Arcare Warriewood

Performance Report

23 Warriewood Road
WARRIEWOOD NSW 2102
Phone number: 02 9483 6400

**Commission ID:** 0935

**Provider name:** Arcare Pty Ltd

**Site Audit date:** 18 November 2020 to 23 November 2020

**Date of Performance Report:** 8 January 2021

# Publication of report

This Performance Report **may 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) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Non-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) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Non-compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Non-compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commission’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; informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Site Audit report received 15 December 2020.

# STANDARD 1 NON-COMPLIANTConsumer 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Some sampled consumers considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

For example:

* While some consumers and their representatives provided feedback that they are not always treated with dignity and respect, consumers and representative feedback is generally positive about the way staff treat consumers.
* Consumers confirmed that, in most instances, they are supported to form and maintain relationships with others.
* Consumers provided feedback regarding being supported to exercise the choice and independence to make and communicate their decisions about their own care and the way individualised care and services are delivered. While some consumers said that staff know their decisions and preferences about care and services, others said although they have informed staff, consultation is inconsistent, and they do not receive care and services in line with their decisions and preferences.
* Most consumers interviewed confirmed that the service maintains their privacy, although it can be difficult for some consumers living with dementia to navigate their way through the service without unintentionally entering the wrong rooms, as there are no dementia-enabling strategies for ease of navigation.
* Most staff interviewed generally spoke of consumers respectfully but not all staff demonstrated an understanding of consumers’ identity, culture and diversity.
* Most staff interviewed were able to describe how they have or would support consumers to take risks to enable them to live the best life they can.
* Care planning documents reviewed did not consistently identify consumers’ culture or reflect what was important to the consumer and provided limited detail of preferences and decisions regarding care and services.

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

## 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 that whilst most consumers and a consumer representative said they are treated with dignity and respect, they also expressed mixed views, and felt that, although staff are doing their best overall, understaffing is increasingly taking its toll on the service and depriving consumers of dignity in relation to caring preferences. For example: morning routines are being disrupted by delays that appear to be due to inadequate staffing.

Care planning documents did not appear to consistently reflect the issues that are most important to consumers. A registered nurse stated that, in relation to the service’s goal to review the plans three-monthly with a full family conference, this has only just commenced.

Staff were observed by the Assessment Team interacting respectfully and courteously with consumers throughout the Performance Assessment. Staff talked with consumers as they walked around the service. Staff also conversed with consumers while assisting them to walk to activities or to the dining area for lunch. Consumers appeared to be enjoying the interaction. Interviews with both direct care staff and maintenance staff confirmed positive interactions with consumers.

The Approved Provider submitted information about the issues raised by the Assessment Team. There is evidence from both the Approved Provider and the Assessment Team acknowledging respect for culture and diversity applied at Arcare Warriewood and the value it has for the consumer. From the evidence provided by the Assessment Team staff interactions were also positive however it was clear that there needs to be more consistency applied to consumers being treated with dignity and respect in association with their identity.

The evidence suggests that although there is a general consensus that some consumers are treated with dignity and respect, with their identity, culture and diversity valued,inconsistencies were highlighted. Records were supplied by the Approved Provider regarding the interviewed consumers however they were completed after the date of the site audit and although they have since taken corrective action and outlined future strategies for the service it was not reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it did not demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

The Assessment Team found that consumers interviewed said they are supported to take risks to enable them to live the life they choose. However, consumer’s care plans were observed to contain risk assessments for dietary preferences and falls, but for the most part did not demonstrate any individualised risk mitigation/intervention plans.

For the consumers sampled, staff were able to describe the areas those consumers wished to take risks and how they were supported to understand the benefits and possible harm associated with their choices.

The Approved Provider also submitted information about the issues raised by the Assessment Team. A procedure document was received as supporting evidence. This alone is not enough to qualify as evidence as it does not show how this works in practice providing care to consumers. The Approved Provider also stated they have taken corrective action and outlined future strategies for the service that were not reflective of the standard at the time of the site audit.

However, in considering the evidence I have placed more weight on the interviews with the consumers and staff and believe that while care plans may not be fully reflective of what is occurring this is not enough to say that consumers are not supported to take risks to enable them to live the best life they can. The onsite interviews with consumers and staff clearly show that consumers are supported to take risks to enable them to live the best life they can. On the matter of inconsistent information contained in care plans this will be addressed in standard 2(3)a.

I am of the view that the Approved Provider does comply with this requirement as it has demonstrated each consumer is supported to take risks to enable them to live the best life they can.

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

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

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

# STANDARD 2 NON-COMPLIANTOngoing 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Some sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services.

For example:

* Some consumers and their representatives confirmed they are involved in care planning, while some consumers and their representatives said they were not aware of what was in their care plan and did not have access to it.
* Some consumers and their representatives were aware of the outcomes of assessment and planning; however, others told the Assessment Team care and services are not provided in line with the care plan. For example, one consumer has a detailed plan including morning and evening routines. Her representative said staff often did not follow the plan. The plan for one consumer included the time and frequency for his shower, however staff offered him a shower when they were able and not according to the care plan.
* Information about consumers is captured in care planning documentation. Consumer’s goals, needs and preferences are individualised. Palliative care and end of life wishes are considered or addressed as part of the consumer’s overall care assessment and planning. Care planning review and/or updates occur as scheduled or when the consumer’s condition changes or an incident occurs. Consumers, their representatives and health professionals are involved in care planning.
* The service was unable to demonstrate assessment and planning delivered safe and effective care and services to all consumers. Consumer choice and risk were not always identified, and individualised strategies implemented. Feedback from consumers and their representatives was care plans were not provided either routinely or on request.
* The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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.*

The Assessment Team found the care planning documents reviewed evidenced comprehensive assessment and planning for the consumers sampled. The care plans are individualised relative to the risks to each consumers health and well-being. Assessment and planning consider other risks associated with each consumer’s condition, care and services. While care plans include some consideration of risks to the consumer’s health and well-being, effective strategies do not always inform the delivery of safe and effective care and services for the consumer. Care plans are generic in nature and lack interventions that reflect consumers’ individual needs.

