Blue Care Warana Beachwood Aged Care Facility

Performance Report

124 Nicklin Way
WARANA QLD 4575
Phone number: 07 5490 2100

**Commission ID:** 5185

**Provider name:** The Uniting Church in Australia Property Trust (Q.)

**Site Audit date:** 15 November 2021 to 18 November 2021

**Date of Performance Report:** 24 December 2021

# Performance report prepared by

N.Grey, 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) | 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) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant  |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | 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** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-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 14 December 2021
* other information and intelligence held by the Commission in relation to the service.

# 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

Consumers interviewed by the Assessment Team said they are treated with dignity and respect, and are supported to live the life they choose, including when they choose to do something that involves risk. They said they are provided with information that is accurate, current, timely and supports them to make informed decisions and exercise choice.

Consumers/representatives said staff know the consumers as individuals, including what is important to them, treat consumers in a dignified and respectful manner, and deliver culturally safe care and services. Consumers described the ways their social connections are supported, both inside and outside the service, and said they are supported to be independent and are encouraged to do things for themselves.

Staff interviewed spoke about consumers in a familiar, caring and dignified manner. Staff demonstrated knowledge of what is important to each consumer and could describe how they ensure consumers’ preferences and choices are supported and respected.

Lifestyle staff described the assessment process and said that on entry to the service, information is gathered in relation to the consumers’ spiritual and cultural needs and preferences and that this information is used to inform the delivery of culturally safe care.

Registered staff said assessments of risk-taking activities occur on entry to the service (in consultation with the consumer/representative and appropriate health professionals) and are reviewed three monthly or more often as required. Risks are discussed with the consumer/representative to provide the opportunity for choice and informed decision-making related to the consumer’s care and services.

Care planning documentation generally provided guidance to staff regarding who and what is important to the consumers and their individual preferences in relation to care and services. Documentation demonstrated communication barriers, such as impaired vision and hearing, is captured, along with corresponding strategies to support consumers’ communication needs. The Assessment Team brought forward information that lifestyle assessments had been completed for consumers however this information had not consistently been reflected in care plans. This was raised with the management team, addressed during the Site Audit and is considered further under Standard 2. Electronic and hardcopy documentation is protected to ensure confidentiality of consumer information.

Staff were observed greeting consumers and visitors with familiarity and interacting with consumers in a dignified and respectful manner. They were able to explain how they supported consumers to maintain significant relationships.

Staff demonstrated respect for each consumer’s personal privacy by knocking on doors before entering their rooms and speaking quietly or moving to a private area when needing to discuss consumers’ care needs.

Policies and procedures relevant to this Standard are available to guide staff and include diversity and inclusion, privacy, confidentiality, understanding sexualities and supporting sexual expression, and choice and decision making.

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

## 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

Consumers/representatives said they were involved in initial and ongoing assessment and planning of the consumers’ care and service requirements. They said they are informed of the outcomes of assessment and planning and are generally informed when there is a change in the consumer’s condition or an adverse event impacts on the consumer’s needs.

Consumers/representatives said they can request a copy of the consumer’s care plan and would feel comfortable doing so.

Assessment and care planning documentation reviewed by the Assessment Team demonstrated that consumers, representatives, medical officers and allied health professionals were involved in planning care. Individual risks to the consumer’s health and well-being were identified in assessment processes and care plans demonstrated consideration of advance care and end of life planning.

Care planning documentation included evidence that care was reviewed when the consumer’s circumstances changed or following an incident.

Staff explained assessment and care planning processes and said they used a suite of validated assessment tools and considered the consumer’s medical history when identifying risks and care needs. Staff were able to describe what is important to consumers in terms of how their personal and clinical care is delivered.

Registered staff explained how they approach end of life discussions with consumers and their representatives and how this information is made available to staff. They said they complete a review of the consumer’s care needs routinely three monthly and when there is a change in the consumer’s condition, when the consumer experiences an incident and on return from hospital.

Policies, procedures and flowcharts relevant to this standard guide staff and include advance care planning and clinical referral.

However, the Assessment Team found that care plans for some consumers were incomplete, did not reflect the outcomes of assessment and care planning and did not contain current information to guide and support staff in the delivery of care.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

### Requirement 2(3)(d) 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 reviewed electronic and hardcopy assessment and care planning documentation and identified that in some instances care plans did not accurately reflect consumers’ personal and clinical care requirements, nor the strategies to support and manage those care requirements. While assessments had been completed, care plans were incomplete for some consumers and did not include detailed information to manage risk or guide care delivery.

The Assessment Team identified deficiencies in the care plans for sampled consumers including those at risk of pressure injuries or falls, consumers with specialised nursing care needs and consumers with complex behaviours. While lifestyle assessments had been completed for consumers, none of the sampled consumers had lifestyle care plans in place.

Care staff advised they have access to care plans via the electronic care management system and can also access printed copies located in each care unit. However, care staff said they do not have access to completed assessments within the electronic care management system and therefore rely on information in the care plan or received through handover, to understand consumers’ care needs.

The Assessment Team reviewed hardcopy care plans in each care unit and identified care related information was missing from the documents or the information was not current. This was raised with staff by the Assessment Team who acknowledged that information held within the hardcopy care plans was not always reflective of consumers’ current care needs.

In response to feedback from the Assessment Team during the Site Audit, management completed a review of all care plans and updated them to reflect current assessments.

