Auburn House

Performance Report

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**Commission ID:** 4491

**Provider name:** St Vincent’s Hospital (Melbourne) Limited

**Site Audit date:** 1 March 2022 to 4 March 2022

**Date of Performance Report:** 12 April 2021

# Performance report prepared by

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

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 6 April 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

Representatives said that consumers are treated with respect and dignity by staff. Sampled consumers said that the service supports them to undertake spiritual activities of their choice and other activities which are important for their sense of purpose and wellbeing. Representatives reported that they the information they need about consumers and their care, for example through Resident of the Day phone calls or when they ask for staff directly for information.

The service demonstrated service provision is culturally safe, with care planning documents identified consumers specified cultural needs and while documentation review showed the service celebrates a range of cultural events, including NAIDOC week, Diwali and Chinese New Year. The Assessment Team observed consumers spending time together in the service and reviewed the service’s dignity of risk tool and sampled consumers’ risk assessment documentation, showing that the service supports consumer risk-taking decisions. Clear and accessible information about activities, complaints and feedback, menus and important events were displayed around the service, supporting consumers to exercise choice.

Staff spoke of sampled consumers with respect and demonstrated knowledge of consumers’ circumstances and backgrounds. Staff knew consumers, their life stories and how they like their care delivered. Staff knew consumers’ cultural preferences and described how spiritual needs of consumers are catered for through church services and special celebrations. Staff described how they encourage independence and choice for consumers, for example by supporting consumers to rise for the day when they choose to, or to select the kinds of music they listen to during activities. Staff knew the risks taken by sampled consumers and the relevant safety measures used to support them. The Assessment Team observed staff working with consumers at their pace, responding to consumer requests and encouraging consumer independence where appropriate. Staff-consumer interactions which observed to be patient, gentle and respectful of personal privacy.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 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

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

The Non-compliance is in relation to Requirement (3)(a). I have provided reasons for my finding in the respective Requirement below.

Consumers and representatives were generally satisfied with assessment and planning at the service, stating that they are involved through the initial admission process, the ongoing Resident of the Day program, case conferences and through direct conversations with staff. Representatives confirmed that they are informed of changes to care and were involved in reviews of care plans following incidents and changes in consumer condition. Representatives said they were aware of the contents of consumer care plans and knew what care and services consumers receive and were comfortable to request a copy of the consumer’s care plan if required. Consumers and representatives advised that they had been given the opportunity to discuss end of life planning or indicted that they did not wish to discuss the topic.

Sampled care planning documentation showed that the service effectively identified consumers’ needs, goals and preferences, including medical treatment planning and advanced care / end of life planning. Care plans reviewed by the Assessment Team demonstrated that others are involved in the assessment and planning process, including, for example, medical officers, physiotherapists, dieticians, speech pathologists, psychiatrist, podiatrists and the consumer and representatives themselves. The service has a referral review process in place, to ensue referrals suit consumer need and care plans showed that input from other professionals is added to care plans and implemented in daily care. Care plans showed who consumers wish to involve in their care and planning and contained evidence of regular scheduled and ad hoc review.

Staff knew sampled consumers well and their understanding of key consumer risks, goals, needs and preferences aligned with information in care plans. Interviewed staff were familiar with the care plan review schedule, review processes in place and how the service involves consumers and representatives in the review process. Staff practice in relation to assessment and planning is guided by policies, templates and tools and incidents are recorded in the service’s Incident Management System (IMS). Interviewed staff understood their responsibility in relation to incident management, reporting and escalation.

## 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 service has established processes for undertaking initial assessments on entry to the service, to identify consumer needs, preferences and risks. Sampled consumer care plans were individualised and included risks specific to each consumer, with related assessments also included. Clinical staff understood the assessment and planning process and schedule and sampled consumers were generally satisfied with the assessment and care planning at the service. However, the Assessment Team identified the service does not complete assessments to justify the use of restrictive practices, as required by legislation and by the service’s own Behaviour Management Policy.

Relevant (summarised) evidence included:

* Two consumers, both identified by the service as being chemically restrained, did not have assessments in place for those restraints.
* Three consumers identified by the service as being environmentally restrained (due to having bedroom door locks in place), did not have assessments in place for those restraints.
* All consumers at the service had their beds pushed against their bedroom wall, which the service had identified as a form of restraint. There were no restraint assessments in place for any of the sampled consumers.

