Aged Care Standards and Accreditation Agency Ltd Review Audit Decision

On 20 December 2001, in accordance with the Accreditation Grant Principles 1999, I decided to vary the period of the accreditation of Rowena Private Nursing Home.

I find that the Service does not have the requisite processes for identifying deficiencies and opportunities for improvement, or a system for acting on identified issues. I am not satisfied that the Service's quality management system has an effective, planned system of evaluation of implemented actions, fundamental to the pursuit of continuous improvement and necessary to demonstrate improved outcomes for residents.

There are 44 expected outcomes in the Accreditation Standards and I have found that the Service has not complied with 13 of these outcomes. I find that the Service's non-compliance with these expected outcomes is of a significant nature and requires a considerable amount of improvement to achieve compliance. I have particular concerns about the lack of provision of staff education and the lack of systems to ensure that staff knowledge is adequate for their duties. I also have concerns regarding the standards of cleaning of the Service's premises, equipment and furniture. These problems affect the quality of life of residents.

It will take considerable effort and time on the Service's part to achieve compliance with the Accreditation Standards. The Service needs to introduce adequate systems to enable it to undertake continuous improvement, to identify deficiencies, to evaluate the effectiveness of actions taken, and to ensure that staff are actively involved in all aspects of continuous improvement activities.

On the basis of my findings of significant non-compliance, I have seriously considered revoking the accreditation of the Service. However, I have decided on balance to vary the Service's period of accreditation such that the Service's accreditation will now expire on 7 December 2002 rather than 7 August 2003. This reduced period constitutes a reasonable time for the Service to undertake the improvements necessary to achieve compliance with the Accreditation Standards and to undertake continuous improvement before the site audit associated with the assessment of an application for a further period of accreditation.

The Service's accreditation now expires on 7 December 2002.

Matters of non-compliance have been referred to the Secretary, Department of Health and Aged Care, in accordance with the Accreditation Grant Principles 1999.

The Agency will undertake support contacts to monitor progress with these improvements and compliance.

Lynn May
Acting State Manager
Victoria & Tasmania

Please note: In making its decision, the Agency has taken into account the following:

- The review audit report; and
- Information (if any) received from the Secretary of Department of Health and Aged Care; and
- Information (if any) received from the Approved Provider; and
- Information (if any) from current or former residents (or their representatives); and
- Any other relevant information.

Review Audit Report - Accredited Service

Service and Approved Provider Details

Service Details

Service Name: Rowena Private Nursing Home

Service I.D. Number: 4116

Number of beds: 30 Number of High Care Residents: 30

Special Needs Group catered for: N/A

Street: 599 Upper Heidelberg Road

City: Heidelberg Heights State: Victoria Postcode: 3081

Phone: 03 9459 4519 Facsimile: 03 9459 9393

E-mail address: N/A

Contact Name and Position at Service: Ms Brenda Troup – Director of Nursing

Approved Provider Details

Provider Name: Kendalle Pty Ltd

Assessment Team

Team Leader: Angela Quero

Team Member: Caroline Richards

Review Audit Report

This is a report of a review audit conducted in accordance with Part 3, Division 3 of the *Accreditation Grant Principles 1999.*

In conducting the review audit, the assessment team has assessed on-site the quality of care provided by the residential care service against the Accreditation Standards. The team has considered comments and/or submissions received from the Secretary of the Department of Health and Aged Care, current and previous residents of the service (and/or their representatives) and the approved provider.

Executive Summary

A review audit was conducted at Rowena Private Nursing Home between 27 November and 5 December 2001 in accordance with 3.21 (1) of the Accreditation Grant Principles 1999. The accreditation body arranged for this review audit to take place as it believed on reasonable grounds that there may not be compliance with the Accreditation Standards or other responsibilities under the Act. The team met with the director of nursing, Brenda Troupe, who was given both written and verbal notice that an audit would take place. The director of nursing gave consent to the team to conduct the review audit. The approved provider did not attend the service at any time whilst the team was on site.

The service lacks effective continuous improvement systems and this is reflected across all the accreditation standards. Education and staff development programs have not been developed, as systems to identify the needs of staff and for the provision of appropriate training and education to meet these needs are not in place. The lack of these core systems has impacted upon the ability of the service to make long-term improvements in clinical care, resident lifestyle programs and to the living environment.

Residents' health and personal care needs are met through a process of assessment, review, consultation with residents and their families and referral to health specialists. Residents' health requirements and preferences are recorded on care plans, which are updated as residents' health status changes.