The approved provider in its response provided a plan for continuous improvement and evidence to demonstrate actions had been taken in response to identified deficiencies. This included a clinical review of consumers to ensure that assessments have been activated in to the care plans. Clinical staff and care staff have received additional education relevant to their roles. Education has included roles and responsibilities, clinical information systems, management of complex behaviours and other care related areas. In addition to this, work instructions were being developed to ensure that care plans are updated in a timely manner following review by allied health professionals.

I note the approved provider accepts that assessment information had not been consistently reflected in care plans. It states though that this information is available to all care and clinical staff although acknowledges that some staff may not have had the knowledge required to access assessments in the information system.

While I acknowledge the actions taken by the service at the time of the Site Audit and those reflected in the approved provider’s response to the Assessment Team’s report, I am satisfied the service was not able to demonstrate that the outcomes of completed assessments were consistently documented in consumers’ care plans. Current information was not available to relevant staff to support the delivery of safe and effective care and services.

I find this requirement is Non-compliant.

### 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

Consumers and representatives were generally satisfied with the personal and clinical care provided to consumers. They confirmed there is access to medical officers and other health professionals when a need is identified including following an incident or a deterioration in the consumer’s health and well-being. Most consumers said they had been involved in discussions with staff regarding end of life care and advance care planning and were confident the service will support them and maximise their comfort as they approach end of life.

Staff were able to explain how they seek support from senior clinical personnel, medical officers and other health professionals in the event of an incident or change in a consumer’s health and well-being.

The service demonstrated that actions have been taken to minimise infection-related risks, including a potential outbreak of COVID-19. An outbreak management plan is in place, an infection prevention and control lead has been nominated, and vaccination rates for seasonal influenza and COVID-19 are tracked. Staff had a shared understanding of the precautions used to prevent and control infections and they steps they take to minimise antibiotic usage.

However, the Assessment Team brought forward information that in some instances consumers were not receiving care that was tailored to their needs and optimised their health and well-being with deficits identified in areas including skin care, wound care and the management of restrictive practices.

Strategies to minimise high impact or high prevalence risks were not consistently detailed in care plans and in some instances staff did not have a shared understanding of consumers’ care requirements.

The Quality Standard is assessed as Non-compliant as two 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 service was not able to demonstrate that each consumer receives safe and effective personal and clinical care that is tailored to their needs, reflects health care directives and optimises their health and well-being.

Strategies to promote skin care and minimise the risk of pressure injuries are not being consistently implemented. The Assessment Team found care plans did not include current strategies staff were using to promote skin integrity and repositioning charting was not being completed. Staff did not demonstrate a shared understanding of consumer’s personal care needs, including in relation to pressure area care and reported that pressure area care is not consistently occurring as directed. A representative told the Assessment Team that when they visited their consumer, who is at risk of pressure injuries, they had observed that their required pressure relieving devices were not in place.

Organisational strategies to promote wound care and monitor the healing process are not being followed. The Assessment Team found staff were not consistently photographing and measuring wounds in accordance with organisational processes and wound descriptors were not being consistently documented. An incident where a wound had deteriorated was not escalated appropriately and in one instance a consumer with complex wounds had not been referred to a wound specialist in a timely manner.

The Assessment Team reviewed care planning documentation for consumers who are subject to restrictive practices and identified that for some consumers consent forms and authorisations lacked detail and had not been signed by the substitute decision maker, additionally there was an absence of evidence that a discussion about the risks associated with restrictive practices occurred. In other cases, there was no evidence of the involvement or consent of the consumer and/or the substitute decision maker. Three representatives of consumers who are subject to restrictive practices were interviewed by the Assessment Team and all provided inconsistent information in relation to their involvement in discussions regarding the use of restrictive practice and whether they had consented to its use.

For some consumers subject to restrictive practice, the Assessment Team found that behaviour support plans were not in place and care plans did not include information to guide staff when delivering care.

Inconsistent documentation was identified in areas relating to the monitoring of fluid intake, blood glucose levels and repositioning, impacting the ability of staff to monitor care delivery. Some staff reported they are unable to effectively monitor care delivery as documentation including repositioning charts are not being consistently completed. While the approved provider in its response states that regular charting for some named consumers was occurring, limited evidence of this was provided.

The approved provider’s response includes an action plan to address deficiencies identified by the Assessment Team. Actions include a full clinical review for consumers that encompasses skin care, wound care, behavioural support requirements, restrictive practices, psychotropic use and where appropriate, referrals have been made to the medical officer. Behaviour management care plans have been reviewed. Alerts have been added to the electronic care management system so that staff are notified of consumer’s assessed needs. Education has been provided to registered nurses and care staff with topics including roles and responsibilities, informed consent and associated documentation requirements, specialised nursing care and recognising a deteriorating consumer including the necessity of reporting skin changes identified during the delivery of daily cares. Additional monitoring processes are being implemented to ensure care is delivered in accordance with consumers’ identified needs and senior clinical staff have received a refresher on clinical monitoring processes.

While I acknowledge the information included in the approved provider’s response and note that action is being taken to address the deficiencies identified by the Assessment Team during the Site Audit, I am satisfied that at the time of the Site audit consumers were not receiving care that was tailored to their needs and optimised their health and well-being.

I find this requirement is Non-compliant.

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

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

The Assessment Team brought forward information under this and other requirements that strategies to manage identified risks associated with the care of consumers including the risk of falls and pressure injuries are not consistently documented in care plans, nor implemented by staff.