The Approved Provider’s response acknowledged some deficits identified by the Assessment Team and outlined the actions taken or planned to address the deficits. Actions include a review of all consumers to identify restrictive practices in place, gain informed consent and attend to required documentation, endorsement of the draft Restrictive Practices Policy, restrictive practices law and policy education for staff and ongoing review of service practice against the policy.

The response also clarified inaccurate evidence in the Assessment Team’s report in relation to one consumer’s bedroom door lock which opens from the inside and the supporting assessment, ongoing review and consent that was in place at the time of site audit. Therefore, I have not considered this information in my finding.

The response also gave some further contextual information about the bed positioning, noting that some consumers had full mobility, others had requested their beds against the wall and that the bed positioning gave maximum space in small rooms. The service acknowledged bed positioning can constitute a restrictive practice and the need for a more effective system for documenting consent for restraints.

I acknowledge the Approved Provider’s response and the undertakings for improvement they have given. However, at the time of the site audit, I find that chemical restraints were used without supporting assessment and the service did not review their impact on the consumers on an ongoing basis, as required. The service did not demonstrate there are assessments to support the environmental restraint for two of three consumers with locks on their doors, and reviews were not conducted.

In relation to the positioning of beds, I find the service did not have informed consents in place for consumers for whom this was a form of restraint. There is also no evidence that the service had assessed the positioning of the bed for each consumer, to ensure that the bed pushed against the wall met their safety needs and other general requirements.

As a result, I find the service’s assessment and planning processes were not effective in identifying, documenting and managing risks posed to the wellbeing of consumers using chemical restraints, the risks inherent in the use of other restraints or the risks posed by having beds pushed up against the wall.

Based on the summarised evidence above I find the service Auburn House, Non-compliant in relation to Standard 2 Requirement (3)(a).

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

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

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

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

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

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

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

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

# STANDARD 3 NON-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

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

The Non-compliance is in relation to Requirements (3)(a) and (3)(d). I have provided reasons for my finding in the respective Requirements below.

In relation to the remaining Requirements in this Standard, the service is compliant.

Consumers and representatives said they were mostly satisfied with their care and services. Representatives sampled were confident the service would support consumers appropriately when end of life care is required. Interviewed representatives considered that consumer needs and preferences are communicated effectively between staff at the service and staff know consumers and their requirements. Sampled consumers and representatives confirmed referrals are made to Medical Officers, specialists and other professionals as needed.

The service has a risk management framework and demonstrated it effectively manages the high impact and high prevalence risks relevant to sampled consumers. Review of care planning documentation showed that the service identifies risks and implements minimisation strategies in relation to, for example, swallowing and choking risk, diabetes management, behaviour and falls. Incidents at the service are recorded in an Incident Management System (IMS) and responded to appropriately, to reduce risk of recurrence. Care planning documentation contained evidence of end of life planning and Advanced Care Directives and reflected input from a range of health and allied health professionals. Appropriate referrals were noted, in response to changes in consumer condition and incidents, and progress notes, care plans and Assessment Team observations demonstrated the service effectively shares information about consumers care needs and preferences between staff and with others involved in care. The service monitors and reports against consumer infections on a monthly basis, has policies and procedures to respond to an outbreak and conducts internal infection control audits.

Interviewed staff knew the individual risks for sampled consumers, the risk minimisation strategies used and could outline how changes in consumer needs, condition, and preferences are communicated throughout the service and to others involved in care. The service uses handovers, care plans and the electronic care management system (ECMS), meetings, memoranda and emails to keep staff abreast of such changes. Staff described how information is shared when referrals are made and how the input of other professionals is incorporated in consumer care. Interviewed staff demonstrated their understanding of infection prevention and minimisation, and antimicrobial strategies that are used at the service.

### 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 the service’s use of restrictive practices was not aligned with best practice as it lacked assessment, informed consent and ongoing review for numerous consumers. Relevant (summarised) evidence included:

* The service’s restraint register lacked detail about chemically restrained consumers and did not list three consumers subject to environmental restraints due to locks installed on their bedroom doors.
* Each consumer’s bed is placed against a wall, which had been identified as a restraint, but which was later said to be a result of space limitations.
* The Assessment Team noted there had been no assessments carried out to support the use of the restraints mentioned above, as well as for two consumers with low bed restraints.
* Informed consents had not been gathered for restraints identified above.
* The service did not routinely review the need for any of the restraints outlined above and there was no regular review schedule with the service psychiatrist.
* Sampled care plans did not contain consistent monitoring for effectiveness of chemical restraints.
* In relation to a sampled consumer, Consumer A, the Assessment Team’s review of their care plan showed that:
	+ The service did not consistently use non-pharmacological strategies prior to the use of ‘as needed’ psychotropic medications and the service’s system for recording and monitoring non-pharmacological strategies was not always followed correctly.
	+ Until January 2022, the consumer was frequently administered ‘as needed’ risperidone. In February, ‘as needed’ oxazepam became the most frequently used medication. The change in practice was triggered when the consumer’s representative complained about the consumer being drowsy during conversation. A review was conducted, and the representative confirmed the consumer is no longer drowsy.
	+ The consumer had been administered ‘as needed’ oxazepam in the hours before and after some falls in February. The service did not recognise or investigate for correlation with the introduction of ‘as needed’ oxazepam.
	+ On two occasions in February, the consumer was administered risperidone and staff had not explored the less restrictive medication options first. On both occasions, the Assessment Team considered that the consumer’s behaviour did not align with the indicated behaviours in the medication charts.
	+ Clinical staff were aware of Consumer A’s increased use ‘as needed’ oxazepam but did not escalate to the psychiatrist for review.
* Consumer B was administered PRN oxazepam on 12 occasions and prior non-pharmacological interventions were not consistently used or documented on each occasion.
* Other evidence that the Assessment Team relied upon has not been included here, as has been considered in other Requirements, where it is more relevant.

In their response, the Approved Provider acknowledged some deficiencies identified by the Assessment Team and did not address others. The response included a plan address the deficits, which includes a review of all existing environmental and chemical restraints, ensuring restraints are used with consent and after prior non-pharmacological interventions are used and documented, further training for staff in the service’s system for documenting prior strategies and training to recognise signs of deterioration following introduction of new psychotropic medication.

In relation to Consumer A, the response acknowledged staff had not recognised the potential correlation between the administration of PRN oxazepam and the consumer’s recent falls. However, they noted the consumer was reviewed by their GP on the day of each fall, the day between the falls and afterwards, as staff recognised the consumer’s declining mental state and escalating behaviours.

The response also provided some clarifying information in relation to other findings, which I have considered in relation to Requirement 2 (3)(a) and clarifying information relating to other deficits identified in the Assessment Team’s report. I acknowledge the Approved Provider’s response and have therefore not considered that evidence provided by the Assessment Team in reaching my decision.

While I acknowledge the Approved Provider’s response and the planned improvements, I find the service is Non-Compliant with this Requirement, for the reasons outlined below.

There is no evidence to show the service had assessed the positioning of the beds to ensure they met both the safety needs of each individual consumer, and their other general needs, including in relation to restraints.

As noted in relation to Standard 2, Requirement 3 (a), two of three consumers with bedroom locks installed were environmentally restrained, there were no assessments in place to justify the practice or assess the risks associated with it, and there was no informed consent or ongoing review of the door locks to determine efficacy or impact on those consumers. As a result, I accept that those consumers’ restraints were not aligned with best practice and were not compliant with regulatory requirements.

I accept the service had Consumer A reviewed by their Medical Officer following their falls. However, there is no evidence they requested the medical officer review the oxazepam use in light of the possible correlation between its use and the consumer’s falls. There is also no evidence the service was monitoring the impact of the chemical restraint on the consumer, in line with best practice. The service also failed to consistently try non-pharmacological strategies with Consumer A, before using chemical restraints, and on two occasions used risperidone without first considering the use of less restrictive oxazepam. I have considered other evidence about the service’s handling of the consumer’s ‘as needed’ risperidone use, under Requirement (3)(d) below.

The service also failed to consistently use and/or document the use of non-pharmacological strategies in relation to Consumer B and failed to assess the need for chemical restraints for Consumers B and two others. Finally, the service failed to assess, monitor and review the need for low-low bed restraints for two consumers and had no informed consent in place for them.

The omissions outlined above demonstrate the service did not ensure that each consumer received effective clinical care that was tailored, and which optimised their health and well-being. As a result, I find the service is Non-compliant with this Requirement.

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

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

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

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

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

The Assessment Team found the service could not demonstrate that deteriorations and changes in consumer mental health, cognitive or physical function, capacity or condition is consistently recognised and responded to in a timely manner. Relevant (summarised) evidence included:

* Consumer A had a fall on two consecutive days in early February and was not reviewed by a physiotherapist until eleven days later. A falls risk assessment and clinical review were immediately completed, along with pain charting which showed nil pain following the falls.
* As outlined previously at Requirement (3)(a) in this Standard, a possible correlation between Consumer A’s falls and administration of ‘as needed’ oxazepam had not been recognised or investigated by the service.
* Clinical staff were aware of Consumer A’s increased ‘as needed’ risperidone use but did not escalate the matter for review by the psychiatrist.
* The consumer presented as drowsy during conversation with a representative in the months prior to the Site Audit and the consumer’s risperidone use was only reviewed by the psychiatrist after the representative complained.