The activities program is limited and does not cater for residents requiring one-to-one attention or those residents with dementia. Residents stated that there is little for them to do during the day and that they are often bored. Systems are not in place to ensure each resident receives appropriate information about the services provided in the home and the relevant fees and charges.

Systems to manage and maintain a safe environment are not in place. The occupational health and safety program does not ensure a safe working and living environment due to a lack of hazard management systems. Manual handling practices in the service present a high risk of injury to staff and these are yet to be

addressed. Cleaning programs require improvement, in particular in communal areas and in residents' rooms.

Recommendation regarding accreditation

The review audit team recommends that the accreditation period of Rowena Private Nursing Home is varied (reduced).

Reasons for the recommendation

Findings

Standard: Management Systems, Staffing and Organisational Development
Rating: Unacceptable
Findings: <u>1.1 Continuous Improvement</u> The organisation does not actively pursue continuous improvement. The service lacks a mature, proactive continuous improvement system that self-identifies improvements required and allows for the measurement of the impact of actions undertaken. Formal mechanisms to record required improvements have only been implemented since 19 November 2001, following the recent appointment of consultants. The system is based on the use of corrective action requests (CAR's) to record any issues for improvement, comments or complaints. The team observed that approximately 28 CAR's have been completed since 19 November 2001 and that the majority of these were completed by the consultants. Prior to the implementation of the CAR system, the service did not have a formal mechanism for capturing improvement activities, comments and complaints. Information on the impact and effectiveness of the new system is not available due to the recency of implementation. As a result, management has been unable to assess the effectiveness of the quality system. The director of nursing (DON) explained the use of the CAR's to staff during fifteen-minute information sessions held on a one-to-one basis shortly after the implementation of the system. However, four staff spoken with by the team were unsure of the system for using the CAR's and the procedure for resolving issues raised. Staff's knowledge of continuous improvement is poor, as this is seen as the DON's responsibility. The service lacks a proactive, systems approach to the implementation of improvements. Changes are not made to systems in order to ensure practices are consistently applied and clearly understood by all staff and training and education is not provided to address deficits in knowledge. Audits have been conducted according to a schedule, however results are not actioned or evaluated and systems of work are not modified, refined or reviewed.

The team reviewed the outcomes of 20 audits conducted during 2001 and identified that recurring problems have not been resolved at a systems level. Where audit findings show non-compliance with policies or procedures, the approach of the service is to speak with the staff concerned and reprimand them for their poor practice. For example, a memo to staff identified that an increase in the incidence of skin tears was "disgraceful" and related to their carelessness, which resulted in poor manual handling of residents. The DON stated that although the issue related to poor manual handling skills she did not think it was related to staff knowledge, or evidence of the need to provide further education and training for staff.

The DON is responsible for monitoring the implementation of improvement actions and stated that the current audit tools will be reviewed in early 2002 to assess their continued relevance. The DON stated that significant improvements will be made, however these have not been identified and documented, and responsibilities and timeframes have not been allocated.

The service does not have a system for obtaining information and feedback from residents and relatives on the services they receive. Policies and procedures are not systematically reviewed. Due to the recent implementation of systems and the lack of staff knowledge and involvement, the team is concerned about the sustainability of systems.

Necessary Improvements:

The service must develop and implement effective continuous improvement systems across all areas of the service and provide training for staff to ensure their participation and involvement in achieving quality outcomes.

1.2 Regulatory Compliance

The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines. The service subscribes to a regulatory information service, and receives updates on changes to relevant legislation. The DON informs staff of any required changes to policy and practice via memos. Staff sign the memos to acknowledge that they have read the information.

1.3 Education and Staff Development

Management and staff do not have appropriate knowledge and skills to perform their roles effectively. Systems to identify the needs of staff and for the provision of appropriate training and education to meet these needs are not in place. The knowledge and skills of staff have not been assessed and documented as the DON stated that appraisals have not been conducted for over 12 months. The service does not have an education and training schedule for the year 2001. The DON stated that education has been conducted on a one-to-one basis for clinical care issues, however none of these sessions have been documented in a training schedule or in staff's personal training records. Funding for a workplace English language and literacy program was obtained for ten staff who participated until June 2001. Since this time only one formal education session has been held.

The DON recently conducted an information session on the use of slide sheets.