For one consumer who was identified as a high falls risk and who had experienced a number of falls, strategies identified by the physiotherapist on more than one occasion to assist in falls reduction had not been implemented by the service and the consumer continued to fall. Care staff and registered nursing staff who worked in the unit where this consumer resided were interviewed by the Assessment Team and in some instances did not have a shared understanding of the consumer’s care requirements.

For a further two consumers who were identified as being high falls risks, care plans did not include current information about how to prevent and manage their falls.

For some consumers at risk of pressure injuries or with current pressure injuries, care plans did not include detailed information to guide staff in relation to minimising the risk of pressure injuries. One representative reported that pressure relieving devices required by their consumer were not in place when they visited.

Staff did not demonstrate a shared understanding of individual consumers’ personal and clinical needs including those associated with high impact and high prevalence risks such as pressure area care. Staff advised that care was not consistently delivered in accordance with the alerts in the electronic care management system or with care directives included in care plans.

Registered staff said they do not receive regular reports about clinical incident data which they said would support them in understanding the current clinical risks to the consumer cohort.

Monitoring processes implemented by the service including clinical audits failed to identify the deficiencies identified by the Assessment Team.

I note the approved provider in its response has acknowledged that equipment to minimise falls had not been implemented in accordance with the physiotherapist’s care directives however states that the use of this equipment will not necessarily prevent falls. I am not persuaded by this argument as an allied health professional had assessed the consumer and identified this strategy to be implemented as a means of improving consumer safety and assisting in injury prevention.

The approved provider in its response states it has updated care plans for those consumers who were identified as being at high risk of falls. Further it states that at the time of the site audit ‘snap shot’ care plans located in consumers’ rooms did include current information that was reflective of assessments. The approved provider states the Assessment Team found staff generally demonstrated an understanding of strategies to minimise risks associated with risks of falls and pressure injuries and I accept this. However, ‘snap shot’ care plans were not submitted as evidence and while staff interviewed could describe risk minimisation strategies in general, they did not have a consistent understanding of named consumers’ individualised care needs. Additionally, staff reported to the Assessment Team that care was not being delivered as planned. While the approved provider states staff can access assessments on the electronic care management system, care staff advised the Assessment Team they did not have access to this information.

The approved provider’s response includes an action plan addressing the deficiencies identified by the Assessment Team during the Site audit. Actions include review of consumers’ clinical care needs, the creation of work instructions to improve communication between allied health and clinical staff, and monthly clinical indicators are to be made accessible to staff and tabled at meetings. Clinical staff are to receive education in clinical monitoring processes and other related areas.

I acknowledge the approved provider’s response but am satisfied that the service was not able to consistently demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, particularly in relation to the risk of falls and the development of pressure injuries.

I find this requirement is Non-compliant.

### 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.*

The Assessment Team brought forward deficiencies in this requirement relating to staff’s failure to identify a gradual deterioration or change in a consumer’s skin related condition. I note that when the change in the consumer’s condition was identified by staff that contact was made with the consumer’s medical officer and the consumer’s representative, wound care was commenced, and the staff monitored the consumer’s pain management. While there were deficits in the care provided to this consumer and there were deficiencies in wound care management and documentation, I have considered this under other requirements in Standard 3 and Standard 7.

The Assessment Team reviewed care planning documentation and found examples of care delivery that identified staff generally respond to a sudden change in a consumer’s health and well-being in a timely manner.

Care staff and registered staff could provide examples and describe how they respond to a change in a consumer’s condition. This included notifying the representative and the medical officer, initiating referrals, transferring the consumer to hospital if appropriate and completing an incident form where this is required.

The organisation has a clinical deterioration and escalation pathway that can be accessed on the intranet and is displayed in the nurses’ station.

The approved provider’s response includes actions to improve communication processes and the provision of staff education that addresses recognising deterioration and escalation processes.

I am satisfied that a deterioration or change in a consumer’s condition is managed effectively.

I find this requirement is Compliant.

### 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.*

The Assessment Team brought forward information in this and other requirements identifying deficiencies in clinical information systems and this has been particularly evident in relation to the transfer of information from assessments into consumers’ care plans.

I note the Assessment Team’s report includes evidence that there are other mechanisms whereby information is communicated, and this includes handover processes and progress notes. Additionally, the Assessment Team found examples of referral forms, hospital discharge summaries and documentation completed by consumers on entry to the service that is available to staff.

Staff referred to handover, meetings, daily ‘scrums’ and the alerts incorporated into the electronic care management system. Observations of the handover process identified that changes in consumers’ care needs were discussed and ad hoc tasks that required completion were raised.

The Assessment Team’s report states that the care plans were updated to reflect current assessments during the site audit and this was confirmed in the approved provider’s response. The response also identifies additional strategies are being implemented to improve the transfer of information about consumers and to support staff in their ability to access the electronic information systems.

I find this requirement is Compliant.

### 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

Consumers/representatives said consumers are supported to engage in activities they are interested in, both inside the service and in the wider community. They said they are supported to maintain personal and social relationships and remain in contact with people who are important to them.

Consumers/representatives said the activity schedules are varied and meet consumers’ needs and preferences, and that other individuals and external organisations are involved in supplementing the activity schedules.

Consumers said the service meets their emotional, social, spiritual and psychological needs by way of the internal support provided by staff, the Chaplain, volunteer workers, and referrals to external counsellors.