In their response, the Approved Provider acknowledged there may have been a correlation between Consumer A’s falls and the change from risperidone to oxazepam as the key ‘as need’ anti-psychotic medication but did not respond to other evidence of Non-compliance outlined above. The Approved Provider gave an undertaking to implement the following planned improvements, through the service’s Plan for Continuous Improvement (PCI):

* Training for staff on assessment, monitoring and responding to consumer deterioration.
* Training for clinical staff relating to the requirements for documentation, referral content and progress notes.
* Training for registered staff on potential side-effects of psychotropic medications.

I acknowledge the service’s plan to address the deficits identified by the Assessment Team in relation to recognising and responding to consumer deterioration. However, at the time of the site audit the service did not ensure that Consumer A’s referral to a physiotherapist occurred in a timely manner, or that an escalation to the psychiatrist was actioned once clinical staff had recognised the consumer’s ‘as needed’ risperidone use had increased.

As a result, I find that at the time of site audit, the service did not always recognise and respond to changes or deterioration in the consumer’s mental health, cognitive or physical function, capacity or condition. Consequently, I find the service is not compliant with this Requirement.

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

Consumers said they participate in activities for daily living that they enjoy, including group and individual activities. A consumer and a representative advised the service caters for the spiritual well-being of consumers, with an onsite Pastoral Care worker and a visiting priest. A representative explained that the service supports their family member to keep in touch through phone calls and, during lockdowns, via window visits, and that they support the consumer to read and watch the musicals they enjoy. Consumers interviewed were generally satisfied with the quality and quantity of the meals provided.

The service has established processes for identifying consumers’ social, emotional and psychological needs and preferences. Upon entry to the service, an assessment takes place to identify consumer interests and a lifestyle plan is developed, then reviewed. Consumers are involved in development and evaluation of the lifestyle program, with consumers having a communication impairment being supported with visual cues to choose activities for inclusion in the program. The Assessment Team observed consumers participating in a range of activities during the Site Audit. Consumers access external services and supports as needed for emotional, pastoral and behaviour support.

Interviewed staff knew the sampled consumers well, and described their favourite activities, spiritual requirements, therapeutic needs, important relationships and consumers’ communication, mobility and support needs. Staff outlined the external services that are engaged to support consumer well-being, the service’s system for purchasing lifestyle equipment and the maintenance program at the service.

Consumers’ care planning documentation included detailed information about preferred activities, spiritual, psychosocial and emotional support needs as well as the strategies staff should use to support them as they participate in lifestyle activities and outings. Care plans contained detailed behaviour support strategies for sampled consumers, emotional support instructions and detailed descriptions of sampled consumers’ dietary requirements and preferences and the information is available to food service staff. Meal times were observed to be relaxed and orderly, meal options were available, and consumers were supported as needed and equipment was observed to be well maintained, clean and suitable.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Representatives interviewed said that the service was welcoming, safe and clean. They considered that consumers enjoy living there.

The service consists of three wings, with each having consumer bedrooms laid out around common areas. Each wing has a dedicated kitchen, dining room and lounge area. Consumer rooms were personalised, and the service buildings are surrounded by gardens, which feature shaded areas for consumers and a designated smoking area. Consumers were observed moving about freely inside the service, with wide, uncluttered corridors promoting consumer mobility. Access to the garden is unrestricted with consumers observed using the outdoor areas for various activities, including gardening and painting.

Staff are encouraging and welcoming of visitors to the service and outlined that consumers are encouraged to personalise their rooms with familiar items. Staff and said that maintenance issues are reported and fixed, and described their furniture, fittings and equipment cleaning tasks.

The service has scheduled cleaning and reactive maintenance programs in place, with staff at the service are able to log requests with the organisation’s wider engineering and maintenance department.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 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

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

The Non-compliance is in relation to Requirement (3)(d). I have provided reasons for my finding in the respective Requirements below.

