounds to staff with another advising the wound was identified by hospital staff. The service was not consistently following their wound management procedure as evidenced through lack of incident reported nor photographs taken when one wound was identified to staff.

The Approved Provider’s written response of 29 September 2022 explained a restrictive practice spreadsheet had not been updated by previous management and advised that the service has undertaken an internal audit in response to the Site Audit to identify and record consumers subject to restrictive practice. The Approved Provider further explained it was implementing a new consent authorisation process. The Approved Provider brought forward evidence to demonstrate that the behavioural support plans for the two named consumers were in place at the time of the Site Audit and further explained that the consumer who suffered a pressure injury was identified and documented on a wound record, and a corresponding incident form had now been completed.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response and remain of the view that at the time of the Site Audit, the Approved Provider did not demonstrate that each consumer received safe and effective personal care, clinical care. I find Requirement 3(3)(a) is non-compliant.

The Assessment Team found deficiencies in the management of end-of-life care within the service and identified one named consumer receiving palliative care for whom pain was not being effectively managed. The Assessment Team found no evidence of consistent pain charting or review, despite the consumer and representatives reporting an increase in plan.

The consumer’s care planning documentation did not include end-of-life information to guide staff practice, there was no palliative care place and consumer choices, and end of life preferences were not documented.

The Approved Provider’s written response of 29 September 2022 acknowledged the named consumer should have commenced on an end-of-life pathway sooner and discussions with the consumer and representatives should have been undertaken. The Approved Provider acknowledged the consumer had an Advance Care Directive in place and detailed some of the steps taken since the Site Audit to help with symptom management.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, however, remain of the view that the service was not consistentlyensuring the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. I find Requirement 3(3)(c) is non-compliant.

The Assessment Team recommended the following Requirement was non-compliant:

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

The Assessment Team drew upon evidence from representatives who felt referrals to other allied health professionals and medical officers could have been actioned more promptly by the service. One representative described delays to speech pathologist, physiotherapist, and nutritionist referrals and stated family have had to request these referrals be actioned. The Assessment Team spoke with the allied health speech pathology team who confirmed it had not been asked to provide any reviews of consumers unless prompted.

The Approved Provider’s written response of 29 September 2022 put forward evidence to show the named consumer was appropriately referred to external health providers, not only in the example identified by the Assessment Team but on a number of occasions including post fall, for weight loss and pain reviews. The Approved Provider submitted additional evidence and care plans to demonstrate that appropriate referrals are made as part of clinical reviews and are undertaken in a timely manner.

Based on the balance of evidence brought forward in the Site Audit report and the Approved Provider’s response, I am satisfied that the Approved Provider ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services. I find Requirement 3(3)(f) is compliant.

I am satisfied the remaining four requirements of Quality Standard 3 are compliant.

Consumers and representatives were satisfied high impact or high prevalence risks are effectively managed. The service has tools to monitor the high impact and high prevalence risks including a report from their electronic care management system, the Care Manager’s monthly report and a focus on consumers through a resident of the day. For consumers sampled key risks identified in care planning documentation included, falls, pain, behaviour, skin integrity, nutrition/hydration, infection, and complex nursing needs. Care planning documentation identified effective strategies to manage key risks and was recorded in assessment tools such as the falls risk assessment tool, care plans and progress notes for sampled consumers.

Changes in consumers' care needs are recognised and responded to promptly through a range of systems and processes such as handover, progress notes, resident-of-the-day reviews, and feedback. Consumers and representatives said they are satisfied with the delivery of care including the recognition of deterioration or changes in their condition. The services policies and procedure guide staff on how to identify, communicate or escalate, respond, and document changes in a consumer's condition.

Information about consumers’ care is documented and effectively communicated within the service and with others where care is shared. Consumers and their representatives are satisfied with the delivery of care including the communication of changes to consumers’ conditions.

Care and clinical staff interviewed demonstrated an understanding of how to minimise infection through hand hygiene, the use of personal protective equipment and ensuring antibiotics are used appropriately. The Clinical Nurse is the Infection and Prevention Control lead at the service further supporting Infection control measures.

