Woodport Aged Care Plus Centre

Performance Report

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ERINA NSW 2250  
Phone number: 02 4365 2660

**Commission ID:** 0489

**Provider name:** The Salvation Army (NSW) Property Trust

**Site Audit date:** 10 May 2022 to 12 May 2022

**Date of Performance Report:** 22 June 2022

# Performance report prepared by

Denise McDonald, 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** | **Non-compliant** |
| Requirement 1(3)(a) | Non-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) | Non-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) | 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) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-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) | Non-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) | 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 9 June 2022.

# STANDARD 1 NON-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 Non-compliant as 2 of the 6 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements 1(3)(a) and 1(3)(f). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team found the service did not demonstrate that all consumers are treated with dignity and respect and some consumers/representatives expressed concerns about this aspect.

The service was found to be culturally safe in delivering care and services. Consumers and representatives considered their cultural, language and religious needs and preferences were met. Staff knew the cultural, religious and personal needs and preferences of consumers and described supporting them to connect to suitable local community groups. The service’s Diversity, Choice and Decision-making procedure stipulates how staff identify consumers’ cultural, spiritual, religious and language requirements, while care plans contained instructions for providing care in line with consumer’s identity and cultural requirements.

Consumers considered they were supported to retain their independence, maintain their important relationships, decide about how their care and services are delivered and participate in activities of their choosing. Staff described how they support consumers choices about their care and services, relationships and preferences and provided examples of how consumers are supported to maintain relationships inside and outside the service. The Assessment Team observed consumers interacting with each other and found care plans contained evidence that consumers were supported in their choices and independence.

Consumers confirmed they were supported to take risks to maintain their quality of life, such as; consuming fluids of their choice, using power tools and continuing to access the community. Staff described how the risk assessment process supported consumers and their representatives to make informed choices and exercise dignity in risk taking.

Consumers confirmed the service provided information they needed to make informed choices in formats and languages they understand. Management and staff outlined how consumers with different language and sensory requirements are supported with large print or different language menus and activity programs. Staff often assisted consumers with sensory impairments by reading information to them. Noticeboards were observed throughout the service, which displayed information about activities and current events at the service.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

The Assessment Team found the service did not demonstrate that all consumers are treated with dignity and respect and some consumers/representatives expressed concerns about this aspect. Evidence presented by the Assessment Team, relevant to the finding included:

* Two consumers said staff provide good enough care, ‘despite short staffing,’ but are not knowledgeable about, or interested in, consumers’ backgrounds or individual identities.
* A consumer and a representative raised concern about personal care being delivered in ways that detract from consumer comfort, privacy and dignity, resulting in one consumer feeling rushed and experiencing pain during personal care, another consumer’s continence aid not being changed frequently enough and having their personal care attended to while room doors are open.
* A consumer in a shared room said their sleep and privacy is disturbed at night when staff attend to personal care of the other consumer and turn on the main light.
* A Registered Nurse described consumers in the Memory Support Unit as “non-compliant.”
* Allied Health Professionals (AHPs) confirmed they did not ask consumers if they prefer massages in their own rooms and were under the impression it was best practice to complete massage in communal areas.
* Staff were observed not always treating consumers with dignity and respect. For example; staff referring to consumers by ‘pet names’ (eg honey), three consumers having personal care attended to with doors or window curtains open, and consumers in the Memory Support Unit appearing dishevelled, wearing stained clothes, unshaven and having greasy hair.
* ‘Pocket lists’ (personal care lists showing consumer needs and preferences) for the MSU referred to consumers as being “a feed.”
* Consumer survey results showed staff do not always explain to consumers the care they are about to perform or involving them in their care.

The Approved Provider’s response acknowledged the observations made in the Assessment Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service reviewed and updated the care and services plans (personal, lifestyle, spiritual and care information) for some consumers after discussing issues identified in the audit with them or their representative.
* A memorandum was issued to nursing staff to remind them about the procedure concerning Aged Care Diversity Choice and Decision-Making.
* The service will continue to utilise the Monthly Social Program Input and Ideas Questionnaire and Bi-monthly Customer and Representative Meeting to gain feedback from residents.
* Further training has been added to the Service’s Plan for Continuous Improvement to cover additional training for staff regarding Dignity and Respect procedures, Person Centred Care session, Dignity and Personalised Care, Understanding Dementia and Effective Communication.
* The Pocket Lists for the consumers in the Memory Support Unit, have been reworded to use more appropriate and dignified wording.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I am not satisfied that staff providing care and allied health practitioners providing treatment, have always ensured consumer’s dignity is respected, or that they consulted consumers in relation to their preferences. I found no evidence that staff using generic pet names for consumers had gained explicit consent that this was their prefered way to be addressed. At least two consumers perceived that staff were not interested in them as individuals. I note the service has taken and identified actions to address the deficits identified by the Assessment Team, however, at the time of the audit, there were several instances where consumers did not appear to be treated in a dignified and respectful way.

This Requirement requires that each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

### 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) Non-compliant

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

The Assessment Team found the service kept personal information confidential however, it did not demonstrate the privacy of each consumer was respected. Evidence presented by the Assessment Team relevant to the finding included:

* Most staff described ways in which consumers privacy was upheld, such as knocking on doors before entering and closing bedroom doors to deliver personal care. However, some staff said they sometimes see personal care being delivered in communal areas, with consumers still positioned in slings, or with bedroom doors open.
* Consumer/representative feedback, relating to personal care being provided in view of others. (see Requirement 1(3)(a) above).
* The Assessment Team observed consumers being provided personal care with doors open or curtains open. (see Requirement 1(3)(a) above)
* The Assessment Team observed consumers and staff talking loudly to each other outside another consumer’s open bedroom door. The consumer was still in bed and had not yet been attended to.
* A consumer being woken at night because the main light was turned on to deliver personal care to the consumer sharing the room.
* Allied health professionals were observed providing massage to consumers in common areas. Two allied health professionals said they did not give consumers a choice where to have their massage, they just gave them where they found them.
* The diversity choice and decision-making procedure showed consumers have the right to personal privacy.