When risks emerge (such as in relation to falls and behaviour of concern), they are investigated, however, appropriate action is not always taken to prevent reoccurrence, including further meaningful review of the care plan.

When a consumer care plan with a set of exercises for staff to complete was mentioned to the clinical lead she was not aware of it. Care staff said they didn’t have time to provide individual exercise programs.

In addition, while assessments had identified risk for a consumer, discussions had not occurred to identify acceptable levels of risk with the consumer and their family and strategies to reduce the risk of falls without restricting movement. Management indicated they had reviewed the care plan; however, they did not consider strategies to reduce falls that were not restrictive, decrease call bell use and engage the consumer in meaningful activities.

Some consumers and representatives interviewed said staff talk to them about their care and services. They said staff accommodate their specific needs and will provide care as agreed. Representatives said they are kept informed when anything changes.

One representative told the Assessment Team while the assessment and care plan identified the specific needs of her mother, staff did not provide care as agreed. She was unsure if staff read the care plan for her mother as they frequently did not follow the plan.

Staff could generally describe how they use assessment and planning to inform how they deliver safe and effective care. Care staff told the Assessment Team they read care plans, however, due to time restraints, are not always able to provide care described in the care plan, for example offered a wash instead of a shower.

The registered nurses said they have a suite of assessments they complete whenever a consumer enters the service. The assessments to be completed are designed to meet the needs, preferences and requirements of each consumer. Risks are discussed with the consumer and their representative; however, management strategies are not always documented in the care plan. The registered nurses explained how they use monitoring information to determine the need for intervention, review and/or referral including following incidents.

The organisation has written materials that support staff to undertake assessment and planning. Clinical staff are responsible for completing and updating assessments and care plans. Assessments are reviewed every three months, or more frequently if triggered by an incident or change in care needs.

The resident of the day process is completed every month and any changes are identified and reviewed by clinical staff. However, the Assessment Team noted staff were not recording all information for resident of the day for all consumers.

The Approved Provider also submitted information about the issues raised by the Assessment Team. A procedure document was received as supporting evidence. This alone is not enough to qualify as evidence as it does not show how this works in practice providing care to consumers. Records were also supplied by the Approved Provider regarding an interviewed consumer however they were completed after the date of the site audit and although they have since taken corrective action and outlined future strategies for consumers it was not reflective of the standard at the time of the site audit.

### I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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) Non-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.*

The Assessment Team found each consumer has a care and services plan. The staff indicated the summary care and services plan is generally accessible to the consumers and includes information that is relevant to the consumers’ goals, needs and preferences*.* The care and services plan is discussed at each case conference and consumers can request a copy. The registered nurses said they discuss the care plan with the consumers and their representatives and consumers have access to their care plans should they request them. Staff interviewed were aware of the processes in place to access and update information on consumers care plans.

Some representatives said the consumer’s care plan was discussed with them during care conferences and they had not requested a copy of the care plan. Others said they do not have a copy of consumer’s care plans but are provided with information when requested and notified of any changes.

Some consumers told the Assessment Team the care and services plan has not been discussed with them and they would like to have a copy of it. They said they have asked repeatedly for a copy and have not been provided with one.

One representative said she would like to have a copy of the care and services plan on display in her mother’s room for staff to use, however, the service manager has told her it cannot be on display.

Most staff could generally describe how the outcomes of care planning are communicated to the consumers sampled and their representatives in line with the consumer’s wishes*.* Care staff said they did not have a handover document. Further discussion with care staff indicated they thought the handover sheet was only for the use of the registered nurses. The care staff said the clinical lead and registered nurse are responsible to communicate with the consumer and representatives about any changes in their care plan.

Care staff told the Assessment Team they do not regularly have a handover process, the registered nurses provide exceptional information only. They are directed to commence work and the registered nurse will find them to let them know if there is anything relevant for the consumers they are providing care to.

Management said handover is by exception only, so when changes occur care staff should be informed. Management were not aware care staff were not accessing the handover document.

The Assessment Team observed care planning documents to be readily available to staff delivering care including a handover sheet containing information about consumers care on each shift. Staff were observed accessing consumer information from the electronic consumer management system and paper-based folders.

The Approved Provider also submitted information about the issues raised by the Assessment Team. A hand over sheet document was received as supporting evidence. This was unclear as it had been redacted and was not dated. The print mark on the document was dated the 15December 2020. It is therefore not possible to assess this document as a form of credible evidence to support standard 2(3)d. In addition, a policy and procedure document was supplied, and this alone is not enough as qualify as evidence as it does not show in practice that the assessment and planning are effectively communicated to consumers and consistently documented.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the outcomes of assessment and planning are effectively communicated within the service and services.

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# STANDARD 3 NON-COMPLIANTPersonal 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Some sampled consumers considered that they receive personal care and clinical care that is safe and right for them.

For example:

* Some consumers and their representatives interviewed confirmed the consumer receives the care they need. Incidents are followed up and strategies implemented to meet the needs of the consumer and optimise their health and well-being.
* All consumers and their representatives interviewed confirmed that they have access to a doctor or other health professional when they need it, noting their medical officer or another medical officer visits regularly. The service organises other health services to visit the site or assists consumers to access required health services externally, such as specialist allied health services and medical consultants. A geriatrician visits the service on request from the medical officer.
* While consumers and their representatives were satisfied that they were receiving good care and services, the Assessment Team identified personal and clinical care were not always being effectively managed, particularly in relation to falls management, wound management and clinical observations.
* The Assessment Team’s general observation was that staff were delivering care in partnership with consumers which was appropriate to their day to day needs, however, their preferences were not always considered. Most consumers were clean, dressed appropriately, seated comfortably or moving around the service freely with appropriate aids. Consumers that were immobile and fully reliant on staff were positioned and repositioned to maximise comfort and were observed to have food, drink and a method to call out to staff in easy reach.
* Effective management of personal and clinical care, that is tailored to the needs of the consumer, was not sufficiently evidenced by the Assessment Team. Infection control processes were not sufficiently developed for COVID-19 preparedness. Care staff were not receiving a clinical handover for all consumers resulting in care and services not occurring in line with the care plan.
* Risks to consumers have not been consistently managed to provide prompt and effective personal or clinical care that is best practice; tailored to their needs; and optimises their health and well-being.