Sampled representatives said they are encouraged to provide feedback and that they would raise any concerns verbally or by completing a feedback form. While sampled representatives said they were aware of external ways to make a complaint, all indicated they were comfortable raising concerns directly with staff or management. Representatives gave examples of times they had voiced concerns to the service, however one representative expressed that their concerns about the laundry service had not been addressed after they raised the issue.

The service demonstrated it has an established complaints and feedback system, supported by a complaints management policy and procedure. Consumers and representatives can provide feedback through a variety of means, including through feedback forms, verbally to staff or management or through representative meetings. The service displays information about translation and interpreting and advocacy services on noticeboards and includes information about both internal and external complaints mechanisms in the consumer handbook which provided upon entry to the service.

Staff had shared understanding of the complaints and feedback system and could describe how they support consumers who require assistance to complete feedback forms or raise concerns. Staff understood external complaints avenues and described how consumers with a need are supported to access interpreters where necessary. In relation to open disclosure, although management demonstrated an understanding of the concept, it was noted that training in the topic was only provided to the nursing unit manager and assistance manager. While staff were able to describe how they would respond to a consumer complaint by addressing the issue or escalating to management, staff did not mention apologies as part of their process for responding to complaints. It was noted, however, that service policy and procedure includes open disclosure processes.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team found the service could not demonstrate their feedback and complaints system is used in continuous improvement in care and service delivery. Relevant (summarised) evidence included:

* The service’s continuous improvement register did not contain complaints documented on the complaints register, how they were resolved, or any improvement actions taken as a result.
* The complaints register did not contain verbal complaints made directly to staff, or complaints raised in consumer meetings. The register also did not show if actions taken had resolved the issues from the perspective of the complainant. Management acknowledged that verbal complaints and feedback are not captured or evaluated in the service’s continuous improvement system.
* Although the service seeks feedback through quarterly consumer surveys, these had not been consistently carried out in the past year.
* The Assessment Team was advised that any major concerns raised through the survey, such as a consumer feeling unsafe, would be documented in the IMS. However, the Assessment Team noted that feedback about feeling unsafe had been raised by a minority of consumers in a recent survey, but there were no corresponding IMS entries documenting the concerns.

In their response, the Approved Provider gave further descriptive information about feedback and complaints mechanisms in place at the service and acknowledged the deficits identified by the Assessment Team. The response contained a PCI which identified planned and implemented actions, including:

* Reinstating the resident experience surveys, to occur quarterly.
* Providing additional training to ensure staff know how to enter complaints and feedback into the Incident Management System.
* A new Audit Results Matrix and Continuous Improvement planning board to monitor trends, guide the service’s response to consumer survey results, decide the appropriate level of response concerns and to track improvement actions.

I acknowledge the Approved Provider’s plan to address the deficiencies identified by the Assessment Team. However, I find that at the time of the site audit, the service was not effectively using the feedback and complaints gathered to inform improvements at the service level. Verbal complaints were not captured and used to drive continuous improvement, the organisation’s requirements for gathering and recording feedback and concerns was not followed, the complaints register contained insufficient detail to perform its function and the continuous improvement register did not contain complaints listed in the complaints register. There was also no evidence that complaints and feedback were being regularly reviewed or trended, prior to the site audit. As a result, I find the service’s system to convert feedback and complaints into tangible continuous improvement activities was not effective and the quality of care and services is not improved as a result of complaints and feedback.

As a result, I find the service is Non-compliant with this Requirement.

# STANDARD 7 NON-COMPLIANTHuman resource

# Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Non-compliance is in relation to Requirements (3)(d) and (3)(e). I have provided reasons for my finding in the respective Requirements below.

In relation to the remaining Requirements, the service is compliant.

Consumer representative feedback against this Standard was generally positive and indicated that consumer’s get the care they need from a workforce that is competent, skilled and caring. Representatives considered consumers are well-looked after, the staff are friendly and helpful, and they value that staff are all qualified nurses with experience in mental health.

Staff feedback against this standard was mixed, with most staff interviewed saying the staff to consumer ratio at the service was sound and staff numbers are adequate. However, one clinical staff member expressed there had been ongoing issues with filling vacant shifts which at times had resulted in consumer care being compromised, but no specific harms to consumers were identified because of this. Management acknowledged the service sometimes struggled to fill unplanned leave shifts, however the service utilises agency staff to address this issue. Difficulties in recruiting suitable qualified staff with prior experiencing in mental health was also cited as a recruitment challenge, noting that the service uses only registered staff (ENs and RNs) in provision of care to consumers.