The Approved Provider’s response acknowledged the observations made in the Site Audit Report and provided additional information in relation to this finding. The Provider also provided information and evidence of actions taken or planned by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* A memorandum was issued to staff to remind them about the Aged Care Diversity Choice and Decision-Making and Dignity and Respect Procedure.
* Posters about the Salvation Army values and behaviour were displayed within the service and education was also conducted regarding Personal Hygiene and Privacy and Dignity.
* Additional training has been added to the service’s Plan for Continuous Improvement covering dignity and respect procedures.
* The Memory Support Unit is designed to provide a home like setting with the small single room bedrooms encompassing a kitchen, dining area, shared bathrooms and lounge rooms. Common areas host activities for the consumers. Closure of bedroom doors, when not requested by the consumer, is considered a restraint and a potential risk of falls being unable to be monitored.
* Further training has been added to the service’s Plan for Continuous Improvement to cover additional training for staff regarding dignity and respect.
* Allied health practitioners have been instructed to consult and document any requests by consumers to have treatments in common areas. Practitioners have received further supporting education on the service’s policy and procedures concerning dignity and respect, and clinical documentation.
* The service’s Plan for Continuous Improvement was amended to include a review of subcontractor management with regards to providing additional education related to; elder abuse, dignity and personalised care and the Quality Standards.

Having considered the evidence in the Site Audit Report and the Approved Provider’s response, I acknowledge the service has responded to the observations promptly, identified opportunities for continuous improvement and followed up with individual consumers to meet their privacy preferences. I accept that operating a communal facility with shared rooms presents practical challenges to ensuring personal privacy. However, at the time of the audit there were a several instances where consumers’ privacy was not sufficiently considered and respected by staff and attending practitioners administering care.

This Standard requires that each consumer’s privacy is respected and personal information is kept confidential.I find the service kept personal information confidential but did not always demonstrate the privacy of each consumer was respected. Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

# 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 5 of the 5 specific requirements have been assessed as Compliant.

The Assessment Team recommended Requirement 2(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 Requirements below.

The service demonstrated assessment and planning processes includes consideration of risks to the consumer’s health and well- being and informs the delivery of safe and effective care and services. The service uses an electronic care management system with a suite of clinical assessments, and charting capabilities which support staff to deliver assessed care needs. The service’s policies and procedures further guide staff in the care assessment and care planning process for consumers.

Consumers felt they were partners in assessment and planning and their chosen representatives and other relevant professionals were involved in the initial and ongoing care assessment, planning and delivery.

Care plans reflected consumers’ current needs, goals and preferences, as well as their advance care directives where they wished. Staff described how assessment and planning occurred at the service and demonstrated knowledge of the current needs, goals and preferences of specific consumers. Care plans evidenced the involvement of a wide range of organisations and individuals including dementia support services, wound clinicians, geriatricians and speech pathologists.

Assessment and care planning outcomes were documented in care plans and progress notes viewable through the service’s electronic care management system. Consumers and representatives said they had not received copies of their care plans, but they did not need them as they were satisfied with the level of consultation they had with the service. Management outlined how staff receive the information they need through care consultation records while consumers are informed of outcomes of assessment and planning through case conferences, phone calls and emails. Observations confirmed regular consultations with consumers/ representatives, notes inform verbal handovers and staff using the electronic system to receive information about changed consumer care needs.

## Assessment of Standard 2 Requirements

### 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.*

The Assessment Team found the service was not able to demonstrate care and services were regularly reviewed for effectiveness, when circumstances change or when incidents impact the needs, goals and preferences of consumers. Evidence presented by the Assessment Team, relevant to the finding included:

* A consumer with a known history of falls and diagnoses of stroke, hypertension, osteoporosis and dementia experienced a recent unwitnessed fall. Documents reviewed showed the service’s falls management policy was not followed post fall, as normal vital observations, instead of neurological observations, were taken. The consumer’s Falls Risk Assessment Tool (FRAT) and falls prevention care plan was updated appropriately.
* A consumer with a suprapubic catheter (SPC) was documented as requiring a size 16 catheter, however incorrect sized catheters were used for five recent changes. Documentation also showed the catheter changes either did not occur as frequently as required, or changes were not documented. Notes did not detail reasons for the differing catheter sizes. The consumer previously had an indwelling catheter which was changed to an SPC in mid-2021.
* A consumer with acute kidney injury and a SPC had care plan instructions to escalate to a registered nurse if the consumer’s urine output fell below a specific parameter. Documentation showed this did not always occur. The consumer’s care plan did not contain instructions that urine overflow should also be escalated for investigation to a registered nurse, which did not always occur.
* One consumer with a diagnosis of behavioural and psychological symptoms of dementia had recently been physically aggressive towards staff. His care plan was last reviewed on 6 May 2022, and it included similar historical incidents but not his most recent incident.
* Documentation showed a consumer with fluid restrictions did not always have their fluid balance monitored and on three recent occasions, low levels of fluid intake were not followed up.
* Management stated staffing levels and increased workload had contributed to some cases of inconsistent documentation. Staff will be educated on clinical documentation.

The Approved Provider’s response acknowledged the observations made in the Site Audit Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* One consumer who had a fall was transferred to hospital so neurological examinations were not performed at the service.
* It was identified the actual catheter size inserted for one consumer was 22CH and not 18CH, as was documented. The registered nurse discussed the catheter size with the doctor and entered a progress note on 9 April 2022 allowing for the size adjustment. They updated the line management form to reflect the correct size.
* One consumer’s doctor provided a progress note on 29 March 2022, stating the consumer is for comfort care. Advice will be sought as to their expected range of urine output. A case conference is being arranged with the family to also discuss their current care and expected outcomes.
* A referral has been sent to Dementia Support Australia, requesting a review of a consumer following their recent physically aggressive behaviour. The consumer’s Cognition, Mental health and Behaviour Support Plan has been updated to include the recent incident.
* One consumer’s oxygen levels were being monitored and when found to be out of range and they were reviewed by a Medical officer on 15 March 2022 and commenced on antibiotics for a chest infection. A follow up review was done by the Medical officer on 29 March 2022. The service requested the Medical officer review and update the expected range for oxygen saturation and instructions if they fall outside this range. The consumer’s oxygen therapy management plan was then updated following medical officer review.
* The consumer with low levels of fluid intake and fluid balance monitoring by staff was reviewed by the Medical officer and care plan updated accordingly. Staff provided training on clinical documentation and their responsibility with completion of fluid intake charts and advising registered nurses.
* Further staff training has been added to the Service Plan for Continuous Improvement covering; Documenting in a Care Environment, Balancing Risk and Falls Prevention and Management, Workplace Violence and Aggression Healthcare, Behaviour Management, Consumer needs and Care Plan, Clinical Governance Procedure on Oxygen Therapy and Suctioning, Reporting to Registered Nurses.