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

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found progress notes (and other documents) for the consumers sampled did not consistently reflect individualised care that is safe, effective and tailored to the specific needs and preferences of each consumer. Records indicate that the service’s psychotropic medication use is not recorded accurately, falls are high and monitoring of clinical interventions is not effective.

Some of the consumers and representatives sampled thought consumers get the care they need most of the time whereas others commented it was some of the time*.*

Some of the care staff expressed concern about some areas of consumers care including managing consumers with challenging behaviour. The staff said most of the consumers are confused and managing falls risks particularly for one new consumer who recently entered the service is challenging.

The care staff said they would escalate concerns relating to consumer’s care to the registered nurse and document in the service’s electronic documentation system.

The registered nurses said for post falls management, they would commence neurological observations at specified times. The registered nurses have access to training and specialist services such as the nurse practitioner, dementia support and allied health practitioners to ensure care and services are safe and effective.

The general manager said at the service level safe and effective care was measured through audits and monitoring of clinical incidents. The organisation has policies and procedures to provide guidelines and resources for the delivery of care that is safe and effective. Staff have access to education and consult with other professional services to ensure information is current. Monthly clinical indicator is used to benchmark the service against other services in the organisation and is reviewed by clinical governance.

The psychotropic use register presented to the Assessment Team was not current and did not provide details about the reason for the use of medication except as needed (PRN) medications. Opportunities to participate were not always individualised. Review dates for medication were not completed for 21 consumers and of the review dates completed, they were all more than three months old. Management said there was another form where the information was current in the electronic system. However, although requests were made for current information, it was not provided.

The service manager provided a copy of the psychotropic medication report from the pharmacy which showed 56% of consumers prescribed psychotropic medications at the end of October 2020. The general manager said no consumers were prescribed psychotropic medications as a chemical restraint however, the psychotropic register did not include diagnosis with regular medications and the medication charts did not include diagnosis for regular medications. The progress notes and care plans for consumers prescribed psychotropic medication were reviewed by the medical officer each time a new prescription was required. Medication has been reduced when possible.

Some wounds were not reviewed according to the directions in the wound management charts.

The Approved Provider also submitted information about the issues raised by the Assessment Team. A work instruction document was supplied, this alone is not enough to qualify as evidence as it does not show in practice that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care. There were inconsistencies in the evidence submitted by the Approved Provider, often only partially addressing issues and mostly after the date of the site audit. It also appeared to show there needs to be continued work on the best practice use and recording of psychotropic medications provided and their appropriate use. In addition, the information provided only addressed certain components of what was identified by the Assessment Team during their visit. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for consumers, however this is not reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care in the areas of psychotropic medication use, chemical restraint, falls management and wound management.

### 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) Non-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.*

The Assessment Team found from the consumers sampled, the care documents (e.g. progress notes or handover documents) provide adequate information to support effective and safe sharing of the consumer’s care. Medical officers write in the electronic consumer management system and the nurse practitioner has external access to consumer records. Allied health practitioners record information in the electronic system.

Most of the consumers and representatives feel that consumers’ needs and preferences are effectively communicated between staff, although they do sometimes have to remind staff about consumer’s care and individual preferences.

Staff described how information is shared when changes occur and how changes are documented in handover sheets, progress notes and care plans. The clinical leads described the process for sharing information when transferring consumers to hospital or to medical appointments.

Care staff said they receive information about changes in consumers care by exception through the handover and they receive alerts from the electronic system. They told the Assessment Team they do not use the handover sheets. Care staff said they are uncomfortable commencing work without the previous shift providing any handover information to them.

Care staff said they were too busy in the mornings to shower consumers at their preferred times and were not always aware of individual preferences. Management said there needed to be a discussion with consumers about their preferred shower time and a list developed to guide staff.

Management described the handover process as by exception – the registered nurse will update care staff on any information relevant to the consumers they are caring for.

The Assessment Team observed a handover between registered nurses. The handover focused on tasks to be completed during the next shift.

The Approved Provider also submitted information about the issues raised by the Assessment Team. A hand over sheet document was received as supporting evidence relating to one of the consumers. This was unclear as it had been redacted and was not dated. The remaining hand over sheets were blank. It is therefore not possible to assess this document as a form of credible evidence to support requirement 3(3)e. In addition, the information provided only addressed certain components of what was identified by the Assessment Team during their visit. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for consumers however this is not reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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 consumers and representatives interviewed were satisfied that the organisation was taking appropriate action to keep them safe from the risk of infectious outbreaks including influenza and COVID-19. One representative said she thought the service had managed the emotional needs of her family member very well during the period of reduced family access.

All staff interviewed were familiar with the principles of infection control, said they have access to personal protective equipment and it is readily available, they have regular education in infection control and were familiar with the service’s handwashing procedures. Staff could describe what to do in the event of an infectious outbreak such as wearing masks and other personal protective equipment, keeping consumers in their rooms and the use of a special bag to launder their clothing.

The registered nurse and clinical leads could describe how infection related risks are minimised at the service including supporting care staff to promote adequate nutrition and hydration, engage consumers in exercise/activities and conducting relevant assessments including urinalysis.

The COVID -19 management plan however, did not include information about surge workforce arrangements and details, personal protective equipment stockists, waste management services or allied health services.

There were no identified areas specifically marked for donning and doffing on two floors of the service. Management advised donning and doffing areas would be set up outside the room of each COVID-19 positive consumer. Density signage was observed in all communal staff areas.