# Standard 4

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

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

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

Most consumers and representatives advised the Assessment Team they did not enjoy the meals provided by the service with feedback generally stating the meals were tasteless, repetitive, often served cold and not of good quality. The Assessment Team spoke to some consumers who advised they bought their own food and said despite raising this feedback for a period, no changes had occurred. The service said it provided fresh cooking onsite using external contractors and tried to accommodate consumers’ individual needs and meal preferences.

A review of a consumer Food Satisfaction Survey in April 2022 found nearly half of consumers surveyed raised concerns about food quality, quantity and often being cold. The Assessment Team attended two lunch mealtimes and observed consumers did not finish their meals. Management acknowledged consumer feedback about the food quality, and stated it was now addressing the food quality concerns by conducting more food surveys.

The Approved Provider’s written response of 29 September 2022 stated the service worked with an external food services company to assist in addressing some of the menu options and food concerns raised by consumers. A new menu spring menu has been introduced with two hot food offerings for each meal. The Chef Manager has moved to alternating his hours of work to oversee dinner service to assist in alleviating issues as they arise. The Approved Provider said Food Focus meetings were well received by consumers and would continue to be scheduled to ensure feedback is raised, logged, and managed as part of the organisation’s complaint follow up processes and meal satisfaction included in the continuous improvement plan.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, and acknowledge the actions undertaken by the service, however at the time of site audit, the service was unable to demonstrate it provided meals of a varied and of suitable quality and quantity and the changes commenced to date will take time to measure effectiveness. I therefore, find Requirement 4(3)(f) is non-compliant.

I am satisfied the remaining six requirements of Quality Standard 4 are compliant.

Consumers interviewed said they were satisfied with how the service supports their individual needs, goals, and preferences and it optimises their independence, health, and quality of life. Staff were able to explain what is important to consumers and the activities they like to engage in, and this aligned with the information captured in consumer care planning documentation in in lifestyle documentation provided to the Assessment Team.

Consumers and representatives could describe how they connected and engaged in meaningful activities satisfying to them. They also provided examples of how the service promoted their spiritual, emotional, and psychological well-being. The consumers stated the service helps them to stay in touch with family and friends for comfort and emotional support and the various methods of staying connected with them during lockdowns.

The consumers and representatives sampled stated they can participate in their community both within and outside the service environment, have social and personal relationships and enjoy doing things of interest them. The staff interviewed were able to describe how they collaborate with community groups to enable consumers to follow their interests and community connections. The lifestyle care plan identified the people important to the individual consumers and the activities of interest to the consumer on a detailed and personalised level.

Consumers confirmed they are provided services consistent with their care needs and all staff are aware of their individual needs and preferences. Staff advised information, changes, and other needs are shared internally at handovers and via its electronic care management system. The service has processes and systems in place for identifying and recording each consumer’s condition, needs and preferences. Care planning documentation confirmed consumers were referred to other organisations and providers of services in a timely and appropriate manner.

Consumers and representatives said consumers felt safe when using the equipment and were comfortable raising any concerns with staff and confirmed maintenance officers addressed issues quickly and efficiently. The Assessment Team observed where equipment is provided, it was safe, suitable, clean, and well maintained to ensure equipment is fit for purpose.

# 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. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings, and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

* The service environment:

(i) is safe, clean, well maintained, and comfortable; and

(ii) enables consumers to move freely, both indoors and outdoors.

The Assessment Team found consumers in the memory support unit were not able to move freely indoors and outdoors as the access doors were locked. Laundry services staff also reported to the Assessment Team a lack of weekend laundry services and identified risks to infection control processes due to the large build-up of consumer clothing on Saturdays and Sundays. Both issues were raised with management during the Site Audit and steps were taken to rectify the matters, including engaging a contractor to reconfigure the door locks concerned.