Having considered the evidence in the Site Audit report and the Approved Provider’s response, I note there have been some deficits identified in documenting care needs however, I am satisfied the service is responding to current clinical care requirements appropriately. I find the 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.

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

# 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 1 of the 7 specific requirements have been assessed as Non-compliant.

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

Most consumers considered they received personal and clinical care which was safe and right for them. Two consumer representatives said the consumer’s personal care needs were not always being adequately provided by staff and these concerns were communicated to management.

Clinical documentation reflected personal and clinical care which was best practice and tailored to the specific needs and preferences of the consumer, including their advance care and end-of-life wishes. The service demonstrated consumers who were nearing end of life have their dignity preserved and care was provided in accordance with their needs and preferences. Staff demonstrated knowledge of individual consumer’s needs and preferences including risks such as; falls, skin integrity, pain or challenging behaviours. Staff understood and described strategies to manage or minimise those risks.

Deterioration or changes in consumer’s clinical care needs were recognised and responded to in a timely manner. Information relating to consumers’ condition, needs and preferences was documented and effectively communicated to others involved in the care. Staff attend shift handover to ensure current information was consistently shared and understood. Care documentation showed timely referrals to, and input from, a range of clinical professionals such as; medical officers, medical specialists, allied health professionals, geriatricians and speech pathologists.

The Assessment Team observed improper infection control practices by staff such as inconsistent use of personal protective equipment to minimise risk of infection transmission.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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.*

### 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) Non-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.*

The Assessment Team found the service did not demonstrate the minimisation of infection related risks through implementing standard and transmission-based precautions consistently. Evidence presented by the Assessment Team, relevant to the finding included:

* The Assessment Team noted there was a lack of instructions/ signage at the service entry for COVID-19 screening procedures. Screening at the front door included completion of a Rapid Antigen Test. When confirmed negative, then entry to the service was permitted upon returning a normal temperature check and answering the COVID-19 screening questions.
* The Assessment Team observed the electronic touch screen at entry was not being wiped in between use, and the option for scanning the QR code was not being utilised. After this was raised, management arranged for the touch screen to be wiped in between use. Management advised that QR code scanning was no longer a requirement in NSW.
* Staff were inconsistently wearing PPE during the site audit. Whilst some staff were wearing face shields and goggles, some staff were not wearing eye protection at all. Staff were observed walking in the corridors with gloves on.
* One staff member was observed coming out of a consumer’s room with gloves on and walked through the corridor. They were observed going back into the same consumer’s room with a white plastic bag and wearing the same gloves. The staff member was then observed placing soiled linen inside the plastic bag and exiting the consumer’s room into the corridor with the same gloves on.
* The wound dressing trolley was observed with multiple dressings on the top surface. It was being taken through multiple areas/rooms and large bottle of wound management solution (unlabelled) was being used. Registered staff said they used the solution for multiple consumers where it is recommended for their wounds.
* The service contacted the Assessment Team and advised there had been a COVID-19 outbreak soon after the site audit had concluded.

The Approved Provider’s response acknowledged the observations made in the Assessment Report and provided additional information in relation to this finding. The Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* A toolbox talk on Infection Prevention and Control was conducted for all staff on duty on 11 May 2022.
* Further training has been added to the Service Plan for Continuous Improvement to cover additional training for staff regarding Hand Hygiene for Healthcare workers, Infection Prevention and Control – The Basics and Infection Prevention and Control – Transmission based precautions.
* Infection Prevention and Control lead staff have been instructed to continue to monitor and address staff behaviour related to incorrect use of personal protective equipment and infection control generally.

I have considered the evidence in the Site Audit report and the Approved Provider’s response. I accept there were new and inexperienced administrative staff working at the front entry. While the latest COVID-19 outbreak at the service may not have been avoided, the service was not exhibiting best practice compliance with infection control procedures. The Assessment Team identified a range of different lapses in staff infection control practices, some of which seemed habitual. I am not confident that the service would have self identified and corrected these lapses in staff practice, had the Assessment Team not drawn attention to them.

While I am satisfied with the service’s antibiotic prescribing and administration practices, I find the service has not demonstrated the minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection. Based on the evidence (summarised above), I find the service Non-compliant with this Requirement.

# STANDARD 4 NON-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 Non-compliant as 1 of the 7 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirement 4(3)(g). Reasons for the finding are detailed in the relevant Requirements below.

Overall consumers considered they received the services and supports for daily living which were important for their health and well-being and enabled them to do the things they want to do.

Consumers/representatives confirmed consumers were supported by the service to undertake lifestyle activities of interest to them and maintain social and emotional connections with those people who are important to them. The service was able to demonstrate services and supports for daily living promoted each consumer’s emotional, spiritual, and psychological well-being.

Review of the lifestyle activity calendars and discussion with staff demonstrated there were a variety of activities offered to meet the different needs and preferences of the consumers. Consumers were observed to be engaged in a variety of group and individual activities.

Overall, consumers/representative expressed satisfaction with the variety, quality and quantity of food currently being provided at the service, however, 3 consumers reported they were not always happy with the temperature of the food. Specific dietary needs such as vegetarian, gluten or lactose free diets were catered for. The dietary information provided to catering staff was current and reflected the preferences and needs of consumers as set out in their care plan.

Menus were displayed in large print on electronic devices throughout the service and there were paper menus in consumer’s rooms. The kitchen and dining areas were observed to be clean and tidy with staff overall adhering to infection control and food safety protocols.

Equipment was not always observed as safe, suitable, clean, and well maintained.