The plan did not set out lockdown processes, including staff assigned to teams to support cohorting. A current list of staff with contact details including detailed rosters and a record of staff who work across multiple aged care services or multiple sites was not available. Processes for clinical handover where not provided and there were no guidelines to determine when to transfer COVID-19 positive consumers to hospital.

The Approved Provider also submitted information about the issues raised by the Assessment Team. An outbreak preparedness checklist was supplied, this alone is not enough to qualify as evidence as it does not show, in practice, how infection risks have been minimised. The Approved Provider did provide evidence of corrective action taken on outbreak management supplying an amended roles and responsibilities COVID 19 Pandemic flow chart however this does not provide evidence of the practice of outbreak management and is not reflective of the standard at the time of the site audit.

There was no evidence provided by either the Assessment Team or the Approved Provider relating to practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated consistently minimising infection related risks (specifically COVID 19) through implementing standard and transmission-based precautions to prevent and control infection.

# STANDARD 4 NON-COMPLIANTServices and support 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The team also examined relevant documents.

Most sampled consumers did not consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

For example:

* + Some consumers said they do not enjoy the activities offered at the service and would prefer to do more things that interest them.
	+ Consumers confirmed they can have family come and visit them however are unsure why they cannot leave the service despite COVID-19 restrictions easing.
	+ Most consumers said they do not like the food at the service.
	+ Leisure and lifestyle assessments are not reviewed and are not considered when planning the monthly activity calendar.
	+ There has been no communication with community to understand when consumers may be able to begin participating in community activities again.
	+ Uncertainty of information relating to menus and consumer choices was identified, with the chef stating this is an area for improvement.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-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.*

The Assessment Team found most consumers sampled said they are not satisfied the supports for daily living they receive at the service, or that they support them do the things they want to do. The activities calendar while updated monthly does not take into consideration the leisure and lifestyle preferences of consumers discussed on entry to the service.

The service enters leisure and lifestyle information about the consumer on entry to the service however there is no formal system in place to reassess this information periodically.

The lifestyle coordinator said the activities program is developed monthly and is based on consumer participation of what has been successful in the past. There is no consideration currently given to assessed leisure and lifestyle interests of consumers when preparing the activities calendar. The Assessment Team were also told that consumer surveys are done every month on the leisure and lifestyle program however only a template was provided and completed surveys were not provided.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included social activity plans for two consumers. While this did display a record of participation and the level on enjoyment it does not provide evidence of consumer’s needs, goals and preferences. In making this decision there has been consideration given to the impact of COVID 19 on the ability for the provision of leisure activities, including reduced ability to provide variety or perhaps even meet consumer preferences, however the evidence does not support that the Approved Provider has suitable processes in place for the recording and actioning of consumer preferences to optimise their independence, health, well-being and quality of life. Consumer feedback also provided significant evidence of their dissatisfaction with their support for daily living.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer does not get 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) Non-compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

The Assessment Team found most consumers say they have day-to-day control over what they take part in, how they take part and who they socialise with within the service. However, the service could not provide evidence of how they assist consumers to participate in their community outside of the service environment or do things of interest to them particularly during COVID-19 restrictions.

Several consumers interviewed said they are frustrated they are not allowed to leave the service to participate in community events and do the things of interest to them.

The lifestyle coordinator initially said that despite restrictions being eased the service is still not allowing volunteers to enter the service and she is not aware of why. Management said consumers can leave the service if they choose although they are cautioned and told it is preferred if they do not go. Further stating that consumers will be allowed to go away for the Christmas break.

Consumers were observed interacting in lounge rooms and the café area of the service. Consumers were also observed at exercise class each morning however no other activities were observed.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a social leave list of consumers leaving this was dated from the beginning of November 2020. It is difficult to apply this evidence as the consumer and staff feedback does not support the standard as stated, to support consumers to participate in their community within and outside the organisation’s service environment. COVID 19 restrictions have had an impact on the services ability to allow community participation either internally or externally to the service however the service should be able to demonstrate at the time of the site audit the impact and the processes that have been undertaken to mitigate the risks to allow for participation in their community within and outside the organisation’s service environment; and have social and personal relationships.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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) Non-compliant

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

The Assessment Team found consumer feedback indicates meals are not of suitable quality and their dietary needs and preferences do not always influence the menu. Catering staff confirm meals is an area the service needs to work on.

Consumer feedback consistently saidthe food is not good and is unappetising. They also consistently said that their complaints about the food were not actioned.

For the consumers sampled, the care planning documents reflect any dietary needs or preferences, and this aligned with consumer feedback.

Discussions with the chef identified the service changes the menu quarterly and he showed the Assessment Team the ‘spring menu’ he is currently working from. He said despite holding the food meeting with consumers earlier in the week he has not received the summer menu and agreed the consumer could not provide input into the menu if they do not have access to it.

Consumers were observed being assisted with eating their meals if required.

The kitchen was observed to be clean and tidy and staff were observed to adhering to workplace health and safety requirements. A whiteboard with consumer dietary requirements was observed to be in the kitchen and this showed an accurate reflection of consumer preferences.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a copy of the dining experience standards. This as a standalone document does not provide evidence of practice for consumers on thevariety, suitability, quality and quantity of meals. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for consumers however this is not reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as the weight of consumer feedback supports it has not that meals are varied and of suitable quality and quantity.

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The team also examined relevant documents.

Most sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment.

For example:

* Consumers interviewed confirmed the environment is welcoming and they feel at home at the service. They said they feel safe and it is clean and well maintained.
* Consumers interviewed confirmed they are free to move about the service and to go out. Those who are less able said they could ask staff to take them outside when they wanted.
* The Assessment Team observed the service to be clean and comfortable. It is well lit and free of clutter.
* Consumers have personalised their own rooms and the service is decorated with paintings and photographs of scenes from the local district.
* The service has cleaning and maintenance systems in place to ensure the service is safe, clean, and well maintained.
* While the service was generally observed to be clean, the Assessment Team observed a consumer’s room to have a strong odour and stained carpet. Routine cleaning of the area was not effective.