Training and education is not provided to address deficits in knowledge. Four staff spoken with by the team were unsure of the system for CAR's and the procedure for resolving issues raised. Staff's knowledge of continuous improvement is poor, as this is seen as the DON's responsibility. The team reviewed audit results and identified that recurring non-compliance with policies and procedures was attributed to carelessness, which resulted in poor practices and an increase in skin tears and falls. (See comments under 1.1 Continuous Improvement)

The service lacks a system to monitor staff development activities and does not evaluate the effectiveness of its approach to staff training and development. Training sessions have not been evaluated and previous training records were not available. On 21 November 2001 a new policy and procedure was implemented by the consultants which states that an annual program will be developed for training. Individual education and staff development records were also introduced and it is the responsibility of each staff member to record training attended and keep these up to date.

Necessary Improvements:

Management must:

- ensure staff have appropriate knowledge and skills to perform their roles effectively and determine the competency levels, skill gaps and training needs of staff;
- develop an appropriate training program to address the identified training needs of staff as well as the organisational requirements of the service. This must include provision for evaluation of training and education to determine the effectiveness of the program.

1.4 Comments and Complaints

Each resident (or his or her representative) and other interested parties do not have access to internal and external complaints mechanisms. The recently introduced complaint mechanism is not yet effective to resolve resident, relative and staff issues. The service implemented a new policy and procedure for comments and complaints on 22 November 2001, using the CAR forms. On 10 October 2001, the DON introduced a register to record complaints and comments following the receipt of three external complaints from the Aged Care Complaints Resolution Scheme. Prior to 10 October 2001 records were not kept of comments and complaints and action taken to resolve issues.

Three relatives spoken to by the team stated that they were unaware of the CAR form and that they raise issues with staff if they need to complain. Analysis of comments and complaints registers from 10 October 2001 showed no record of complaints from residents and family members raised verbally. Analysis of comments and complaints corrective action requests has not taken place as yet. Staff stated that they would raise issues with the charge nurse, as they were unsure of the system for using CAR's and the procedure for resolving complaints.

The team noted two CAR's that recorded complaints from relatives regarding lack of adherence to residents' preferences. The CAR register noted that discussions were held and documentation had been updated, and that the issues had been resolved. However, the team observed that changes to these residents' care plans had not been made.

Four complaints have been referred to the service from the Complaints Resolution Scheme. Following the receipt of three complaints from the scheme, the DON prepared a letter to all relatives expressing her disappointment that a relative had lodged a complaint to the complaints resolution scheme, and concern that, "any accumulation of complaints may cause difficulties in the future however unfounded they may be." The letter explains the procedure for making a complaint as follows: "The first contact for lodging complaints and concerns is the charge nurse on duty. The second contact is the DON." The team is concerned that the letter may discourage relatives from accessing external complaints mechanisms, rather than ensuring that residents and relatives have access to all information about internal and external mechanisms so they may decide which avenue is the most appropriate.

Necessary Improvements:

Management must ensure that residents have access to an effective complaints mechanism. In addition, training must be provided for management and staff in handling complaints.

1.5 Planning and Leadership

The organisation has documented the residential care service's vision, values, philosophy and objectives and commitment to quality throughout the organisation. Quality initiatives have only recently begun to be documented and improvement activities have so far only included the DON. Staff do not participate in the quality process, or in the development of quality plans, although an occupational health and safety (OH&S) committee has been in place for some time and staff are conducting basic audits. Communication systems with staff are limited to staff memo's and a weekly meeting where clinical care staff participate in a more detailed handover exercise. Regular staff meetings have not been held – the last staff meeting was conducted on 20 March 2001, however a clinical care meeting was held on 31October 2001. During discussions the DON stated that she proposes to:

- Have regular monthly staff meetings; the next staff meeting has been scheduled for 15 December 2001.
- Develop a standard format for meetings and agenda items will include continuous improvement/CAR's, regulatory compliance, OH&S, review of incident reports.
- Review all policies and procedures in 2002.
- Review all job descriptions in early 2002.
- Conduct staff appraisals.

Suggested Improvements:

The service would benefit from documenting the above planned improvements and allocating timeframes, resources and responsibilities to ensure completion of activities.

1.6 Human Resource Management

There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

Orientation is conducted for new staff and position documentation is available. Position descriptions include key performance indicators. However, staff have not had their performance appraised for over 12 months and the training and education needs of staff have not been identified and met. The service may benefit from reviewing the current communication processes in place (e.g. staff meetings) and ensure staff have access to information and training on the accreditation standards and continuous improvement principles.

1.7 Inventory and Equipment

Stocks of appropriate goods and equipment for quality service delivery are available. Maintenance requests are completed when repairs to furniture and equipment are required. Preventive maintenance schedules are not in place although those items requiring regular servicing have this documented in contracts with the service providers. A new fan has been installed in the pan room in response to the Agency's support contact record of 24 October 2001 which identified the strong odours in the home.