## 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.*

### 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.*

### 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) Non-compliant

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

The Assessment Team found equipment was not always safe, suitable, clean, and well maintained. Evidence presented by the Assessment Team, relevant to the finding included:

* Equipment in the Memory Support Unit (MSU) was observed to be unclean. Four-wheel walkers, wheelchairs and comfort chairs were observed to be ‘caked’ with remnants of old food.
* Tray tables needed wiping down in several of the rooms in the MSU.
* Tablecloths in the MSU were not changed between meals and had obvious staining.
* While mobility aids in some areas were observed to be clean and well maintained, some mobility aids in the MSU were in need of cleaning and/or repair.
* Two consumers in the MSU were observed self-propelling in wheelchairs. There were no footplates attached to either wheelchair, making it unsafe for them in this instance and if a staff member were to be pushing the wheelchair for them.
* Staff interviewed were not aware of the potential dangers of consumers operating wheelchairs without footplates.
* Wheelchair footplates were observed to be on the floor in one consumer’s room and the wheelchair was not sighted.
* The service had a wide range of lifestyle activity products such as books, magazines, music, DVDs in the communal areas, TVs in rooms and communal areas, board games, sensory and reminiscing resources and art and craft equipment.
* Equipment used to provide laundry, cleaning and catering was observed to be clean and in working order.
* Consumers/representatives and staff reported having access to sufficient equipment, including; mobility aids, shower chairs and manual handling equipment, to assist them with their daily living activities.
* Staff said shared equipment is cleaned with disinfectant wipes after each use however, the Assessment Team did not observe this being done in the MSU.

The Approved Provider’s response acknowledged the observations made in the Assessment Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* Management have reviewed the cleaning duties list and initiated a cleaning team to clean down all equipment in the MSU immediately.
* A memorandum has been sent to all staff reminding them of their responsibilities to ensure furnishings and equipment are kept clean and tidy at all times.
* The management team have conducted a stocktake of all tablecloths to ensure adequate supply of stock and have instructed staff to remove tablecloths for launder, wipe down tables before replacing clean tablecloths after each meal.
* Further training has been added to the Service Plan for Continuous Improvement to cover additional training for staff Regarding Manual Tasks in Aged Care; Setting Table and Clearing; Housekeeping for Care Staff.
* The service was promoting independence and dignity to some consumers in the MSU who could safely self-propel their wheelchairs by foot. Case conferences will be conducted to reapproach the subject of each consumer self-propelling in their chair and gaining informed consent.
* Customer Risk Safety Assessments were completed for residents in the MSU that were self-propelling in wheelchairs.
* The service will ensure wheelchair footplates were provided and educate staff on the principles of safe transfers and how to identify hazards.

Having considered the evidence in the Site Audit report and the Approved Provider’s response, I am not satisfied that, at the time of the audit, equipment was always safe, suitable, clean, and well maintained.

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

# 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 3 of the 3 specific requirements have been assessed as Compliant.

Overall, consumers/representatives said the service environment was welcoming and they felt safe, comfortable and they belonged. Most consumers/representatives said the service was safe, clean, and well maintained and they could move freely indoors and outdoors, when they chose to. Consumers confirmed they can decorate and individualise their rooms as they wish. Consumers’ rooms were personalised with furniture, photographs and artwork with names of consumers on doors. The memory support area had memory boxes to identify consumer’s rooms.

The service has a main entrance where visitors sign in and complete COVID-19 screening processes. The reception area appeared welcoming with signage to guide consumers and visitors. The service environment has several lifestyle features such as activity rooms, a café, a tea house, courtyards, and a fishpond. The external areas featured a garden gazebo, balconies and lawn areas. Consumers were observed accessing activities in different areas of the service, including outdoor, undercover areas. Consumers were participating in lifestyle activities and meeting with others to socialise. Access doors to internal courtyard areas were unlocked, allowing consumers to move indoors and outdoors freely. Some consumers rooms have access to outdoor patio areas. Most external pathways were generally clear of trip hazards and well maintained.

Downstairs were multiple communal dining and lounge areas providing a homelike environment. The service’s corridors were equipped with handrails and were observed to be free of clutter. Laundry services were provided for personal clothing and linen.

The service has independent living units (ILU) and a Memory Support Unit (MSU) upstairs. Some consumers partners live at the ILU and visit regularly. The MSU has 20 consumers with individualised doors for ease of recognition and 2 outdoor balcony areas. All beds in the memory support unit were against the wall. There was an elevator operating which enabled consumers from the memory support unit access to other outdoor areas on the ground level of the service. Staff said consumers from the MSU enjoyed attending activities in the outside area and they assisted consumers to attend. A consumer in the MSU said they would like to be able to walk in the gardens downstairs when their grandchildren visit. However, the Assessment Team did not observe consumers from the MSU being assisted downstairs during the audit period.

The service environment was observed to be generally safe, clean, well maintained and enabled free movement. However, the dining area in the MSU did not appear to be a nice environment for dining and consumers did not seem to be enjoying the meal service. The Assessment Team observed dirty tablecloths, no cutlery or table settings and breakfast crockery with uneaten food left in plates which remained at lunch time. I considered this reflective of Non-compliance, however have included this information under Requirement 4(3)(g).

Lifestyle staff were observed walking with consumers outside the service. Consumers were observed enjoying morning tea within the courtyard café/dining area. Cleaning staff were observed to be interacting and engaging with consumers and visitors in a polite and respectful manner.

Fire safety equipment, fire evacuation diagrams and illuminated exit signage are in evidence. Other directive signage was noted on most of the fire doors. Documentation confirmed fire systems and equipment are part of the preventative maintenance schedule.

A resident survey dated January 2022 showed 85% of consumers/representatives say they have clean and hygienic rooms and amenities, and rooms are well maintained.

Most equipment was observed to be clean, well maintained and appropriate to consumer needs, however some mobility aids were viewed by the Assessment Team as having dirt on the handles and arm rests and no footplates on wheelchairs.

The service’s preventative maintenance schedule showed regular maintenance is occurring although the maintenance forms were not always closed out after the task was completed. Maintenance issues reported by staff and consumers were observed to be resolved in a timely manner.

The Assessment Team observed equipment audits were conducted and the call bell system was operating effectively. Staff meeting minutes showed staff were reminded to check on the operation of equipment and to report any maintenance issues.

## Assessment of Standard 5 Requirements

### 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.*

### 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 4 of the 4 specific requirements have been assessed as Compliant.

Consumers/representatives said they were encouraged and supported to give feedback and make complaints, and that appropriate action was taken. Consumers/representatives said they had been made aware of community advocacy services, language services and described a variety of ways they can safely raise their concerns including; use of feedback forms, consumer surveys and by speaking directly to staff or management. Generally, consumers spoke directly to staff or management if they had concerns and they said they were heard and promptly responded to.

The service has a feedback and complaints system ‘Your Matters Matter’ and consumers/representatives, staff and visitors to the service were encouraged and supported to provide feedback and make complaints verbally, via email, externally or by using the paper-based system. The service had written policies and procedures to promote feedback and complaints to continually improve the care and services.