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

## 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.*

The Assessment Team found observed fire safety systems in place. The service has a security system including electronic entry/exit and video surveillance.

The resident of the day checklist includes an environmental check for all consumers on a monthly basis. Any problems identified ae entered in the maintenance book to be actioned. Any safety issues would be reported to management and recorded in the hazard log.

The living environment has wide corridors and is uncluttered. There are sitting rooms and furniture around the corridors to enable consumers to rest. There is access between floors by lifts. External areas were observed to be clean, safe and well maintained and consumers were observed moving freely indoors and outdoors.

Some consumers interviewed said they can come and go as they please. Consumers were generally aware that the exit doors in the service required codes to leave the building. Some consumers stated they did not know the codes to the exit doors, but they could ask staff at any time.

Maintenance staff explained the system for reactive and preventative maintenance. The preventative maintenance program uses contractors for most of the services required. The maintenance officer oversees contractors on site. Maintenance at the service is monitored by the manager of the service. Maintenance staff confirmed they have annual training related to work health and safety, fire safety, manual handling, chemical safety and incident reporting.

Cleaning staff confirmed they have their regular schedule but are flexible to accommodate consumers’ needs and requests. Management stated consumers with limited mobility are encouraged to move around the service environment by providing them with ongoing occupational therapy, physiotherapy and exercise programs. Consumers with limited mobility have access to their own mobility aids.

A review of the cleaning schedule and records shows cleaning is carried out regularly for all parts of the service. A review of the maintenance program and records shows reactive maintenance is carried out in a timely manner and preventative maintenance is carried out according to the schedule. A review of fire safety records showed fire safety equipment and monitoring systems are being regularly inspected, tested and maintained as scheduled.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a copy of fortnightly environmental review plan. Plan proformas do not provide suitable evidence of the service environment in daily practice. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for consumers.

When considering if this service has a systemic issue with the service environment being safe, clean, well maintained and comfortable there was only one issue identified by the Assessment Team. On balance, this combined with the other evidence provided by the Assessment Team, does not constitute a systemic issue which would necessitate a finding of non-compliance.

I am of the view that the Approved Provider does comply with this requirement as it demonstrated 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 NON-COMPLIANTFeedback 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Overall consumers did consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken.

For example:

* Most sampled consumers and representatives interviewed were aware of complaints and feedback mechanisms at the service and said they receive information initially and on an ongoing basis on this.
* Consumers said they raise issues; however, they don’t always get a response and the complaints are not resolved.
* The organisation enters all complaints into its risk management system with a risk rating and analyses trends in complaints and feedback. Those with a higher risk rating are automatically escalated to senior management in the organisation.
* The organisation has a comprehensive open disclosure policy, however, consumers expressed dissatisfaction with the way complaints were managed at the service. Staff were unable to provide examples of open disclosure and how it is used in the service.

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

## 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) Non-compliant

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

The Assessment Team found one representative provided the Assessment Team with a range of situations where she has had conflict with staff about her mother’s care, including on one occasion when she thought staff had given her mother incorrect medication and her mother became unwell. She said she was accused of abusing a staff member. The state manager spoke with her; however, she does not recall an apology being made.

Once consumer told the Assessment Team she feels like the service hears her, but they don’t action anything. Finishing with “they need to listen more and act…”

Consumers have raised complaints about not being showered in the morning in time to go to exercises and being left sitting in chairs for too long. They told the Assessment Team staff were too busy to attend to them.

Some staff interviewed stated they were aware of the service’s complaints policies and procedures, including the requirement for open disclosure.

The electronic complaints register, contained in the organisation’s risk management system, was sighted and contained information on issues identified and steps management had taken to address the identified issues. Review of complaints information showed complaints were being handled by management according to the organisation’s policies.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included daily systems meeting notes, list of call bell waiting times longer than eight minutes and training documents. These documents were dated after the Assessment Team on site visits so is therefore not reflective of what was occurring at the time. The evidence provided is however and indication that corrective action has been taken and there is also a plan for future strategies for improvement.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated 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-COMPLIANTHuman 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

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Most sampled consumers did not consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

For example:

* Most consumers said that staff are rushed and short. With some consumers saying that staff are sometimes rough when assisting with personal care.
* Most consumers said staff know what they are doing however said they could benefit from more training in dignity, respect, English and communication.
* All consumers interviewed said the service does not have enough staff and they know this because staff tell them, staff don’t answer call bells or come in and say they are coming back but don’t, or they have to move to alternatives dining rooms as there is no staff to assist in theirs.
* The Assessment Team reviewed call bell reports, rostering and unfilled shifts for the month of October 2020 and identified numerous unfilled shifts and extended call bell response times.
* Discussions with staff indicated a level of concern on their ability to deliver appropriate care to consumers, saying there is a lot of unplanned leave and they are required to care for double the number of consumers they are supposed to.
* Education and training competencies are not up to date and there is not effective system at monitoring completion of these or those staff who have not completed mandatory training. Performance appraisals are not up to date with requests for training and education identified through these discussions not being monitored.

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

## 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 review of the call bell data identified that call bells are not always responded to within the eight minutes as set by the service. Review of the unfilled shifts indicated numerous shifts per week to be unfilled across all areas of the service including, nursing, care staff and medicators.

The service manager told the Assessment Team they are undertaking interviews for staff currently. They are seeking approximately 10 catering staff, 10 care staff and one registered nurse. One registered nurse said the service is “very under staffed” and she said she does not have time to complete her work, further stating she was working today across two floors.

Four care staff told the Assessment Team they are short staffed. One care staff said, she doesn’t have time to complete her work and this impacts on her ability to deliver good care to the consumers. Discussions with the lifestyle coordinator identified the lifestyle team is currently down two staff. These staff have not been replaced in the lifestyle team.

Management agreed with the Assessment Teams findings of an average of 19 unfilled shifts a week in October 2020. The service manager said the staff are used to the way it was before COVID-19 earlier in the year, however agreed the service is only 30 consumers down from being at full capacity and there are a lot of unfilled shifts.