Most consumers provided positive feedback in relation to the meals and stated that the meals align with their dietary needs and preferences. Consumers said they have been involved in discussions about the menu and any modifications that are made.

Staff had a sound understanding of what is important to the consumer, the activities that they liked to engage in and relationships of importance. Staff were familiar with the actions they should take if they noticed that a consumer experienced a change in their emotional or psychological well-being. They said they referred to the care planning documentation for guidance and would escalate the situation to a registered staff member for further assessment.

Management advised changes in consumers’ condition, needs and preferences (including lifestyle preferences and required supports) are discussed during shift handover and at the daily ‘scrum’.

Lifestyle staff said that activities are planned on a fortnightly schedule and are offered Monday to Saturday. Activities include concerts, bus outings, bingo, reminiscing, religious services and consumer-led Bible study. Consumers are supported by staff to undertake their preferred interests as well as group activities and lifestyle staff provided examples of consumers who enjoyed gardening and those who are war veterans and had special interests associated with their past. For consumers with cognitive impairment there are additional activities that are designed to meet their needs.

Consumer satisfaction with the lifestyle program is monitored through surveys, feedback from consumers meetings, general feedback and complaints mechanisms; and this information is used to improve the program. The Assessment Team reviewed consumer meeting minutes and identified that consumers are provided with opportunities to have input into the activity program.

Care planning documentation demonstrated each consumer’s condition, needs and preferences are effectively communicated within the organisation and with others who provide services and supports for daily living, and timely and appropriate referrals are made to other providers of care and services as required.

Dietary information is available to guide staff when preparing and serving meals and when changes occur these are communicated to kitchen staff through diaries in kitchen areas, communication lists and verbally by the Chef. The seasonal menu is to be upgraded in 2022 and will include additional options. Consumers have input into the menu through providing feedback, making complaints and completing food specific surveys. The Assessment Team confirmed consumer involvement and consultation in relation to the meals.

The Assessment Team observed lifestyle and leisure supports and equipment to be clean, well-maintained, safe and suitable to the needs of the consumer cohort. Large groups of consumers were engaging in activities held across the service including games, a bus outing and happy hour. In addition to this, consumers were observed engaging in individual activities in their rooms, such as reading, listening to music, and crafts.

The Assessment Team observed several meal services and delivery of meals to consumers in their rooms. Kitchen staff were observed to be reviewing the meal preferences and requirements of consumers and verbally confirming meal choices.

The kitchen and serving areas were observed to be clean and tidy with kitchen staff observing food safety and infection control protocols, such as wearing gloves and hairnets.

The organisation has documented policies and procedures in place for making referrals to individuals and other providers outside of the service to support the lifestyle needs of consumers.

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

## 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

Consumers/representatives said that they felt safe and comfortable in the service, the equipment they use is clean and well-maintained and they could access indoor and outdoor areas should they choose to do so. They said visitors are welcome at the service.

Staff could describe the processes they follow to ensure cleaning is completed in a way that minimises the risk of infection. They said they had sufficient equipment to support them in their roles. Staff demonstrated an awareness of how to report maintenance requests and documentation reviewed identified reactive maintenance is attended to in a timely manner with preventative maintenance undertaken as scheduled.

Management advised cleaning is provided seven days per week and includes cleaning of communal areas and consumer rooms in accordance with a cleaning schedule and individual preferences.

Management reported they encourage consumers to provide feedback on the service environment through various mechanisms including verbally, via consumer surveys or through the compliments and complaints process.

The Assessment Team observed the service (including consumer rooms, communal areas and external gardens) to be secure, clean and well-maintained. Cleaning was being undertaken at multiple locations throughout the service at various times.

Consumers were observed moving freely through indoor and outdoor areas, and consumers and staff were using equipment that was suitable to the needs of the consumer.

The service has wide, well-lit, unobstructed corridors and clear signage to optimise consumers’ independence and safety when mobilising. Communal areas provided a home-like atmosphere where consumers congregated to watch television, listen to music or take part in other activities.

The service recently installed a garden sitting area external to the service entrance, designed in consultation with consumers, to enable consumers to spend time with friends, relatives and loved ones who were not able to enter the service due to mandated vaccine requirements.

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.*

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Consumers said they are encouraged and supported to provide feedback, suggestions and make complaints, and that appropriate action is taken thereafter. Consumers/representatives said they feel safe to make a complaint or provide feedback using the feedback forms, through direct communication with management or staff, or with the support of a representative or advocacy service. Consumers said their preference was to speak to management and staff directly.

Consumers were familiar with internal and external complaints mechanisms and were confident that any feedback or suggestions made are implemented by the service as far as reasonably practicable.

Consumers are provided an information book on entry to the service which provides details about complaints avenues, advocacy and translation services that are available to them. Additionally, it includes a prepaid envelope and feedback form and additional forms are available at reception together with a locked suggestion box.

Monthly consumer meetings are a forum for seeking consumer feedback and feedback about care and service delivery is sought during care review processes.

Surveys are conducted four monthly to gauge consumer satisfaction with care and services. In the event of a negative trend being identified, the service completes targeted audits to secure additional information about areas of concern and to tailor any improvement actions that are to be initiated.

Staff were able to describe the avenues available for consumers/representatives if they wanted to provide feedback to the service and the process they follow should a consumer raise an issue with them directly.