Staff demonstrated an understanding of the complaints management system and accessing external providers if required and could describe how they respond to consumer/representative feedback, support consumers to discuss and lodge their feedback and how they escalated concerns to registered staff and management.

Staff knew how to access interpreter and advocacy services but said they have not had to assist consumers to access these services. They often assist consumers/ representatives navigate the internal complaints process through ‘Your matter matters’. Staff assist consumers who have cognitive impairments or difficulty communicating and will involve the representatives, where necessary.

The service demonstrated appropriate action was taken in response to complaints and an open disclosure process was employed when things went wrong. Management said they had an open-door policy and described how they responded to complaints, including speaking directly to the consumer/representative to gain further information and acknowledge their concerns prior to undertaking an investigation. Management always met with the consumer/representative to discuss their concerns and offer an apology using open disclosure. Staff demonstrated an understanding of open disclosure and described how they have applied open disclosure when something has occurred or gone wrong.

The service’s feedback and complaints register captured compliments, feedback, and complaints from a range of sources including; verbal, email, consumer meetings and reports made by staff on behalf of consumers. Complaints were monitored from lodgement through to closure, with evidence of consumer engagement, an apology, and actions to prevent reoccurrence noted. Progress notes recorded instances of open disclosure use in relation to complaints.

The service demonstrated that feedback and complaints were recorded, analysed and used to improve the quality of care and services. Complaints were documented in an electronic complaint register, reviewed at monthly meetings, and reported on by management. Where service improvement opportunities were identified, these were added to the continuous improvement plan (CIP) for monitoring and action. Improvement actions were subsequently evaluated in consultation with consumers/representatives at monthly meetings.

## 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.*

### 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 1 of the 5 specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirement 7(3)(a). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement 7(3)(b), 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.

Most consumers confirmed that staff were kind and caring, knew what they were doing. Consumers and representatives felt they received quality care and services from people who were knowledgeable, capable, and respectful. Some, consumers said staff did not always have time to complete tasks and were often rushed due to being short staffed. Consumer/representatives advised that staff were competent and knew what they were doing but some said there was not enough of them.

The service rosters and allocates staff to ensure there are sufficient staff to meet the care and service needs of consumers. Staff losses due to COVID-19 had created significant challenges. Management and other staff were working additional hours including night shifts. Management said the central coast region has 46 other residential aged care facilities all bidding for the same staff. Management had done number of recruiting drives and created staff incentive packages to reward and acknowledge staff for attending additional shifts.

Management and staff confirmed it was important to them that consumers had staff that knew them and how to care for them. Some staff said they were worn out from consistent staff shortages.

The service had systems in place to identify training needs, provide education to staff and monitor staff performance. Training records demonstrate staff have been trained in restrictive practice requirements, infection prevention and control, including COVID-19, and the introduction of the Serious Incident Reporting Scheme on 1 April 2021. Staff were competent and qualified to perform their roles.

While staff had been trained in restrictive practices, the Assessment Team noted staff could not all demonstrate a shared understanding of restrictive practice.

## 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 that while the service undertook workforce planning and rostering, the service was often unable fill staff rosters in order to consistently deliver safe and quality care and services. Evidence presented by the Assessment Team, relevant to the finding included:

* Most consumers/representatives said there were insufficient staff overall, and whilst staff were kind and caring, their care needs were not always met in a timely manner.
* One representative expressed concern their parent's continence aids were not changed often enough or their oral hygiene was attended to regularly, as they often found food remaining in their mouth.
* One consumer said they had to wait a long time for staff to come back after they had transferred them to the toilet early in the morning. They said they were scared of being left on their own because they may have a heart attack. They said this was a regular occurrence. The relevant call bell response times for the consumer were 7 minutes and 3 minutes.
* One consumer said the staff were kind and caring however, don’t always do what they want. They said they don’t want their bed against the wall and they lost their hearing aids 2 days ago and haven’t got them back.
* The Assessment Team did not see consumers in the memory support unit always being assisted with their meals during the 3-day audit. They questioned if the lack of staff was a contributing factor to meals not being eaten and weight loss. Management responded with information about a project to address weight loss and improve the dining experience and minimise food waste.
* The Assessment Team observed some consumers’ appearance was poor, including consumers with unbrushed greasy hair. Most male consumers in the memory support unit and some consumers from other wings had not been shaved.
* The Assessment Team observed one consumer’s catheter bag was overfull required emptying. They did not have their hearing aids in and were having difficulty communicating to the Assessment Team.
* Call bell response times are monitored by management. The call bell responses greater than 7 minutes mostly occurred in the shared bathrooms.
* Overall, staff said they were tired from working double shifts and covering vacant or sick shifts since the isolation due to the COVID-19 outbreak. Staff acknowledged management were trying their best and it was hard to get staff. Staff said they were motivated by maintaining consistent care for the consumers.
* Most staff said they feel rushed, and consumers do not always get the care and services planned, due to being short staffed.
* One care staff said when they are often short staffed and unable to get staff from other areas to help, they ask consumers if they would be willing to change shower times until the afternoon when there was more staff. They acknowledged when they were short staffed there was not always time to shave consumers or attend to oral hygiene.
* Another care staff said it was not easy as sometimes there were only 2 staff to assist all consumers at mealtimes in the memory support unit.
* Catering staff advised they do not always have sufficient staff and time to complete their duties impacting on consumers receiving meals on time.
* Registered staff said the care staff are often short staffed and struggle to complete the consumers’ care.
* Management described the process for rostering staff, including how the service manages planned and unplanned leave. The workforce is planned, based on the new homecare model which has the same staffing hours on weekdays and weekends for continuity of care. The leadership team acknowledged it was difficult to get qualified staff to fit the role in this region.
* Management said recently there were 3 to 4 complaints of low staffing levels. Management introduced a temporary roster for a fortnight offering 12-hour shifts to staff.
* Management advised they were continually recruiting care staff to fill vacancies. There had previously been around 600 rostered hrs per fortnight unfilled across all areas of the service and this was down to 200 hours per fortnight. This was due to putting systems in place for additional shifts, recruiting and staff doing double shifts.