The regional manager told the Assessment Team that call bell response times had not been reviewed since the beginning of 2020. They are now reviewing this data daily and information is being sought from the registered nurse and subsequently the care staff regarding call bells exceeding eight minutes.

The Assessment Team reviewed information provided by the service manager for the period of 1 October 2020 to 1 November 2020 which identified unfilled shifts at the service. It indicated that on average 19 shifts have not been filled each week. These were observed to be across various roles and shifts across the service and include registered nurses, personal service workers (PSW), PSW medicators and enrolled nurses.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a copy of work instructions for dedicated assignment and a supporting email informing staff to familiarise themselves with the process upon implementation. Whilst the Approved Provider did implement the strategy there is no supporting documentation of review to confirm success or identify if there was a need for continuous improvement. This is therefore not enough evidence of the daily staffing practice of the service. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for improvement however this is not reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

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

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

The Assessment Team found consumer feedback indicates that staff interactions with consumers are not always kind, caring and respectful. Consumers provided examples including being washed with cold water after toileting and speaking a language other than English during care delivery. Observations by the Assessment Team indicated most interactions to be respectful, however, staff do not always provide explanations or an apology for interruptions or explain information to the consumer.

The Assessment Team mostly observed interactions by staff with consumers to be kind, caring and respectful. However, during an interview the Assessment Team observed a registered nurse to walk away mid-way through conversation to answer the phone without explanation or apology.

During an interview the Assessment Team observed two different care staff to enter the room to reposition a motion sensor, however neither staff greeted the consumer when they entered his room, nor did they explain what they were doing while in there.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a copy of a team member information guide and supporting proformas. Whilst the Approved Provider has supporting documentation for staff to reference there is no supporting documentation of a review process to ensure standards are being maintained and/or identifying a need for continuous improvement. This is therefore not enough evidence of the staff interactions practice at the service. The Approved Provider did provide evidence of corrective action taken and outlined future strategies for consumers care however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

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

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

The Assessment Team found consumer feedback indicated they are satisfied that staff are competent and have the right knowledge to provide care and services. The service has a system in place to ensure staff are competent on commencement of employment and on an ongoing basis. However, the learning and development manager said staff competencies are not are up to date, and there is no regular and effective tracking of this information.

Consumers said staff are skilled enough to meet their care needs. A consumersaid he recently had a wound on his head following surgery. The registered nurse helped with cleaning and bandaging, and he is happy with the care delivered.

The regional manager advised that staff must have minimum of certificate three to work at the service. Following employment all staff must undertake a two-day induction program which includes; handwashing competencies, personal protective equipment (donning and doffing), manual handling and fire training. The service also has annual competencies for staff to complete. However, the learning and development manager indicated that competencies have not been completed by all staff for the 2020 year.

Previously, competencies were submitted and recorded on a spreadsheet however this was inconsistent, and information was not being recorded accurately. The learning and development manager said she was keeping track of some information on her own spreadsheet however this has also ceased.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included several training policies and calendars. The Approved Provider also supplied evidence of the minimum qualification levels for staffing on commencement at the service. Whilst this is an important component of ensuring that staff are suitably qualified the Assessment Team have identified and provided evidence that improvements in the ongoing training of staff including the planning, review and completion rates are necessary. In addition, the Approved Provider did provide evidence of corrective action taken and outlined future strategies for staff training however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-compliant with this requirement as it has not demonstrated the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

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

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

The Assessment Team found most consumers said staff know what they are doing. However, two consumers said staff need extra training in dignity, respect, English and communication. Staff were happy with training and education provided by the service however most could not recall training on the new Quality Standards and associated areas like that of antimicrobial stewardship, restraint, open disclosure, comments and complaints and risk and manual handling. Management provided the Assessment Team with information on mandatory training topics however a definitive list of staff who have not completed this training was not provided despite requests.

Most consumers said they feel staff know what they are doing and are happy with the delivery of care and services. One representative said the staff need training in dementia. A consumer said staff need more training in dignity, respect and courtesy.

This care staff said she had been at the service for approximately seven months. One care staff member said she has received training in the new Quality Standards, restraint, dignity and respect, infection control, COVID-19, fire and manual handling.

Two registered nurses said they had plenty of training and they understand the new Quality Standards. However, one was not aware of antimicrobial stewardship and neither could talk to open disclosure, comments and complaints or risk. Both registered nurses said they have recently had training on wounds following their request.

The learning and education manager said there has been a training needs analysis survey recently released however responses are not due until early December 2020. She also said that tracking of education and training requests identified through performance appraisals or feedback from training evaluation records is not being done.

Discussions with the management team identified the service has several mandatory training topics every year. The Assessment Team asked for the status of the mandatory training particularly the number of staff with outstanding mandatory training. However, a clear and definitive list was not provided.

Discussions with the state manager identified training and education on the new Quality Standards was previously offered in the induction process, however this may have dropped off due to COVID-19 and staff that started after the restrictions may not have received this as of yet. A process of review is underway to ensure all staff who have started after COVID-19 restrictions receive training on the new Quality Standards.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a list of mandatory training completed by staff upon commencement. Whilst this is an important component of ensuring that staff are suitably qualified the Assessment Team have identified and provided evidence that improvements in the ongoing training of staff including the planning, review and completion rates are necessary. This would indicate that staff require additional support in training and support to consistently deliver quality outcomes. In addition, the Approved Provider did provide evidence of corrective action taken and outlined future strategies for staff training however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

The Assessment Team found the service was unable to demonstrate that performance appraisals are up to date and that feedback provided by staff relating to training is considered in a timely manner.

The service manager advised the Assessment Team that staff performance reviews are conducted annually at the service. However, on commencement of new staff another appraisal is done at approximately six months prior to final probation. The performance reviews are a two-way dialogue and include the staff member providing goals and areas they would like extra improvement or training in.

The service manager said performance appraisals are currently not up to date with approximately 50 appraisals outstanding.

Staff could not provide the Assessment Team with examples of changes made to support them resulting from the performance appraisal process.