The Assessment Team reviewed the complaints register and identified the service documents feedback, suggestions, complaints and compliments received from consumers/representatives, takes appropriate and timely action and consistently applies an open disclosure process. The service categorises complaints by severity and this process enables the service to prioritise the resolution of complaints, and ensure actions taken are reflective of the categorised severity.

Recent complaints received by the service have generally related to meals and the service was taking action to improve consumer satisfaction; this included further consultation with consumers and the Chef.

Policies and procedures relative to this Standard guide staff practice and include open disclosure, complaints and compliments and dispute resolution. Staff and management reported they had not received training in open disclosure processes however the Assessment Team confirmed open disclosure processes were applied when required and in accordance with organisational policies.

The Quality Standard is assessed as Compliant as four of the four specific requirements have been assessed as 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) Compliant

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

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 NON-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

Consumers generally said they receive quality care and services when they need them and that staff are kind, caring and respectful of their identity, culture and diversity. Consumers/representatives told the Assessment Team that there are sufficient staff to support and deliver the consumer’s care and services, and that requests for assistance are generally responded to in a timely manner. However, some consumers/representatives expressed concerns regarding the adequacy of staff training and the knowledge of staff delivering care and services.

During the site audit, interactions between management, staff, and consumers/representatives were observed to demonstrate a kind, caring and respectful approach, and care and services were delivered in a timely manner.

The service demonstrated there are established performance management and development processes for staff, and rosters are managed to ensure there are sufficient staff to meet the care and service needs of consumers.

Not all members of the workforce were able to demonstrate competency in relation to key areas of their roles and responsibilities, nor that they have the knowledge or confidence to effectively perform their roles. The Assessment Team identified staff competency and knowledge deficiencies in relation to aspects of assessment and care planning, use of restrictive practices, personal and clinical care delivery (specifically in relation to pressure area care and wound care), recognising and responding to deterioration, and clinical oversight and monitoring.

Processes to monitor and ensure the completion of mandatory training were not effective. The Assessment Team found that mandatory training modules had not been completed by all staff with some staff reporting they had not received adequate training or support to effectively perform their roles, including in the management of challenging behaviours and the provision of personal and clinical care.

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

## 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) 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 brought forward information under this and other requirements demonstrating that staff do not consistently have the knowledge and skills to perform their roles. This was evident in relation to assessment and care planning processes, various aspects of personal and clinical care including documentation and charting processes, wound care, skin care, risk minimisation strategies, the management of restrictive practices and clinical monitoring.

A number of staff interviewed by the Assessment Team stated they (or their colleagues) did not have the knowledge to effectively perform their roles. Staff said they lacked confidence and provided examples of how they were inadequately prepared for certain aspects of their roles. This included being required to work in areas that they had not been orientated to, being required to mobilise consumers without having the required knowledge or competencies completed in relation to manual handling and lacking the knowledge to manage consumers with complex behaviours.

Some consumers expressed dissatisfaction with staff knowledge and provided examples of those experiences where they had concerns about the staff’s capacity to effectively perform their roles.

At the time of the Site audit, the management team committed to engaging with staff and implementing additional training in order to address staff knowledge and skills. The approved provider, in its response to the Assessment Team’s report stated that there will be increased monitoring of the completion of required orientation and training modules and the local orientation will include an explanation of the role and the allocation of ‘buddy’ shifts. Follow up of new staff will occur to ensure confidence in areas including manual handling and a training needs analysis is to be completed to identify additional training needs.

I acknowledge the approved provider’s response however I am satisfied that at the time of the Site audit staff did not consistently demonstrate the knowledge and skills to perform their roles.

I find this requirement is Non-compliant.

### 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 brought forward information under this and other requirements demonstrating that staff have not been consistently trained and supported to deliver care in accordance with consumers’ needs and preferences and in accordance with the standards.

The majority of staff interviewed by the Assessment Team were dissatisfied with the level of training they had been provided and provided examples of care related areas where they felt their training was deficient. This included managing complex consumer behaviours, recognising and responding to deterioration, the Serious Incident Response Scheme and recent changes to restrictive practices.

Management staff did not have a shared understanding of those training modules that were mandatory and could not demonstrate how this was monitored or how the mandatory competency program was monitored to ensure staff completion.

One care staff member advised the Assessment Team they had been required to assist consumers with mobilisation prior to undertaking manual handling training and that this training was not provided to them for several months. They said that at the time they were assisting consumers with mobilisation and had not had any previous experience in aged care. Another care staff member advised they had not completed the required mandatory training associated with their role and while the service had said they would be removed from the roster unless mandatory training was completed this had not occurred and they continued to work.

The Assessment Team reviewed a mandatory training compliance report and noted significant non-compliance with staff either being overdue for training or having not completed required training. Training modules including hand hygiene, emergency first response, infection control and general evacuation training were areas that had significant non-compliance and, in some instances, more than 40% of staff were either overdue or had not completed their training in these areas.

At the time of the Site audit, the management team committed to engaging with staff and implementing additional training in order to address staff knowledge and skills. This included identifying the modules required within mandatory training program and contacting those staff who have outstanding training requirements.

The approved provider, in its response to the Assessment Team’s report acknowledged that the mandatory training program has not been completed by some staff and that oversight of the on-line training program is inadequate and processes to support the delivery and completion of the training program need review. Actions are being taken to identify staff who have outstanding training needs and ensure staff complete relevant training including behaviour management and Serious Incident Response Scheme. The service also plans to contact the organisation’s learning and development team to seek further guidance as to how to support staff education and training.