The Approved Provider’s response acknowledged the observations made in the Site Audit Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service has responded to the consumer that felt their wait times in the bathroom were too long (recorded as 7 and 3 minutes). It should be noted that this consumer had complex care needs which impact their perception.
* The consumer was recently admitted to the service and had not previously raised their concern about their hearing aids being lost or their bed being against the wall. These issues were resolved promptly with the consumer once they were brought to the attention of the service.
* The service implemented the Model of Care in September 2021 and staffing increases were made to key positions. Since then, vacant shift hours have reduced by more than half to approximately 4% of total hours in the fortnight. Importantly, vacant shifts are defined as shifts that are not ‘rostered’ as part of the ordinary hours of a permanent employee. Vacant shift hours do not represent hours the centre is unable to fill.
* The figure of 200 hrs unfilled per fortnight indicated by the Assessment Team is misleading, this figure relates to the number of hours that are not allocated to a permanent staff member when the roster is published two weeks in advance, prior to putting out to the casual and part-time staff to fill. Vacant shifts are filled by the centres casual pool workers, part time employees picking up additional hours, full time staff working overtime, or agency workers.
* Recruitment over the last 6 to 7 months has seen the centre employ 10 care service employees, 7 of whom are permanent and 3 casuals.
* The average call bell response time was 4 minutes over the last 6 months. The call bell response times will be more critically analysed in relation to the location of the call to ensure that areas with longer response times are identified and addressed.
* The service will complete the “Dementia Practice Health Check” through the Centre for Dementia Learning to assess the current dementia capability of the workforce and to prioritise areas for improvement and identify opportunities for staff development.
* The service had already initiated an unplanned weight loss project and has added further training to the Service Plan for Continuous Improvement regarding nutritional needs for people in aged care; assist to eat and observation of plate waste.

I have considered the evidence in the Assessment Report and the Approved Provider’s response. I have considered issues relating to consumers being treated with dignity and respect under Standard 1(3)(a). I acknowledge the aged care sector generally is experiencing significant challenges, including maintaining staffing levels. While the service is making efforts to address staffing shortages, the evidence indicates staff felt pressured, fatigued and staff shortfalls have impacted on the provision of care and services to consumers. I find the service has not demonstrated the number and mix of members of the workforce deployed enables, 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.*

The Assessment Team found the service was able to demonstrate most workforce interactions with consumers were kind and caring, and most staff were respectful of each consumer’s identity, culture and diversity. However, the Assessment Team observed some interactions which did not appear respectful. Evidence presented by the Assessment Team, relevant to the finding included:

* Consumers/representatives said some staff engage with them in a respectful, kind and caring manner, however they felt rushed and didn’t always get the care they required, or their preferences met.
* Staff demonstrated an in depth understanding of consumers and their needs and preferences. This aligned with consumer feedback and their care plans. However, staff said, due to staff shortage, they were not always able to provide the care set out on the consumer’s agreed care plan.
* Management advised they monitored staff interactions with consumers and representatives through observations, formal and informal feedback and complaints.
* Most staff engaging with consumers and their family members in a respectful and personable manner. However, the Assessment Team heard staff referring to consumers as “darl, love and lovely” instead of their preferred names.
* One consumer was observed walking in the corridor with their dressing gown tucked into their sacrum and no staff they walked past rectified this.

The Approved Provider’s response acknowledged the observations made in the Assessment Report and provided additional information in relation to this finding. The Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service followed up with one consumer to discuss and address concerns they had raised. The management team reviewed and updated their care plan to reflect current needs and preferences.
* A memorandum was issued to nursing staff to remind them about the procedure concerning Aged Care Diversity Choice and Decision-Making. The service will include this topic during the mandatory training for staff-scheduled on June 29, 2022.
* Posters about the Salvation Army Values and Behaviour were displayed around the service at the time of the audit.
* Further training has been added to the Service Plan for Continuous Improvement to cover additional training for staff about; Dignity and Personalised Care, Salvation Army-mission/vision/values, unreasonable use of force, Quality Standards Introduction, Person Centred Care.
* A memorandum was sent to staff regarding dignity and respect and being mindful of potentially demeaning language when communicating with consumers. Toolbox education was also conducted about this topic.

I have considered the evidence in the Assessment Report and the Approved Provider’s response. I have considered issues identified by the Assessment Team related to staffing levels under 7(3)(a) above. Issues related to consumers’ being treated with dignity and respect and their personal privacy have been considered under Requirements 1(3)(a) and 1(3)(f).

Aside from these issues, I note the Assessment Team found that workforce interactions with consumers were kind and caring, and that most staff were respectful of each consumer’s identity, culture and diversity. I am therefore satisfied that the services’ workforce interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity.

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

### Requirement 7(3)(c) Compliant

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

### 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 5 of the 5 specific requirements have been assessed as Compliant.

The Assessment Team recommended Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) as not met. However, my finding differs from the recommendations and I find these Requirements Compliant. Reasons for the findings are detailed in the relevant Requirements below.

Most consumers considered that the organisation was well run; and they could partner in improving the delivery of care and services. Consumers and representatives stated they have a good relationship with management. Some consumers said their care and needs were not always met, due to lack of staff.

The service has a variety of avenues for consumers and representatives to engage with the service and provide feedback such as; regular care plan reviews, feedback and complaints, audits, surveys and consumer meetings. All feedback is brought forward to the Board ensuring consumer feedback drives improvement actions at the service.

The service demonstrated how legislative changes were discussed from the service floor to the Board level. The clinical governance framework addressed anti-microbial stewardship, and open disclosure. The Assessment Team considered there were gaps in how restrictive practices were minimised, especially in the Memory Support Unit (MSU) and how allied health contractors comply with the service’s policies.

The service had effective governance systems and risk management systems and practices that were supported by a clinical governance framework.

## 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.*

The Assessment Team found the service demonstrated the organisation’s governing body promoted a culture of safe, inclusive quality care and services. However, the Assessment Team could not see how it translated to the delivery of care and services or how it was always monitored to ensure consumers were not at risk.