Two care staff said they have not had a performance appraisal including one at the end of their probation. They have been at the service for approximately seven months.

The learning and education manager told the Assessment Team that no one is monitoring the performance appraisals for feedback relating to education and training requests.

The Assessment Team reviewed staff files provided and identified from those completed performance appraisals that staff had requested extra training. This included; wound assessment and management, ACFI, palliative care, manual handling, behaviour, medication training and documentation training. The Assessment Team note these performance appraisals were conducted in July and August 2020, however there was no information provided on when these topics may be considered for training and education.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a comprehensive range of documents to facilitate monitoring and reviewing performance of staff. These documents are only considered to be evidence if they are completed and show the reviewing and monitoring in practice at the service. In addition, the Approved Provider provided evidence of corrective action taken and outlined future strategies for reviewing staff performance however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

# STANDARD 8 NON-COMPLIANTOrganisational 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

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Some sampled consumers did not consider that the organisation is well run and that they can partner in improving the delivery of care and services.

For example:

* Some consumers said they do not believe the service is well run because they do not have enough staff, staff are too rushed, staff interactions are not always kind and caring and that call bells are not always answered promptly.
* Consumers could not provide examples of how they have been involved in the development, delivery and evaluation of care and services. Some consumers said they feel the service hears them but feel they do not action feedback well.
* Discussions with management identified they seek feedback from consumers during consumer meetings however did not provide examples of changes to the development, delivery and evaluation of care and services based on these discussions. The service plans to implement a consumer experience committee and consumer advocate however these have not yet commenced at the service.
* The organisation has a clinical governance and risk management framework in place along with several associated policies/work instructions. However, staff could not demonstrate knowledge on these or provide examples. Management advised that education has not been conducted with staff on risk and clinical governance.

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

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Non-compliant

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

The Assessment Team found whilst the service seeks input from consumers in the development, delivery and evaluation of care and services through consumer meetings, they did not provide examples of this engagement from consumer meetings. The consumer experience committee and consumer advocate have also not yet commenced at the service and as such examples were not provided.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a range of documents to facilitate consumer engagement. These documents are only considered to be evidence if they are completed and show consumer engagement for evaluation of care and services. An extract of a governance report dated December 2020 on relative and representative feedback relating to COVID 19 was also submitted. This is not considered to be evidence as it is not fully reflective of the standard at the time of the site audit nor does it show that consumers are engaged in the development, delivery and evaluation of a broad range of care and services. In addition, the Approved Provider provided evidence of corrective action taken and outlined future strategies for engaging consumers however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

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

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

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

### Requirement 8(3)(d) Non-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.*

The Assessment Team found the service provided a risk management framework to however this was approved in October 2020 and does not have an education program yet developed for staff. While risk is identified and reported to the board the risk management framework and clinical governance framework has not been provided to staff. The service did not provide the Assessment Team with information on high impact and high prevalence risks nor did they provide information on supporting consumers to live the best life they can. Staff could not provide examples of what these policies may contain.

The organisation provided policies describing how abuse and neglect of consumers is identified and responded to.

Staff could not provide examples relating to supporting consumers to live the best life they can or high impact or high prevalence risks.

Management were able to provide examples of the way care, and service were planned, delivered or evaluated as a result of the implementation of the risk management framework. Since the employment of a risk manager the service has improved on the way risk is identified and reported to the clinical governance committee and the board. Discussions with management regarding high impact, high prevalence risks and supporting consumers to live the best life they can identified the service does not have policies relating to them.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a range of documents to facilitate riskmanagement systems and practices. Whilst these documents do show a level of clinical governance these are only relevant if they are used in practice. No additional evidence was supplied to show how they are used in practice. In addition, the Approved Provider submitted evidence of corrective action taken and outlined future strategies for risk management systems and practices however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated 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.

### Requirement 8(3)(e) Non-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 organisation has documented policies relating to antimicrobial stewardship, restraint and open disclosure. A clinical governance framework was also provided to the Assessment Team. Most staff were able to discuss the restraint policy and some registered nurses could explain antimicrobial stewardship. However, open disclosure was not known by any staff and the education has not been provided to staff on the clinical governance framework.

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Staff had not been educated about the policies and were not able to provide examples of their relevance to their work. Staff told the Assessment Team the service does not use restraint at the service.

Management were asked what changes had been made to the way that care and service were planned, delivered or evaluated as a result of the implementation of these policies. Management were not able to provide examples. The clinical governance framework was approved in September 2020 however an education program has not been rolled out for staff yet. Management said antimicrobial stewardship is monitored and the service has information regarding this and infection rates. However, on review of the clinical governance monthly report this information was not located. The Assessment Team did see this information discussed at the medication advisory committee meeting minutes which was held in May 2020.

The Approved Provider also submitted information about the issues raised by the Assessment Team. The information included a range of documents relating to clinical governance (including meeting minutes) and the attention placed on antimicrobial stewardship. At a governance level, it does appear that the required documents are in place and governance meetings are occurring however there is still the concern about evidence showing how the service utilises this particularly in transferring clinical governance knowledge to staff. In addition, the Approved Provider submitted evidence of corrective action taken and outlined future strategies relating to clinical governance however this is not fully reflective of the standard at the time of the site audit.

I am of the view that the Approved Provider is non-complaint with this requirement as it has not demonstrated 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.

# Areas for improvement

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

### Requirement 1(3)(a)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Consistently facilitating choice, listening and responding to consumers to ensure dignity is maintained encapsulating their identity.
* Reviewing care plans consistently so they are completed to better represent cultural preferences, privacy and dignity.
* Continuing with corrective actions as applied to the interviewed consumers but also ensure these are consistently applied to each consumer.
* Continue to work on rosters to ensure consistency of care for consumers to ensure they are treated with dignity across all their care requirements.