I am satisfied that systems and processes were not effective in supporting staff to ensure they were trained and equipped to delivery care and services in accordance with consumers’ needs.

I find this requirement is Non-compliant.

### Requirement 7(3)(e) Compliant

*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

Overall consumers felt that the organisation is well run and that they can partner in improving the delivery of care and services. Consumers said they participate in the consumer/representative meetings, consumer experience surveys and by utilising complaints and feedback mechanisms. Consumers said they are encouraged to make suggestions and that they are supported to live the best life they can.

The governing body promotes a culture of safe, inclusive and quality care and services and was accountable for their delivery. The organisation implemented systems to ensure their accountability for care and services provided and had established communication processes to and from the governing body.

However, organisation wide systems in relation to information management, continuous improvement, workforce governance and regulatory compliance were not effective.

Information sharing processes did not ensure effective communication between key personnel had occurred. Consumer care plans were not reflective of consumers’ individual care needs to inform the delivery of safe and effective care.

Continuous Quality improvements were not completed within set timeframes. The service’s quality monitoring processes were ineffective, and staff were not sufficiently trained and supported to deliver the outcomes required by these standards.

Staff did not have a shared understanding in relation to the Serious Incident Response Scheme and the use of an incident management system. Training was not provided for staff in relation to recent legislative changes pertinent to the safe delivery of clinical and personal care.

The organisation was unable to demonstrate it had effective risk management systems and processes, including the management of high impact and high prevalence risks associated with the care of consumers and the prevention and management of incidents.

The organisation did not have effective clinical governance systems and processes in place to support the delivery of safe and quality clinical care to ensure satisfactory clinical outcomes were achieved for each consumer.

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) Compliant

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

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

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

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

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

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

The service did not have effective organisation wide governance systems in place as evidenced by deficiencies identified during the site audit in relation to information management, continuous improvement, workforce governance and regulatory compliance.

Care planning documentation did not include critical information relating to the individual care needs of consumers to inform the delivery of safe and effective care. Care staff could not access assessment information through the service’s electronic care management system.

Hardcopy assessment and care planning documentation did not accurately reflect consumers’ personal and clinical care requirements, nor strategies to support and manage those care requirements. While staff advised they could access both hardcopy and electronic care and service plans, information outlined in hardcopies was not reflective of consumers’ current care needs.

Management were unable to demonstrate a shared understanding of clinical information relating to consumers at the service. Communication processes were not effective to ensure equipment was purchased to support the needs of consumers.

Organisational policies and procedures in relation to incident management and responding to the abuse of consumers were not consistently reviewed and updated to reflect legislative changes in a timely manner. The organisation did not have a policy to guide staff practice in relation to the Serious Incident Response Scheme.

At the time of the Site audit, the management team committed to reviewing all care and service plans and manually including the outcomes of assessments which the Assessment Team confirmed had been completed. However, information to demonstrate how staff would be informed about the updated care and service plans was not provided. Further to this, management advised that, the service’s information sharing processes would be reviewed to ensure communication between key personnel occurred effectively.

The approved provider states that at the time of the Site audit ‘snap shot’ care plans located in consumers’ rooms did include current information that was reflective of assessments however, ‘snap shot’ care plans were not submitted as evidence.

The approved provider provided a plan for continuous improvement and evidence to demonstrate actions had been taken in response to identified deficiencies. This included a clinical review of consumers care information to ensure that assessments have been activated into care plans.

The approved provider’s response includes an action plan addressing the deficiencies identified by the Assessment Team. Actions include the redevelopment of meeting schedules with staff, the Clinical coordinator and allied health personnel and utilising a standing agenda for meetings to ensure legislative policy and specific business items are followed up. Additional actions planned include, the uploading of individual assessment and care plan information, improved daily communication processes amongst staff, education for clinical staff to improve clinical monitoring processes, the dissemination of information to staff pertaining to the Serious Incident Response Scheme, restrictive practices and changes to national quality indicators.

The organisation’s quality framework outlined processes for the delivery and management of continuous quality improvements. Continuous quality improvements were recorded in the service’s electronic system which were accessible by various organisational governance committees however, several activities commenced in 2020 remained outstanding. These included staff education on challenging behaviours and updating medication charts, restrictive practice charts and care and service plans with information pertaining to chemical restraint.

While management demonstrated a shared understanding in relation to which sources contribute to the service’s continuous improvement processes, the service’s quality monitoring mechanisms failed to identify deficiencies in some staff practices regarding assessment, planning and the delivery of personal and clinical care.

The approved provider in its response acknowledges the Assessment Team’s findings and has planned actions to address the deficiencies in relation to continuous improvement. These include, reviewing and updating the service’s plan for continuous improvement, the development of a plan to complete the outstanding items within achievable time frames, plan and undertake a service wide review of all consumer care plans and assessments, review the service’s current roles and responsibilities in relation to the management of their plan for continuous improvement, schedule regular reviews of the service’s plan for continuous improvement and review the service’s psychotropic register.

The approved provider’s action plan states that a standing agenda item will be established for staff meetings to action and delegate continuous improvement activities and the service’s plan for continuous improvement activities from 2020 will be actioned. While consumer/representative and staff meetings had not occurred each month as scheduled, between July and September 2021, meetings for all consumer and staff cohorts were scheduled to recommence in November 2021.

The service was able to demonstrate that financial governance systems and processes were established and supported care and service delivery.