* The service management said the governing body promotes and is accountable for a culture of safe, inclusive and quality care and services.
* The Clinical Governance and Operational Compliance team has regular meetings and examines risks occurring at the service. The team engage with the Board on all aspects of the service.
* Audits were conducted by the service to monitor performance and there were quarterly quality reports of clinical indicators. The Assessment Team could not see how the monitoring of clinical indicators was being translated or understood at site level.
* The Assessment Team postulated that unplanned weight loss could relate to insufficient staff however, the organisation did not link the lack of staff and consumers not being assisted with meals to the weight loss.
* The Clinical Governance and Operational Compliance minutes dated 16 March 2022, evidenced the monthly clinical indicators were discussed which provides clinical indicator and risk information for the service to the Board. Restrictive practices were discussed, and the unplanned weight loss project was implemented noting analysis of high incidence of unplanned weight loss.
* The minutes included complaints in the complaint register stating there was an increase in use of agency staff due to vacant shifts and unplanned leave.
* Minutes show complaints regarding staff not following COVID-19 entry requirements. There was no action regarding increased monitoring for consumers or education for staff. The Assessment Team observed check-in procedures were not being done correctly. The new administration staff did not appear to be adequately instructed so they had a thorough understanding of their role in monitoring the check in process.

The Approved Provider’s response acknowledged the observations made in the Site Audit Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service acknowledged the administrative staff were new to the organisation and they have since corrected the infection control practices at the service entry. At the time of the audit, education was provided to the new administrative staff about their role in ensuring entry requirements were met.
* The service had in place entry requirements related to COVID-19 including; returning a Rapid Antigen Test (RAT), answering screening questions and a temperature check.
* Signage was put up by the entrance door to inform visitors of visiting hours, entry requirements and to press buzzer for assistance.
* A memorandum had been sent to the retirement village residents on 31/5/22 advising family, visitors and carers who use the lift they must return a negative RAT and wear a mask before entering. Residents were also encouraged to wear a mask when using the lift and not stop to socialise.
* Prior to the audit, the service had identified some staff as non-compliant with Rapid Antigen Test requirements and reminded them of expectations and given a verbal warning.
* Further training has been added to the Service Plan for Continuous Improvement to cover additional training for staff regarding Hand Hygiene for Healthcare workers, Infection Prevention and Control – The Basics and Infection Prevention and Control – Transmission based precautions.
* The service refuted the Assessment Team’s hypothesis that unplanned weight loss related to staffing levels and staff not assisting consumers with meals.
* The service had already implemented the unplanned weight loss project as a direct response to weight loss. The service had already identified a range of contributing factors including: contracting COVID-19, existing disease progression, dementia, mental health, lockdowns, appetite loss etc. The service conducted assessments of each consumer and implemented the dieticians' recommendations into each consumer’s care plan.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I have considered issues identified by the Assessment Team such as infection control, staffing levels and unplanned weight loss elsewhere in this report. While lapses in practice have been identified at the operational level, I have not seen evidence these issues can reasonably be attributed to a failure in the organisation’s governing body being accountable in promoting a culture of safe, inclusive and quality care and services.

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

### 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.*

The Assessment Team found the service demonstrated effective organisation wide governance systems relating to; information management, financial governance, workforce governance and feedback and complaints. The Assessment Team did not consider the service had effective governance systems relating to continuous improvement and regulatory compliance. Evidence presented by the Assessment Team, relevant to the finding included:

* Management considered the service had implemented effective governance systems relating to; information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints.
* The Assessment Team considered the service’s monitoring systems did not identify that consumers’ unplanned weight loss was due to; staff shortages, lack of monitoring of nutritional intake and not taking action when consumers’ meals were not consumed.
* The Assessment Team considered the service’s infection control procedures did not identify failures in staff practices relating to infection control.
* The Assessment Team considered the service’s regulatory compliance systems did not identify that beds against the wall were a form of restrictive practice and needed to have authorisation by an approved health practitioner and informed consent by consumer/representatives.
* The organisation could not show the contractor’s knowledge or practices were aligned with the organisation or that they were aware of the policies and procedures of the organisation. The organisation did not monitor its contractors to ensure safe delivery of care or appropriate education that was aligned to the Quality Standards and regulatory compliance.
* The contracted allied health team did not understand they were to follow the policies and procedures of the organisation or what these policies were in regard to assessment of consumers, restrictive practice or the privacy policy and procedure.

The Approved Provider’s response acknowledged the observations made in the Site Audit report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service acknowledged a small number of staff were identified not to be consistently wearing face shields. Staff have the option to wear their preference of a face shield or goggles. A text message was sent to all staff to remind them to wear mask and face shield/googles appropriately and toolbox discussion on Infection Prevention and Control was conducted to all staff on duty.
* Further training has been added to the Service Plan for Continuous Improvement to cover additional training for staff regarding Hand Hygiene for Healthcare workers, Infection Prevention and Control – The Basics and Infection Prevention and Control – Transmission based precautions.
* The service refuted the Assessment Team’s hypothesis that unplanned weight loss related to staffing levels and staff not assisting consumers with meals.
* The service had already implemented the unplanned weight loss project as a direct response to weight loss. The service had already identified a range of contributing factors including: contracting COVID-19, existing disease progression, dementia, mental health, lockdowns, appetite loss etc. The service conducted assessments of each consumer and implemented the dieticians' recommendations into each consumer’s care plan.
* The service asks consumers about their preferred bed placement on admission. A Customer Safety Risk Assessment Form is discussed and completed if they prefer to have their bed against the wall. Consideration was given as to whether the bed placement is possibly restrictive practice at this time.
* The service cited Aged Care Quality Bulletin #20- 26 June 2020, which states that placing a bed against the wall does not necessarily constitute restraint and will depend on the circumstances.
* Allied health practitioners have been instructed to consult and document any requests by consumers to have treatments in common areas. Practitioners have received further supporting education on the service’s policy and procedures concerning dignity and respect, and clinical documentation.
* The service’s Plan for Continuous Improvement was amended to include a review of subcontractor management with regards to providing additional education related to; elder abuse, dignity and personalised care, Quality Standards.

I have addressed issues related to infection control practices under Standard 3(3)(g). Having considered the evidence in the Assessment Report and the Approved Provider’s response, I note the service’s additional information around bed placement processes and weight loss risk. The service had self-identified the risks around consumers’ mental health and weight loss; and initiated the unplanned weight loss project autonomously prior to the audit. The placement of a bed against a wall is not necessarily a restrictive practice (depending on the circumstances) and the service had a risk assessment and consent process for the placement of beds which respected consumer’s dignity and choice.