Suggested Improvements:

The service may benefit from the development of a maintenance schedule that documents all regular preventive maintenance and ensures furniture, plant and equipment is proactively managed and maintained in a fit state.

1.8 Information Systems

Effective information systems are in place. Files and documentation have recently been reviewed and the consultants and DON have rearranged folders, files and audit reports to ensure related documentation is stored together. Quality system documentation sighted by the team has recently been implemented. The service would benefit from ensuring that improvement actions taken to address issues are documented, to assist in evaluating the system in the future.

Procedures for storage, archiving and destruction of documents are in place. Current residents' histories and files are stored securely.

1.9 External Services

Externally sourced services are provided in a way that meets the residential care service's needs and service quality goals. Whilst these have not been documented, general service contracts have been developed with most service providers who have sent their contracts to the approved provider or the DON. The DON stated that individualised service agreements are not in place and that quality standards or the needs of the service have not been identified or documented. Reviews of current arrangements have not been conducted.

Suggested Improvements:

The service may benefit from the development of a preferred provider's list to document all contracts with external service providers and any other arrangements or conditions imposed by either party for the delivery of quality outcomes.

Standard: Health and Personal Care

Rating: Satisfactory

Findings:

2.1 Continuous Improvement

Refer to 1.1

2.2 Regulatory Compliance

Refer to 1.2

2.3 Education and Staff Development

Refer to 1.3

2.4 Clinical Care

Residents receive appropriate clinical care. The team reviewed six care plans that accurately reflected residents' assessed needs. Monthly review of care plans is undertaken and any identified changes in residents' care needs are updated on the document and in the progress notes. The team noted that some updates on the care plan are not dated to show when the change came into effect. The charge nurse stated that residents and/or relatives are consulted in relation to the information on the care plan. Of the six care plans reviewed by the team, five had been signed by the resident's relative.

The team noted some isolated examples of inconsistent documentation in use and information recorded in inconsistent places.

Suggested Improvements:

The service would benefit from:

- ensuring that all updates to the care plan are dated;
- formalising a systematic and coordinated approach to completing residents' assessments and recording information.

2.5 Specialised Nursing Care Needs

Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff. The service currently provides specialised nursing care for residents with enteral feed tube and diabetes. The team reviewed the files of four residents with enteral feed tubes and the one resident with diabetes. All care plans contain current information on residents' care requirements, including feeding regimes, care of the stoma site, and the specific care needs of residents with diabetes. The records of the resident with diabetes show that blood sugar monitoring is being performed in accordance with the doctor's orders.

2.6 Other Health and Related Services

Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences. Residents have access to visiting health specialists including a dietitian, pharmacist, physiotherapist, podiatrist and an aromatherapist. Staff provided examples of residents being referred to other health services such as psycho-geriatric specialists. The service's information brochure states that residents are encouraged to access complementary therapists.

2.7 Medication Management

Residents' mediation is managed safely and correctly. All medications are administered from their original bottles and packaging by a registered nurse division 1 (RN Div 1). The team reviewed 16 medication charts. All but one resident (a new resident admitted on 13 November 2001) had photograph identification attached to the medication chart and allergy stickers where appropriate. The team sighted minimal evidence of medications not being signed for by the RN Div 1 and all orders sighted were legibly written by the doctor. All residents have their medications reviewed by a pharmacist on a six monthly basis and a night duty nurse conducts weekly audits of the medication charts and medications in stock. The medication trolley is stored in a locked room.

2.8 Pain Management

All residents are as free as possible from pain. Residents are assessed for pain as indicated. The team reviewed the assessments and care plans for three residents with pain. The assessments showed that alternative pain relief strategies are trialled during the assessment period and that appropriate information is recorded on the care plan.

2.9 Palliative Care

The comfort and dignity of terminally ill residents is maintained. The team reviewed the files and care plans for two residents currently receiving palliative care. Both residents' records show that appropriate care is being provided, in consultation with the residents' doctor and family members. Care plans have been updated to reflect the residents' changing care needs in areas such as activities of daily living, participation in diversional therapy, and pain management. The team also reviewed the files of two deceased residents; both showed that appropriate care was delivered to these residents during the palliative phase.

Of three additional files reviewed, all residents had terminal care wishes recorded.