### Requirement 2(3)(a)

### Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Consistently conducting assessment and planning, including consideration of risks to the consumer’s health and well-being for each consumer.
* Ensuring, as per supplied action plan, that a review of care plans for each consumer is completed and copies of these are provided to the consumer or their representative. These should include a consideration of risk and risk mitigating actions.
* Ensuring staff are aware of all facets of a consumer’s care plan that will inform the delivery of safe and effective care.
* Training staff in risk identification, planning and ongoing assessment.

### Requirement 2(3)(d)

The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Reviewing handover practices and ensure they are occurring and documented consistently.
* Completing training for staff on handover procedures to ensure consistency
* Changes to consumer care requirements are consistently transferred to relevant documents such as care plans and communicated consumer and staff.

### Requirement 3(3)(a)

Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

1. is best practice; and
2. is tailored to their needs; and
3. optimises their health and well-being.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Continuing staff training on diabetes, wound care and dementia
* Improving the monitoring of clinical interventions for safe and effective personal care.
* Increasing knowledge of best practice and implement changes relating to psychotropic medications.
* Changing the pain relief process for consumers so it is accessible and adjustable seven days a week.
* Seeking more input from consumers and staff to optimise consumer health and well-being.

Seeking more input from consumers so that their care is more tailored to their needs.

### Requirement 3(3)(e)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Reviewing handover practices and ensure they are occurring and documented consistently.
* Completing training for staff on handover procedures to ensure consistency
* Changing to consumer care requirements are consistently transferred to relevant documents
* Applying the future plan for a dedicated assignment model
* Keeping open conversations with consumers and their representatives regarding individual preferences and ensuring these are clearly and consistently documented.

### Requirement 3(3)(g)

Minimisation of infection related risks through implementing:

1. standard and transmission-based precautions to prevent and control infection; and
2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Implementing the improvement as specified in the outbreak management plan.
* Reviewing and ensuring that the Approved Provider ensures the addition lockdown processes, transferring possible infected consumers to hospital for a pandemic.
* Ensuring consistent records are maintained for staff contact details, rostering and those working across multiple aged care facilities to ensure transmission-based precautions are in place to control infection.
* Ensure consistency with donning and doffing personal protective equipment across all areas of the service.
* Reviewing to ensure practices are in place to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

### Requirement 4(3)(a)

Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Reviewing consumer preferences regularly and making sure they are action and accommodated where appropriate.
* All staff work together to collate and initiate where possible consumer’s needs, goals and preferences.

### Requirement 4(3)(c)

Services and supports for daily living assist each consumer to:

1. participate in their community within and outside the organisation’s service environment; and
2. have social and personal relationships; and
3. do the things of interest to them.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Considering alternate forms of communication to consumers about the changing restrictions on their ability to interact and have external visitors or outings to avoid confusion or lack of knowledge.
* Facilitating and encouraging community participation.
* Accommodating personal interests.

### Requirement 4(3)(f)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Working with consumers to have input into planning menus and their preferences.
* Reviewing the standard of meals for the quality including taste and appearance.
* Considering the use of favourite consumer recipes in menu planning.

### Requirement 6(3)(c)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Ensuring the service in monitoring and responding in a timely manner to complaints including open disclosure.
* Reviewing past complaints to ensure they have been addressed
* Ensuring there are multiple ways (including culturally diverse methods) that a consumer or their representative and staff can raise concerns and know that they will be heard and receive a response.

### Requirement 7(3)(a)

The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Reviewing implementation and maintenance of dedicated assignment as indicated in action plan.
* Continuously improving staffing levels where required and listening to consumer feedback when they comment on staff stress levels and care concerns.
* Finalise recruitment and conduct appropriate onboarding and training ensuring it is completed and reviewed for effectiveness.

### Requirement 7(3)(b)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Developing robust methods for monitoring staff competency and daily care standards provided by staff to consumers.
* Ensuring that staff are provided with an ingrained culture that is positive and supportive of one another to perform to a high standard though many different avenues.
* Listen to consumers and ask for feedback on workforce interactions.

### Requirement 7(3)(c)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Addressing the systemic issue of ensuring staff complete ongoing training to effectively perform their roles.
* Addressing the systemic issue of recording and monitoring ongoing training that is due for completion or has been completed for all staff.

### Requirement 7(3)(d)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Conducting Aged Care Quality Standards training for all staff.
* Consistently providing training for staff in risk management, restraint, open disclosure and complaints, dignity and respect and infection control. Other topics should also be included as deemed necessary by staff and management.
* Tracking the completion of all staff training.
* Tracking training requests and those identified through performance appraisals to ensure they are actioned.
* Ensuring that all staff are consistently supported, trained and equipped to deliver the outcomes required by the standards.

### Requirement 7(3)(e)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

Regularly and consistently assess, monitor and review of the performance of each staff member and ensure it is ongoing, timely and recorded.

### Requirement 8(3)(a)

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

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Continuing and improving consumer meetings to involve consumers and seek feedback.
* Listening to consumers and actioning their ideas so they are engaged in the development, delivery and evaluation of their care.
* Creating the client experience committee which will be led and involve consumers in developing and evaluating care and services.
* Employing a consumer advocate who will help consumers in the development, delivery and evaluation of care and services.

### Requirement 8(3)(d)

Effective risk management systems and practices, including but not limited to the following:

1. managing high impact or high prevalence risks associated with the care of consumers;
2. identifying and responding to abuse and neglect of consumers;
3. supporting consumers to live the best life they can.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Ensuring effective risk management systems and practices are followed through by staff and they are fully aware of the requirements under these systems and practices.
* Staff familiarisation on risk management framework and clinical governance of high impact and high prevalence risks and consumers being supported to live the best life they can.

### Requirement 8(3)(e)

Where clinical care is provided—a clinical governance framework, including but not limited to the following:

1. antimicrobial stewardship;
2. minimising the use of restraint;
3. open disclosure.

The Approved Provider must improve to ensure compliance with the Quality Standards by:

* Increasing awareness of clinical government framework with staff.
* Ensure that staff understand thoroughly and consistently the governance framework around the use of restraint and open disclosure.
* Reviewing and continuously improving clinical governance framework and maintaining evidence in relation to improvements.