I am satisfied the service had effective governance systems relating to information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints. Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### 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.*

The Assessment Team found risk management systems and practices had been implemented by the organisation and a process was established to monitor and ensure their effectiveness. However, the Assessment Team found the service did not adequately demonstrate safe care for all consumers in relation to mechanical restrictive practices, the effective management of weight loss risks. Evidence presented by the Assessment Team relevant to the finding included:

* The organisation’s clinical and care governance framework includes systems and practices to identify and mitigate risks. Policies and procedures guide staff in areas such as; care assessment and planning, incident management, reportable assaults and infectious outbreaks.
* Assessment processes identify high impact and high prevalence risks that effect consumers and care planning processes develop risk minimisation strategies.
* Staff receive training in risk management procedures and demonstrated understanding of how to apply the procedures when providing care. Staff receive training in elder abuse and it’s reporting processes.
* The organisation has a documented procedure and risk assessment matrix to identify high impact and high prevalence risks.
* The service’s risk management systems enable consumers to live the best life they can by being supported to do things such as; going out into the community, smoking, and walking independently when they wish.
* The service’s incident management system (IMS) identifies, assesses, responds and records all incidents and near misses. Staff know their roles, how to respond to incidents and there are systems to record incidents.
* The service had conducted a review of incidents to identify opportunities for improvement and to reduce the risk of a similar incident.
* The organisation takes a leadership role in promoting a safety culture and provides management and staff with the tools and training to respond, record and report incidents.
* The service has policies and procedures to support reporting serious incidents under the Serious Incident Reporting Scheme. The service is aware of their legal reporting requirements.

The Approved Provider’s response acknowledged the observations made in the Site Audit report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* Due to external factors such as COVID-19, the service has experienced significant challenges in maintaining staffing levels but is actively recruiting staff and has reduced the shortfall from 600 open hours per fortnight down to 200 hours.
* The service acknowledged the devastating effects on consumers and their mental wellbeing when unable to have face to face visits during the mandatory COVID-19 lockdowns over 2020-2021.
* The service refuted the Assessment Team’s hypothesis that unplanned weight loss related to staffing levels and staff not assisting consumers with meals.
* The service had already implemented the unplanned weight loss project as a direct response to weight loss. The service had already identified a range of contributing factors including: contracting COVID-19, existing disease progression, dementia, mental health, lockdowns, appetite loss etc. The service conducted assessments of each consumer and implemented the dieticians' recommendations into each consumer’s care plan.
* The service asks consumers about their preferred bed placement on admission. A Customer Safety Risk Assessment Form is discussed and completed if they prefer to have their bed against the wall. Consideration is given as to whether the bed placement is possibly restrictive practice at this time.
* The service cited Aged Care Quality Bulletin #20- 26 June 2020 which states that placing a bed against the wall does not necessarily constitute restraint and will depend on the circumstances.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, I note the service’s additional information around bed placement processes and weight loss risk. As the service had self-identified the risks around consumers’ mental health and weight loss, and initiated the unplanned weight loss project autonomously, I am satisfied the service has effective risk management systems and practices that enable risks to be identified and managed.

I find the service demonstrates effective risk management systems and practices which address; high impact /high prevalence risks, identifying and responding to abuse and neglect; supporting consumers to live the best life they can, and managing and preventing incidents. Based on the evidence (summarised above), I find the service Compliant with this Requirement.

### 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 the service had a clinical governance framework however, they considered it was not generally understood by all members of the workforce. Deficiencies were identified in relation to infection control practices and restrictive practices. Evidence presented by the Assessment Team, relevant to the finding included:

* The service provided an organisational clinical governance framework which included policies on; antimicrobial stewardship, minimising restrictive practice and open disclosure.
* The Assessment Team observed deficiencies in daily screening and monitoring of consumer/representatives and staff in the service. Staff were observed not adhering to infection control and public health unit directives in regard to minimising potential risk of COVID-19 outbreak.
* Both the service and associated independent living units was identified as being at risk of a potential COVID-19 outbreak due to cross contamination, incorrect screening and lack of RAT testing visitors including independent living consumers and staff adhering to infection control procedures.
* The service manager advised the Assessment Team the day after the audit that 4 consumers had tested positive to COVID-19. The service contacted the Assessment Team again the following day (13 May 2022) to say 19 consumers had tested positive to COVID-19 and they had notified the Public Health Unit.
* The Assessment Team noted the service had not followed their processes for minimising the use of restrictive practices for all consumers with beds against the wall.

The Approved Provider’s response acknowledged the observations made in the Site Audit Report and provided additional information in relation to this finding. The Approved Provider also provided information and evidence of actions taken by the service to address gaps identified by the Assessment Team. The Approved Provider advised:

* The service’s entry procedures are designed to comply with all relevant Commonwealth and State public health and directives and advisories. All staff, contractors and visitors must return a negative Rapid Antigen Test, answer COVID-19 screening questions and pass a temperature check prior to entry.
* Consumers who access the community are also risk assessed and scheduled with Rapid Antigen Testing as directed by NSW Health.
* The administrative staff were new to the organisation and they were promptly educated about oversighting the entry requirements. Signage, hand sanitiser, sanitary wipes and rubbish bins were organised for the entrance by day 2 of the site audit.
* The service asks consumers about their preferred bed placement on admission. A Customer Safety Risk Assessment Form is discussed and completed if they prefer to have their bed against the wall. Consideration is given as to whether the bed placement is possibly restrictive practice at this time.
* The service cited Aged Care Quality Bulletin #20- 26 June 2020, which states that placing a bed against the wall does not necessarily constitute restraint and will depend on the circumstances.
* Restrictive Practice Authorisation and Customer Safety Risk Assessment forms are currently being reviewed.
* Further training has been added to the service’s Plan for Continuous Improvement to cover additional training for staff regarding restrictive practices and restraint.

Having considered the evidence in the Assessment Report and the Approved Provider’s response, while I note there were observed lapses in staff practice in relation to infection control practices and questions raised around restraint, I do not attribute these to the absence of an appropriate clinical governance framework. I have further considered lapses in staff compliance with infection control practices under Standard 3(3)(g).

I am satisfied that the service has a suitable clinical governance framework, which covers, antimicrobial stewardship, minimising 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.

* 1(3)(a) - Ensure that each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* 1(3)(f) - Ensure the personal privacy of each consumer is respected.
* 3(3)(g) - Ensure the minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection.
* 4(3)(g) - Ensure that equipment is always safe, suitable, clean, and well maintained.
* 7(3)(a) - Ensure that 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.