2.10 Nutrition and Hydration

Residents receive adequate nutrition and hydration. A dietitian was involved in the development of the menu and assesses residents with altered nutritional intake as required. Residents' weight is monitored monthly and appropriate action is taken if significant weight loss is identified. Alternatives to the menu are available. Residents reported satisfaction with the quality and quantity of meals. A list of residents' food preferences and other dietary needs is kept in the kitchen. The team noted that some of these forms have not been updated since 1999.

Suggested Improvements:

The service would benefit from developing a process to regularly update residents' food preference lists in the kitchen.

2.11 Skin Care

Residents' skin integrity is consistent with their general health. Skin integrity risk assessments are being completed for all residents and appropriate strategies implemented. All wounds are recorded in a dressing book, where staff record the ongoing review of wounds. Documentation for two wounds in the dressing book does not indicate that timely review has taken place.

Suggested Improvements:

The service would benefit from ensuring that all residents' wounds are evaluated and the results recorded in a timely manner.

2.12 Continence Management

Residents' continence is managed effectively. Assessments are undertaken to determine residents' continence status and toileting requirements. Staff spoken to were aware of the need to toilet residents in accordance with the toileting regime which is recorded on the care plan. Residents are provided with disposable continence aids consistent with their assessed needs. Staff education in relation to continence management was held on 28 November 2001 and is planned again for April and October 2002.

The team noted a strong smell of urine throughout the facility on both days of the audit.

Suggested Improvements:

The service should investigate further options for addressing the smell of urine throughout the facility.

2.13 Behaviour Management

The needs of residents with challenging behaviours are managed effectively. Assessments are conducted to determine patterns and to trial and identify effective strategies. These strategies are recorded on the care plan; the team noted that a range of strategies are recorded. Staff provided three examples of residents who have been recently referred to psycho-geriatric specialists for assistance with behaviour management.

2.14 Mobility and Dexterity

Optimum levels of mobility and dexterity are achieved for all residents. The physiotherapist, who attends on a weekly basis, undertakes assessments for all new residents and reviews those programs already in place. Exercise programs developed by the physiotherapist are implemented by the care staff; this was verified in discussions with two staff members and on the 'exercise implementation' sheet.

2.15 Oral and Dental Care

Residents' oral and dental care is maintained. A baseline assessment of residents' oral and dental status is undertaken at the time of admission. If any problems are identified, residents are referred to a dentist. The charge nurse reported that residents can visit a dentist in the community or wait to be seen by a dental service that attends the nursing home intermittently; referral to dental services was verified throughout residents' progress notes. The team reviewed two care plans that contained up to date information on the residents' oral and dental needs.

2.16 Sensory Loss

Residents' sensory losses are identified and managed effectively. The charge nurse stated that residents' sensory losses are identified at the time of admission; this was verified in the files of four residents. The same four residents' care plans stated the care requirements of the residents in relation to sensory loss. Residents are referred to hearing and vision specialists for assessment as required; appropriate referral was verified throughout residents' progress notes.

2.17 Sleep

Residents are able to achieve natural sleep patterns. Residents' sleep is monitored over a three day period to determine sleep patterns; this was verified in the files of four residents. The care plan contains limited information relating to residents' sleep preferences and routines.

The team sighted a corrective action form relating to a complaint made by a resident. The resident complained that staff 'put her to bed in the evening at 6pm even when she does not wish to go". The corrective action form stated that the issue had been addressing by recording the resident's preference on the care plan. On review of the care plan, the team noted that this information had not been recorded either on the resident's care plan, daily living care plan or in the progress notes.

Suggested Improvements:

The service would benefit from developing a system to identify, document and act on residents' sleep routines and preferences.

Standard: Resident Lifestyle

Rating: Unacceptable

Findings:

3.1 Continuous Improvement

Refer to 1.1

3.2 Regulatory Compliance

Refer to 1.2

3.3 Education and Staff Development

Refer to 1.3

3.4 Emotional Support

Each resident receives support in adjusting to life in the new environment and on an ongoing basis. The DON meets with all prospective residents and their families to discuss the care and services offered by the nursing home. On admission, there is an informal process to orientate new residents and their families. Residents and relatives are provided with an information package on admission (see comments under 3.9 Choice and Decision-Making).

Suggested Improvements:

The service may benefit from formalising the orientation program for new residents.

3.5 Independence

Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

The activities worker provided four recent examples where two residents have been taken to a community concert. Another resident is regularly assisted to go shopping. Staff stated that other residents frequently go on outings with their family members.