In relation to workforce governance the service was unable to demonstrate the workforce (specifically inexperienced and/or new care staff to the service) were competent, nor had the knowledge, training and support to effectively perform their roles and deliver the outcomes required by the Quality Standards. The service did not have effective processes in place to ensure mandatory staff training and competency assessments were completed by staff. Organisational monitoring processes did not identify or take actions to address staff who had overdue or had not completed mandatory online training modules. This information has been further considered in Standard 7 Requirements 7(3)(c) and 7(3)(d).

The approved provider in its response discussed the processes established by the service to support new staff in their roles. Processes include buddy shifts which are monitored and evaluated by management, providing staff access to an electronic online learning system and a commencement pack containing the organisation’s code of conduct and position description relevant to their role. Probation meetings are completed throughout the probationary period and ongoing meetings with management are held with staff throughout the year to identify future learning needs. External education is provided for staff on a variety of topics and staff are encouraged to access the service’s intranet for a variety of training and education options relevant to their roles.

The approved provider in its response acknowledges that manual handling training over the past year has been disrupted due to COVID-19 restrictions imposed in the Brisbane area. External contractors based in Brisbane were not able to provide training as scheduled. In response, the approved provider said on these occasions the service engaged their onsite manual handling trainer to complete the training. However, evidence to demonstrate staff had completed mandatory training was not provided in the approved provider’s response.

Mandatory training is required to be completed prior to the commencement of an employee’s role and annually thereafter. Electronic mail reminders are sent to staff and management to ensure it is completed. The approved provider states in its response that staff are removed from the roster until their mandatory education is completed. While I acknowledge the service has processes in place to alert staff and management of pending expiration dates for mandatory training, I am not satisfied these processes have been effective as evidence by the Assessment Team’s findings in relation to the deficiencies identified in Standard 7 Requirement 7(3)(c) and 7(3)(d).

The approved provider’s action plan states that the Service manager will monitor the workforce requirements of staff to ensure they are completed.

Management advised the service tracked changes to aged care law through correspondence received from external agencies and regulatory bodies, including the Aged Care Quality and Safety Commission, Queensland Health, the Department of Health and other industry alerts. These changes were disseminated to staff through staff meetings, electronic mail correspondence, staff education and training sessions.

However, monitoring processes were not effective in identifying the need to develop or amend, organisational policies and other documentation or to disseminate information regarding legislative changes to staff.

Staff did not have a shared understanding of the Serious Incident Response Scheme and confirmed they had not received training on the topic. While staff described the service’s escalation processes, progress notes reviewed by the Assessment Team for one named consumer who had sustained an abrasion to their forehead on 11 October 2021, did not reflect this had occurred.

The approved provider states in its response that this incident was investigated by the Clinical coordinator in October 2021 who determined that the incident did not meet the serious incident reporting criteria. While I acknowledge the service’s assessment of the incident, information to demonstrate the incident had been recorded and appropriately investigated in the service’s incident management system was not provided. This has been considered further under Standard 8 Requirement (3)(d).

The Assessment Team identified that the service did not record in the service’s incident management system whether incidents involving two named consumers in November 2021 were reportable under the serious incident reporting scheme. The approved provider said in its response states that both incidents were logged as reportable incidents by the Residential service manager within the correct timeframes however, evidence to demonstrate this had occurred was not provided.

The approved provider in its response states that changes to mandatory reporting requirements and the Serious Incident Response Scheme have been discussed with staff during the previous three staff meetings and were scheduled for discussion on 21 November 2021. However, I am not persuaded that this was effective as evidenced by staff’s lack of understanding. Evidence to support training for and discussions with staff in relation to the Serious Incident Response Scheme and the use of an incident management system had occurred, were not included in the approved provider’s response.

The approved provider provided further information and included an action plan to address deficiencies identified during the Site Audit in relation to regulatory compliance. Actions include alerting organisation care governance personnel of outdated policies, policy reviews by staff relevant to their roles, the development of a system to monitor the knowledge of staff in relation to changes to legislation policy, disseminating information to staff, ensuring Serious Incident Response Scheme information is accessible by all staff, providing Serious Incident Response Scheme information to consumers and reinforcing the accountabilities of staff for the interpretation and application of information provided to them by the service.

In relation to feedback and complaints the service was able to demonstrate systems and processes employed by the service encouraged consumer/representative feedback and complaints were effectively actioned and contributed to service wide improvements.

While I acknowledge the improvements initiated and planned to address the deficiencies identified by the Assessment Team, I am of the view that it will take some time to effectively address these deficiencies and ensure that systems and processes are ensuring appropriate consumer outcomes.

I am satisfied that at the time of the Site Audit organisation wide systems were not effective in relation to information management, continuous improvement, workforce governance and regulatory compliance.

Therefore, it is my decision this Requirement is Non-compliant.

### 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*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team brought forward information under this and other requirements demonstrating that the service did not have an effective risk management system specifically in relation to the management of high impact and high prevalence risks associated with the care of each consumers, and the management and prevention of incidents.

Organisational policies in relation to this Requirement were provided to the Assessment Team however, policies in relation to the abuse and neglect of consumers and incident management had not been updated to reflect current legislative requirements. Staff confirmed they had not received a copy of organisational policies in relation to this Requirement, accessed these policies on the service’s intranet or received training on these topics.

The service could not access the service’s risk management framework electronically during the Site Audit.