Observations by the Assessment Team showed that consumer-workforce interactions were kind, gentle and unrushed, and where there were unplanned leave shifts during the Site Audit period, the Assessment Team observed management taking steps to fill them by moving shifts around and using agency staff. It was noted the service has established processes in place to track staff worker screening clearances, APRHA registrations and COVID-19 vaccination statuses.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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.*

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

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

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

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

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

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

The Assessment Team found the service’s workforce is not adequately trained to deliver the outcomes required by these Standards. Relevant (summarised) evidence included:

* Evidence of various trainings completed by staff was not provided to the Assessment Team during the Site Audit, with information being stored in different areas.
* Some clinical staff could not recall any training in antimicrobial stewardship, restrictive practices or open disclosure. Management could not recall restrictive practices or open disclosure training.
* The Assessment Team requested evidence to show how management tracks staff training completion, but this was not provided.
* Some staff could not demonstrate awareness of open disclosure principles and one staff member said there were no restrictive practices used at the service.
* In-house training had been delivered in relation to elder abuse, the Serious Incident Reporting Schemes (SIRS), the Quality Standards and Continuous Improvement but low levels of staff attendance were recorded, particularly in relation to the elder abuse session.
* Open disclosure training was only offered to Nursing Unit Managers and Assistant Managers, not all staff.
* The Open disclosure training consisted of a one-page information handout only.

In their response, the Approved Provider acknowledged some of the deficiencies identified by the Assessment Team and did not respond to or acknowledge others. Relevant (summarised) arguments and further contextual information provided included:

* The service tracks whether staff have completed training via a dedicated platform that is separate to the training platform itself. Managers are required to report against mandatory training completion rates for staff.
* There are local daily ‘huddles’ at the service, aimed to support staff learning in a real time environment. These are facilitated by management or Nurse-In-Charge.
* While formal training on antimicrobial stewardship, restrictive practices and open disclosure has not yet occurred for all staff, there has been informal awareness raising on those topics using tools and resources from the state government’s Pubic Sector Residential Aged Care Services (PSRACS) bulletin and other resources.

The response also included a PCI, with planned actions to address the deficits, including completion of training on antimicrobial stewardship, SIRS, elder abuse, restrictive practices and open disclosure for relevant staff and review of the service’s systems for monitoring staff completion of training. The plan also notes that SIRS and Elder Abuse training will be incorporated into orientation and mandatory annual training.

I acknowledge the Approved Provider’s response and their planned actions to address the deficits identified during the Site Audit. I also acknowledge the service has established formal and informal training forums in place, which support staff in their roles. However, at the time of the site audit, the service had multiple deficits in staff understanding and skills relating to topics essential for the delivery of care and services that are compliant with these Standards. I accept that staff had either not been adequately trained and/or that insufficient numbers of staff had completed training in relation to antimicrobial stewardship, open disclosure principles and restrictive practices.

I also find that while the service may have had implemented systems and electronic platforms for monitoring training completion, there is no evidence to show that the service was effectively using those tools to track training completion rates and take action when it was identified that staff had not completed mandatory trainings.

As a result, I find staff at the service were not adequately trained to perform effectively in their roles. There is also no evidence the training provided was monitored for effectiveness and as a result, I consider staff were not provided the support to deliver the outcomes required by these Standards.

I find the service is Non-compliant with this Requirement.

### 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 did not have a policy or procedure to guide management in the regular monitoring and performance assessment of staff. Relevant (summarised) evidence included:

* Management confirmed there is no formal performance monitoring process, and monitoring occurs informally, through feedback from other staff members.
* Management advised of an online performance appraisal process used at the service, with appraisals in the process of being completed.
* There is no formal policy concerning performance appraisals.
* Two interviewed staff were not familiar with the process described by management, neither could recall their last performance review and one mentioned that they had received an email that day about the new process described by management.
* The Assessment Team requested information about the percentage of performance reviews that had been completed but the information was not provided during the site audit.
* The Assessment Team asked repeatedly for evidence of the performance reviews for two sampled staff members. When information was eventually provided, the performance review for one sampled staff member was included, but information for the second staff member was omitted. A performance review for a different staff member, dated February 2019, was instead provided.

In their response, the Approved Provider acknowledged some of the deficiencies identified by the Assessment Team and did not respond to or acknowledge others. Relevant (summarised) arguments, planned improvements and further contextual information provided included:

* The organisation’s performance review policy was being reviewed at the time of site audit and has since been updated, published on the organisation’s intranet and promoted with staff.
* The remaining staff appraisals are scheduled for completion prior to June 2022, with monitoring and tracking to occur using the established staff huddles, monthly organisational level quality and safety committee meetings and existing online systems.