3.6 Privacy and Dignity

Each resident's right to privacy, dignity and confidentiality is recognised and respected. The team observed staff practices that ensure residents' privacy is respected. For examples, curtains are drawn and doors are closed when residents are undertaking personal activities. Residents and relatives stated that staff are kind, caring and courteous. Confidentiality of residents' personal information is maintained. The team sighted two residents with name tags visible on the arm of their glasses and one resident with their name written on the heel of her shoe (visible to others); such practices may compromise the dignity of residents.

Suggested Improvements:

The service needs to consider the dignity of residents when labelling their personal items such as glasses and shoes.

3.7 Leisure Interests and Activities

Residents are not encouraged or supported to participate in a wide range of interests and activities of interest to them. The activities worker is employed for three hours per day, five days per week. The DON reported that there are plans to increase this to six hours per day early in the new year.

The activities program is limited and the same activities are offered on a weekly rotational basis. For example, bingo is played every Tuesday and a pianist comes to play every Thursday. In addition to this, a gospel group attends once a month and a special lunch, such as a barbecue or fish and chips, is held every second week. The activities worker stated that she provides one-to-one sessions as time allows for residents who are bed bound or who choose not to attend group sessions; the activities worker agreed that there was limited time to see all residents requiring one-to-one attention. The activities worker stated that there are no group outings as the service does not have access to a bus and support from relatives and volunteers is minimal.

The activities program is not suitable to meet the needs of residents with dementia. During the two days of the review audit, the team observed two residents with dementia to wander aimlessly around the home for the length of the day (approximately 9am to 5pm.) Another resident was observed to sit in a chair, restrained with a screw-in table, for both days of the review audit (approximately 9am to 5pm). Interaction with this resident occurred only when the resident was toileted or assisted with meals. The team did not observe any attempts to involve these residents in meaningful activities. On the first day of the audit, the team did not observe any activities occurring other than residents watching the activities worker putting the Christmas tree up in the day room. On the second day of the audit, the activities worker ran an 'exercise to music' group.

The team observed that approximately five residents were able to physically participate in this session; approximately four other residents watched the exercise group. A painting group was held later in the same day where one resident watched the activities worker do a painting, with minimal participation from the resident. Three residents told the team that there was usually little for them to do during the day and that they were often bored.

Lifestyle assessments are completed and an activity care plan has recently been introduced. Eight activity care plans have been completed so far. The activities worker records participation in activities in the residents' files. However not all participation is recorded. The team observed four residents' files; these did not record residents' participation in activities for periods ranging from four and twelve weeks, despite staff confirming that these residents participate in activities on a regular basis. The current system for recording participation in the activities program does not enable effective evaluation or review to occur.

Necessary Improvements:

The service must:

- review the resources allocated to the activities program to ensure it meets the needs of all residents;
- ensure that the program accommodates the needs of residents with dementia;
- ensure that the program accommodates the needs of residents who do not wish to participate in group activities;
- implement a system to regularly evaluate and review residents participation in and satisfaction with the activities program.

3.8 Cultural and Spiritual Life

Residents' individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered. A representative from the Anglican church conducts a service at the nursing home every second week; residents from all denominations may attend this service if they choose. Representatives from other churches visit specific residents at the nursing home.

Limited information is recorded in residents' files regarding their cultural, religious or spiritual beliefs. However, staff spoken to demonstrated knowledge of residents' preferences in this area. Staff stated that there are currently no residents with particular cultural or ethnic backgrounds but provided examples of where residents' cultural preferences had been catered for and respected in the past.

Suggested Improvements:

The service would benefit from recording more comprehensive information regarding residents' cultural, religious and ethnic backgrounds, beliefs and preferences.

3.9 Choice and Decision-Making

Each resident (or his or her representative) does not participate in decisions about the services the resident receives, and is not enabled to exercise choice and control over his or her lifestyle.

Systems are not in place to ensure each resident receives appropriate information about the services provided in the home, and the relevant fees and charges. The DON stated that she explains these issues to residents and their relatives on admission, as this information is not made available in writing and residents and relatives are not advised of changes or updates, verbally or in writing. The DON acknowledged that this requires improvement and generated a CAR to address the lack of information provided to new residents.

Residents and relatives do not have access to an effective complaints mechanism. (See 1.4 Comments and Complaints). The residents' information package includes a brochure on the home (with outdated information), a brochure on the external complaints resolution scheme, as well as a copy of a letter from the DON expressing her disappointment that a relative had lodged a complaint to the complaints resolution scheme. Information on the new internal complaints mechanism has not been updated in the information package for new residents.

Resident and relative meetings are held on a three-monthly basis and the next meeting is scheduled for 15 December 2001.