In its written response of 29 September 2022, the Approved Provider advised of the steps taken in response to the Site Audit, which included an audit of the daily volumes of laundry undertaken at the service, engagement between management and laundry staff to further understand the issues experienced by staff, which resulted in steps commenced to purchase a larger washing machine for the site and additional hours added to the laundry roster. While the written response did not address the locked doors to the memory support unit, I note that the issue was rectified during the Site Audit and the Assessment Team observed the doors to the outdoor courtyards unlocked.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, and acknowledge the actions undertaken by the service regarding the laundry service and the reconfiguration of the locked doors, however I remain of the view that at the time of site audit, the service was unable to show the service environment was safe, clean, well maintained, and comfortable; and enabled consumers to move freely, both indoors and outdoors. I find Requirement 5(3)(b) is non-compliant.

I am satisfied the remaining two requirements of Quality Standard 5 are compliant.

Consumers interviewed stated the service environment is welcoming to their family and friends, they feel comfortable, and it feels like their home. Consumers said all staff are friendly and feel like their extended family and have a sense of belonging. Consumers were observed to be accessing dining areas to make tea and coffee and could be seen sitting and around and chatting with each other in the lounge rooms.

All consumers interviewed said the furniture fittings and equipment are clean, well maintained, and suitable for them. Staff said any maintenance issues were addressed promptly and the service had a reactive process and preventative maintenance schedule in place.

# Standard 6

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

## Findings

Consumers and representatives stated they felt encouraged, safe, and supported to provide feedback and make complaints. Consumers stated they were able to talk directly to the service manager or other staff if they had an issue to raise. Staff confirmed their awareness of supporting consumers who wanted to provide feedback or make complaints and the process to do so. Information regarding internal and external complaints and feedback processes is provided to the consumers via a consumer handbook, Complaints and Comments forms are located at each nurse's desk.

Brochures for external complaints, advocacy, and translation services are available in multiple languages and are also displayed in the communal entrance/lounge area. Staff stated they can also use consumer’s representatives to help translate as required.

Management and staff demonstrated knowledge of the open disclosure process and described the process of action taken following a complaint, including saying sorry and offering an explanation. The service’s Open Disclosure Procedure provides a clear description of the purpose and scope of how its open disclosure is to be conducted and documented.

Consumers and representatives were able to advise of the changes that have been made at the service as a result of feedback or complaints. Staff could describe the processes available to consumers if they wished to lodge a suggestion or raise a complaint.

Management was able to demonstrate the process when a complaint or feedback is received and gave examples of how they collaborate with the complainant to resolve the issues to their satisfaction.

# Standard 7

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

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is 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 spoke with staff who reported felling under pressure and due to rostering restrictions felt there was insufficient time to provide care, laundry staff reported the lack of a weekend shift resulted in a build up of work the following week. Consumers and representatives said staff were always busy and under pressure, one representative described having to assist a family member as there were not enough staff, however, no consumers felt that their care had suffered due to the pressure on the staff. The Assessment Team reviewed the roster for the previous three weeks, which shows registered nurses are allocated on all shifts, but not all shifts were filled, and staff were sometimes not replaced when sick calls were received. The Assessment Team also noted that due to a recent Covid-19 outbreak, agency staff were relied upon to fill shifts during the outbreak. The Assessment Team reviewed the call bell logs whilst on site and no adverse findings were noted or discussed.

The Approved Provider’s written response of 29 September 2022 explained it had held a mandatory staff meeting to address concerns raised during the site audit. As a result of the staff engagement, additional shifts were funded and implemented for an afternoon shift in a new wing, a full roster review was also undertaken and additional shifts implemented in the master roster for morning and afternoon shifts for personal care workers, additional laundry shifts for the weekend and additional administrative support.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, and acknowledge the actions undertaken by the service, however, also consider these changes will take time to measure for effect. I find that at the time of site audit, the service was unable to show the workforce is planned to enable the delivery and management of safe and quality care and services. I find Requirement 7(3)(a) is non-compliant.

I am satisfied the remaining four requirements of Quality Standard 7 are compliant.

Consumers and representatives said staff engage with them in a respectful, kind, and caring manner. Management advised they monitored interactions through observations, and formal and informal feedback from consumers and representatives. Training records demonstrate staff complete online modules providing them with knowledge and skills relevant to this requirement, such as dignity and personalised care.