I acknowledge the actions the service has already taken and the improvement actions they have planned to address the deficits identified in the site audit report. However, while the service has systems in place, supported by organisational policies and procedures to review staff performance annually, at the time of the site audit the system was not being used effectively to monitor the performance of staff. Performance appraisals were significantly behind schedule and staff were unaware of the performance appraisal process outlined by management.

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

# 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

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

The Assessment Team recommended Requirements (3)(a) and (3)(e) in this Standard as Non-compliant. Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement (3)(a) to be Non-compliant but I have reached a different decision than the Assessment Team in relation to Requirement (3)(e). I have provided reasons for my finding in the respective Requirements below.

The service is part of a wider organisation, whose governing body is underpinned by subcommittees, the organisation’s Executive Leadership Team and the CEO. Clinical Governance activities are distributed across various governance areas including risk, finance and legislative compliance programs. The governing body receives quarterly reports on Quality Indicators and deals with escalated high-risk issues. Management gave a specific and recent example of Board involvement with the service to improve safety, leading to emergency works being carried out in one of the wings of the service, to address a mould issue. The service, led by the governing body’s Aged Care Committee, has established a new Aged Care Subcommittee in response to the Aged Care Royal Commission.

The Assessment Team found the service has effective, organisation-wide governance systems in place regarding information management, with the service using a range of information technology systems to store and manage data. The service has a continuous improvement plan aligned with the Quality Standards, and there are financial delegations in place, with expenditure authority linked to particular roles in the organisation. Management was able to provide examples of recent expenditure on consumer-specific needs. The service is supported by the organisation to learn about changes in compliance requirements, and to update policies and procedures as required.

The service has effective governance systems to manage risks including in relation risks associated with care of consumers and recognising and responding to abuse and neglect of consumers. The service has an incident management system to identify, report, action and monitor consumer incidents which is used to identify and report serious incidents. The service has a clinical governance framework which guides the minimisation of restraint, supports antimicrobial stewardship and use of open disclosure, however the service does not consistently implement the policies and procedures.

## 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 the service could not demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are not supported to do so. Relevant (summarised) evidence included:

* Consumer feedback is not being sought as regularly as required by the service’s own policy and procedure. For example, the last resident meeting minutes were from October 2021, when the terms of reference for the committee require the meetings be held monthly. The most recent lifestyle activity evaluation form was from December 2021.
* Resident surveys and results requested by the Assessment Team were not provided during the site audit.

In their response, the Approved Provider acknowledged some of the deficiencies identified by the Assessment Team and provided further contextual information. Relevant (summarised) arguments, planned improvements and information provided included:

* The service engages consumers through resident and representative meetings, quarterly consumer surveys, suggestions boxes, newsletters, emails and through the organisation’s patient liaison officer.
* The response noted that consumer meetings have resumed, and it acknowledged that resident surveys had not been conducted as frequently as the organisation requires but have now been reinstated in line with organisational policy.
* The response acknowledged the organisation’s expectation that all feedback is entered in the IMS had not been met by the service, and reiterated that training is planned for staff to address this.

I acknowledge the Approved Provider has existing organisation expectations, standards and guidelines to direct how the service includes consumers in the design, delivery and evaluation of care and services. However, at the time of site audit, the service was not consistently following the organisation’s standards and expectations. I also note the service’s existing governance arrangements had either not identified this deficit or had identified it but had not acted to address it.

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

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

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

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

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

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

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

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

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

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

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

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

The Assessment Team found the service does not have a clinical governance framework that encompasses antimicrobial stewardship, minimising the use of restraints and open disclosure. Relevant (summarised) evidence included:

* The service has no antimicrobial stewardship policy in place and staff interviewed could not recall ever having received training on it.
* Staff also could not recall having received training on open disclosure or restrictive practices.
* Restrictive practices systems at the service were not effective and did not support effective governance. For example, the restrictive practices register did not contain names of prescribed medications or the last review date. The register also did not identify all forms of restraint at the service. Where restraints had been identified and placed on the register, there was not always an assessment supporting the use of the restraint, or informed consent gathered.
* The service’s behaviour management policy reflected the old standards, though an updated policy in draft format was provided.
* The service did not follow the organisation’s behaviour management policy which outlined that restrictive practices should be supported by relevant assessments justifying their use.
* The service’s policy on minimising the use of restraint had not yet been endorsed and was not in place.