Necessary Improvements:

The service must continue with the review and development of the residents' information handbook to ensure information is provided to residents and relatives on services, fees and charges, as well as information on internal and external complaints mechanisms.

3.10 Security of Tenure

Residents have secure tenure within the residential care service and understand their rights and responsibilities. Conditions of tenure are documented in the residential agreement. Agreements are offered to all residents. The DON stated that a copy of the agreement is provided to all new residents and/or their relatives and that she explains the provisions regarding security of tenure in the document. The team notes that a schedule of the level of care and services to be provided is attached to the agreement, however the document is blank. A copy of the charter of residents' rights and responsibilities is also attached.

Suggested Improvements:

The service would benefit from providing information regarding specified care and services to all current residents, and to all new residents and their relatives.

Standard:	**Physical Environment and Safe Systems**
Rating:	Unacceptable

Findings:

4.1 Continuous Improvement

Refer to 1.1

4.2 Regulatory Compliance

Refer to 1.2

4.3 Education and Staff Development

Refer to 1.3

4.4 Living Environment

Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.

A maintenance man conducts repairs to the building one day a week, and a gardener maintains the garden and surrounds fortnightly. The DON stated that the CAR system has replaced the previous system for documenting and reporting faults. The new system relies on the DON to allocate timeframes to the resolution of issues once the CAR's have been registered and corrective action decided upon. However, the DON is then transcribing the relevant information from the CAR's into the maintenance register. The team suggested rationalising this double handling. Analysis of the CAR register confirms that the system is in the early stages of development.

Rowena has begun addressing deficiencies previously identified in relation to restraint. All residents are undergoing risk assessments to determine if restraint is required. Records show that approximately eight of these have been completed to date. Through the completion of risk assessments, the use of bedrails has been reduced to nine. One concave mattress has been ordered and was delivered on the second day of the audit. The DON reported that if the mattress is suitable, more will be purchased as necessary.

The team reviewed the risk assessments for three residents. These showed that alternatives to restraint are being trialled during the assessment period, including repositioning the resident, offering reassurance, providing drinks and food, and distraction. Of the three risk assessments for restraint reviewed by the team, only one provided information on what behaviour initiated the intervention. The team discussed the need to ensure that this information is always recorded to enable specific strategies to be identified.

The team reviewed the records for four residents with a form of restraint in place. All four residents had a current restraint authorisation on file, showing evidence of consultation with family members and the doctor, and monthly review. The team noted that the majority of monthly review comments stated only 'no change' or 'effective'. Staff should be encouraged to record further information to support the ongoing use of restraint. A resident was observed to sit in a chair, restrained with a screw-in table, for both days of the review audit. The team observed this resident to be released from the restraint only when assisted to the toilet (refer also to expected outcome 3.7). Although the appropriate documentation was in place, the service is encouraged to further assess this resident's needs to determine if restraint is required for the entire length of the day and whether the type of restraint used is the least restrictive type possible.

Suggested Improvements:

The service would benefit from:

- ensuring that risk assessments clearly describe the behaviour or actions of the resident that initiate the intervention;
- ensuring that the monthly restraint reviews record information to support the ongoing use of restraint.

4.5 Occupational Health and Safety

Management is not actively working to provide a safe working environment that meets regulatory requirements. Occupational health and safety meetings are held monthly with representatives from all service areas of the home. A new health and safety representative was in the process of being trained. A staff member conducts a visual inspection of the service on a monthly basis using a simple checklist. However, the checklist has not been designed for use in an aged care setting and does not cover high risk areas such as the bathrooms, kitchen, laundry and residents' rooms.

The consultants recently implemented a new incident reporting procedure. An incident report audit conducted by the DON on 5 November 2001 identified that the incidence of skin tears remains too high due to poor manual handling skills. Strategies to address the high number of skin tears have not been developed, and training for staff in manual handling techniques has not been provided as a possible means of addressing the issue.

Following a visit from Worksafe Victoria, manual handling risk assessments were conducted on 7 and 8 November 2001 on each resident using a transfer guide. Although the findings show that high risk methods of transferring residents are used, strategies to eliminate or reduce the risks have not been implemented. The DON reported that the health and safety representative will address the issue following his attendance at a training course. The DON hopes to purchase another lifting machine and some have recently been trialled.

Necessary Improvements:

The service must:

- implement a proactive hazard management system to ensure and maintain a safe working environment, and
- immediately implement systems to eliminate or reduce manual handling risks.