Consumers said they felt confident staff were sufficiently skilled to meet their care and clinical care needs. Management described how they determine whether staff are competent and capable in their role. Prior to commencement, staff were required to undertake an induction and site orientation, as well as mandatory training. Position descriptions set out the expectations for all roles at the service. Management explained annual performance discussions were used to identify any skill shortages reported by supervisors or staff members. Organisational recruitment and selection policies and procedures demonstrated a structured approach was in place to ensure staff have the required qualifications and credentials. Staff credential and reference checks are conducted before staff commence in their roles and expiry dates for registrations and police checks are tracked by the organisation’s centralised human resources team.

Staff said they received training in Quality Standards as part of the orientation provided by the service. Staff said they also receive training at staff meetings, handover meetings, emails and via memorandums are displayed on notice boards. Staff demonstrated awareness of the service’s performance development processes, including performance appraisals which include discussions of their performance and areas where they would like to develop their skills and knowledge. The organisation has a staff performance framework including annual performance appraisals and mandatory education.

# 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. | Non-Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management. 2. continuous improvement. 3. financial governance. 4. workforce governance, including the assignment of clear responsibilities and accountabilities. 5. regulatory compliance. 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers. 2. identifying and responding to abuse and neglect of consumers. 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship. 2. minimising the use of restraint. 3. open disclosure. | Compliant |

## Findings

I have assessed this Quality Standard as non-compliant as I am satisfied the following requirement is non-compliant:

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

Consumers and representatives said they are not consistently provided with ongoing input into how consumer care and services are delivered, and others felt that they had not been supported in the development, delivery and evaluation of care and services in relation to their admission to the service. The Assessment Team put forward examples from several consumers who had expressed dissatisfaction with their movement to Westminster Village from another service due its closing. Other examples put forward included consumers not being aware, prior to their relocation of not having access to personal mobility equipment and personal belongings for their rooms. It was noted by the Assessment Team reviews of recently relocated consumers emotional wellbeing were incomplete.

The Approved Provider’s written response of 29 September 2022 advised the organisation underwent extensive consultation process with all consumers regarding the closure of the Regency Green facility. Consumers were offered multiple relocation options and consultation occurred. While all three named consumers voiced concern consultation had not occurred, records indicated consultation occurred over a number of months and support was offered to assist them in making their informed decision. The Approved Provider advised they have lodged all concerns on their consumer feedback log and have been working with each resident individually. All consumers were offered alternative living options as part of their complaint follow up. The Approved provider did not address the issues of personal belongings or mobility equipment in their response.

I have considered the evidence brought forward in the Site Audit report and the Approved Provider’s response, while I acknowledge the additional information provided by the Approved Provider, I have also given weight to the feedback provided by consumers to the Assessment Team and remain of the view that consumers were not appropriately engaged in the development, delivery and evaluation of care and services. I find Requirement 8(3)(a) non-compliant.

I am satisfied the remaining four requirements of Quality Standard 8 are compliant.

The Board satisfies itself the Quality Standards are being met with the service through the monthly Chief Executive Officer Report reporting on the services performance and including operational trends, risks, governance, and quality outcomes. The organisation also has a Quality and Safety Governance committee attended by members of the Board and the corporate Quality and Risk Manager. Outcomes from these meetings and committees are communicated to the service.

Staff interviewed were able to demonstrate effective organisation wide governance of systems relating to information management, continuous improvement, financial governance, regulatory compliance, and feedback management. Overall, the service demonstrated it had overarching processes and procedures for workforce governance, however, noting deficiencies in workforce planning as discussed under Requirement 7(3)(a).

The service provided the organisation’s 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, and incidents are managed and prevented. Management was able to describe how incidents are analysed, used to identify risks to consumers and inform improvement actions.

Overall, the service was able to demonstrate the organisation’s clinical governance systems ensure the quality and safety of clinical care, and promote antimicrobial stewardship, the minimisation of restrictive practices, and the use of an open disclosure process. The service was able to provide organisational policies relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. Staff were asked whether policies related to the delivery of safe and quality clinical care including antimicrobial stewardship, minimising the use of restraint, and open disclosure had been discussed with them and what they practically meant for them.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)