In their response, the Approved Provider acknowledged the deficiencies identified by the Assessment Team, however provided further contextual information which was relevant to my decision. Relevant (summarised) evidence included:

* The organisation has an antimicrobial stewardship policy in draft format, that is being developed in consultation with the organisation’s Senior Pharmacist for Antimicrobial Stewardship, Infection Control Department, site managers, site Infection Prevention and Control (IPS) leads and the organisation’s IPC Lead Group. The organisation is in the process of implementing a range of infection control and prescribing audit tools.
* The Medication Advisory Committee (MAC) meetings have resumed, after being paused in 2021 for a terms of reference review and to develop a new reporting platform.
* Restrictive practices auditing occurs through the PSRACS program and psychotropic medication auditing occurs through an external independent auditing program which generates reports and feedback to prescribers.
* The response acknowledged that streamlining and standardising of the auditing data they capture is required, and a draft policy to support this has been developed and is awaiting endorsement.
* There is an organisational required learning policy, which specifies the learning and development required for the different clinical disciplines. It defines mandatory training, how training is delivered, monitored and recorded.
* The service had a training calendar developed in relation to Aged Care Standards, SIRS and clinical assessments, with training being delivered from July 2021. The response acknowledged that the calendar did not adequately document staff attendance.
* The response acknowledged there was no formal training on AMS, Restrictive Practices and Open Disclosure, but noted the informal awareness raising efforts that had taken place, using tools and resources disseminated via the PSRAC bulletins and from a leading aged care training provider.

The Approved Provider’s response acknowledged the clinical governance framework is in development and outlined the improvements already implemented and/or planned to address deficiencies identified by the Assessment Team. Relevant improvements include endorsing and implementing the antimicrobial stewardship policy and restrictive practices policy currently in draft format, introducing new audit procedures, expand open disclosure training to all staff and reviewing the system for recording staff training attendance.

Although the response acknowledged the deficiencies identified by the Assessment Team, I disagree with the Assessment Team’s recommendation. I find that the Service, supported by the wider organisation and through its inclusion in the PSRAC, had a clinical governance framework in place at the time of site audit, which features policies and governance relationships relating to antimicrobial stewardship, open disclosure and minimising the use of restraints. While I note some policies were in draft format, I find the service is compliant with the wording of this requirement.

Finally, I note the wording of this Requirement does not mention effectiveness of the clinical governance framework, only that the service must demonstrate they have one. I find that shortcomings in staff training and knowledge gaps are more relevant to Requirement 7 (3)(d) where they have been assessed, and that effectiveness of the clinical governance framework is not a focus of this requirement.

I acknowledge the Approved Provider’s commitment, and efforts to date, to address the issues highlighted by the Assessment Team. I find the planned and implemented improvements identified by the Approved Provider, and the normal governance process the organisation is following to update existing polices, develop new ones and to have these endorsed, satisfies this Requirement.

For the reasons detailed above, I find the service is Compliant with this Requirement.

# Areas for improvement

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

Standard 2 Ongoing assessment and planning with consumers

* Requirement (3)(a) Ensure assessments and plans are completed in line with the organisation’s procedure and regulatory requirements for restrictive practices. Ensure risks related to bed positioning are assessed and restrictive practices are supported by assessments, used with informed consent and only as a last resort.

Standard 3 Personal care and clinical care

* Requirement (3)(a) Ensure each consumer gets safe and effective clinical care which is in line with best practice and the consumer’s needs. Ensure staff practice in relation to restrictive practices, particularly chemical restraints and psychotropic medication use, are in line with best practice, regulatory requirements and the service’s own procedures.
* Requirement (3)(d) Ensure deterioration or change in consumer’s physical or mental condition is recognised and responded to appropriately and in a timely manner.

Standard 6 Feedback and complaints

* Requirement (3)(d) Ensure feedback and complaints from all sources are reviewed, trended and used to inform continuous improvements efforts.

Standard 7 Human resources

* Requirement (3)(d) Ensure staff are provided sufficient training where deficits in staff knowledge and practice have been identified. Ensure training completion is monitored and actioned where necessary.
* Requirement (3)(e) Ensure ongoing monitoring and review of staff practice and performance occurs to identify deficits, areas for improvement and opportunities for further training and support. Ensure performance appraisals are brought up to date and remain up to date.

Standard 8 Organisational governance

* Requirement (3)(a) Ensure consumer and representative feedback and complaints from all sources are used to inform continuous improvement efforts.