4.6 Fire, Security and Other Emergencies

Management and staff are actively working to provide an environment and safe systems of work that minimises fire, security and emergency risks. Fire fighting and detection equipment is regularly checked and maintained. Fire safety training was last held in January 2001 and training is proposed for January 2002. The team observed floor plans and emergency procedures displayed in the nurse's station. The DON reported that staff's knowledge of fire safety systems is tested every six months as a questionnaire is distributed to all staff. Chemicals were observed to be stored safely and securely and a new chemical dispensing system has recently been installed in the laundry.

4.7 Infection Control

An effective infection control program is in place. A monthly register for recording infections is in place, however no analysis or comparison of findings has been conducted. The monthly register is used to capture information for benchmarking infection control statistics with two other nursing homes nearby. The information has not been utilised to identify any internal trends or patterns. The DON stated that training for staff has not been provided in infection control although she has assessed the competency of staff when conducting audits in the kitchen, laundry and in general areas. An infection control audit was conducted on 30 October 2001. Surveillance programs are not in place.

Suggested Improvements:

The service may benefit from analysing infection control data for internal improvement and development purposes

4.8 Catering, Cleaning and Laundry Services

Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment. Residents and relatives stated that food quality is good and that preferences are respected. Information is collected on food stocks and deliveries, temperatures of freezers and fridges, food likes and dislikes of residents and special dietary requirements of residents. Procedures are in place for appropriate food storage in fridges and freezers and disposal of waste.

Cleaning programs are not effective. The team noted poor standards of cleaning throughout the communal areas and in residents' rooms.

In particular, high cleaning, scrubbing of walls and floors, and dusting of furniture and fittings requires improvement. Items such as shower chairs, wheelchairs, other furniture and fittings are dirty and not well maintained. The smell of urine was noticeable throughout the service, particularly near soiled linen trolleys and near the pan room.

The team also noted that due to the design of the laundry, delineation between clean and soiled linen areas is difficult. However, laundry staff explained that new work procedures were recently implemented to minimise the risk of cross-infection. Infection control surveillance programs are not in place for cleaning and laundry programs. The team noted that the laundry staff member was using plastic gloves instead of rubber gloves and was not wearing an apron when handling soiled clothing as recommended in the service's policy. Staff and the DON stated that bleach will continue to be used to soak soiled linen until supplies are exhausted.

However, appropriate personal protective equipment (PPE) is not available for decanting the bleach and material safety data sheets (MSDS) are incomplete. Following discussion with the team about the lack of PPE and MSDS, the DON agreed to cease the use of bleach immediately and dispose of the remaining supplies.

Recommendations for further support contacts

The review audit team recommends the following schedule of support contacts:

Recommended Time of Contact	Recommended Form of Contact
1. February 2002	Visit
2. August 2002	Visit

Angela Quero - Team Leader 12 December 2001

Caroline Richards - Team Member 12 December 2001

APPENDIX 1

Overall Rating for Residential Care Standards

A Standard would be rated:

commendable if a service scores at least one commendable rating for an outcome and no unacceptable or serious risk ratings in the Standard.

satisfactory if a service scores fewer than 3 unacceptable outcome ratings in the standard and all other outcomes satisfactory or commendable or by scoring all outcomes satisfactory.

unacceptable if a service scores 3 or more unacceptable outcome ratings in a Standard.

critical if there are 1 or more critical outcomes, or 50% or more unacceptable outcomes in a Standard.

serious risk if there are any serious risks to the health, safety and wellbeing of residents.

Required Action by the Agency

Where a published report indicates an “Unacceptable”, "Critical" or “Serious Risk” rating for one or more standards the Agency will continue to work with the service until a “Satisfactory” rating is achieved.

This process involves consultation between the Agency and the service’s approved provider to reach agreement on the time required for the service to implement an improvement action plan. Support contacts from the Agency to the service monitor progress on the implementation of the improvement action plan. Where it is not satisfied that, at the agreed time, the service complies with the Accreditation Standards, the Agency must recommend to the Secretary whether or not sanctions should be applied by the Department of Health and Aged Care.

Where “Serious Risk” or non-compliance is identified the Agency is required to notify the Secretary, Department of Health and Aged Care, and to recommend whether or not sanctions should be applied (Part 4, Division 3, Section 4.4, 4.5 and 4.6 *Accreditation Grant Principles 1999*).

The Agency will continue to undertake support contacts until it is satisfied that a sustainable improvement has been achieved by the service.

The *Accreditation Grant Principles 1999*, under the *Aged Care Act 1997*, provide details of actions required by the Agency when conducting assessment of residential aged care services.