Management and staff had a shared understanding of the high impact and high prevalence risks associated with the care of consumers at the service. However, the service was unable to demonstrate effective risk management systems were in place in relation to high impact or high prevalence risks, specifically risks of falls and pressure injuries.

Care planning documentation did not consistently reflect strategies and care directives to manage the risks associated with the care of each consumer. While staff had a shared understanding regarding generalised risk minimisation strategies to prevent falls and minimise the risk of pressure injuries, care planning documentation of sampled consumers did not evidence strategies were consistently implemented.

While the service’s electronic care management system alerts staff to complete tasks during each shift, this is not consistently completed. Monitoring processes implemented by the service including clinical audits failed to identify the deficiencies identified by the Assessment Team. This information has been further considered under Standard 3 Requirements 3(3)(a) and 3(3)(b).

Clinical incident data was collated and analysed each month to identify trends however, the Assessment Team identified pressure injury incidents were not recorded between August and October 2021. Management responded to the Assessment Team’s feedback during the Site Audit and advised that the service’s clinical monitoring system did not identify pressure injuries that require ongoing care.

In relation to the management and prevention of incidents, management and staff demonstrated a shared understanding in relation to the service’s escalation and incident management processes. However, progress notes for a named consumer who was found on the floor of another consumers room on 11 October 2021 demonstrated staff did not follow these processes. Management were not informed; an investigation was not conducted, and incident documentation was not completed.

Organisational policies and procedures in relation to incident management, including the incident management framework were not reflective of the Serious Incident Response Scheme and associated reporting requirements. Mandatory training modules in relation to identifying and responding to incidents and the abuse and neglect of consumers had not been completed by all staff.

Staff had a shared understanding of how they supported consumers to take risks to live the best life they can and what constitutes elder abuse and neglect however, this was not within the context of the Serious Incident Response Scheme.

Management advised during the Site Audit that the following actions would be planned in response to the Assessment Team’s feedback. These included mandatory education for staff regarding the management of high impact and high prevalence risks specifically in relation to falls and pressure injuries, training in relation to incident identification, escalation and the Serious Incident Response Scheme and additional support and education for the Clinical coordinators following their return from leave. Further to this, management reviewed all care and service plans and manually included the outcomes of assessments to ensure strategies to effectively manage high impact or high prevalence risks were available to guide staff practice.

The approved provider in its response acknowledges staff failed to adhere to the service’s incident management processes on 11 October 2021. As a result, the service has developed an incident checklist has been developed to ensure incident reports are completed.

Further to this, the approved provider acknowledges organisational policies and procedures in relation to incident management are not reflective of the Serious Incident Response Scheme and the associated reporting requirements.

The approved provider included an action plan in its response to address the deficiencies identified by the Assessment Team for this Requirement. Actions include, distribution of a memo to all staff advising how to access organisational policies through the organisation’s electronic policy portal, updating the incident management policy and information from the organisation will be disseminated to staff accordingly.

I acknowledge the approved provider’s response, but I am satisfied that the service did not have effective risk management systems and practices in place to manage high impact or high prevalence risks (specifically in relation to falls and pressure injuries) or to manage and prevent incidents including the use of an incident management system. I am concerned that clinical incident data monitored by the organisation is not reflective of the high impact or high prevalence risks associated with the care of consumers.

Therefore, it is my decision this Requirement is Non-compliant.

### 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 service did not have effective clinical governance systems and processes in place that are aligned with the organisation’s clinical governance framework, policies and procedures.

The organisation had a documented clinical governance framework, and policies and procedures in relation to minimising the use of restrictive practices, antimicrobial stewardship and open disclosure. However, staff had not reviewed these policies or received education on the topics.

While an organisational policy in relation to restrictive practices had been established and reflected recent legislative changes, the management, monitoring and use of restrictive practices at the service was not consistently best practice and did not meet legislative requirements. Care planning documentation for more than half of the consumers subject to restrictive practices did not consistently evidence consultation with, and consent by, the consumer and/or their substitute decision maker regarding the use of restrictive practices

Behaviour support plans for consumers subject to restrictive practices were not consistently completed to enable safe and effective management of challenging behaviours, and appropriate use of chemical restraints when required. This information has been further considered in Requirements 2(3)(d) and 3(3)(a).

The approved provider in its response states where a signatory authority from family/next of kin is unattainable, a verbal authority is provided and recorded by the Clinical coordinator. To ensure this occurs, the approved provider has changed their processes to maintain records of electronic mail correspondence from family/next of kin who are unable to provide written authority for the provision of restrictive practices.

Clinical monitoring processes were primarily the responsibility of the Clinical coordinator. These processes included overseeing staff’s compliance with organisational policies and procedures, daily, weekly and monthly processes to ensure care directives are followed up and completed, the monthly analysis and reporting of clinical incident data and the submission of the National Quality Indicator Program data to the Department of Health every three months.

While clinical monitoring processes had been established, they were not effective and failed to identify and/or bring to the attention of management the deficiencies identified by the Assessment Team. These deficiencies were in relation to the completion of consumer assessment and care planning information, the delivery of care and services, the completion of clinical monitoring documentation, the ineffective management of risks associated with the care of each consumer and staff practices and/or knowledge deficiencies in relation to identifying and escalating incidents and the delivery of effective personal care including pressure area care and wound management.

Clinical oversight provided by management and the Quality safety officer in the Clinical coordinator’s absence, did not identify the beforementioned deficiencies. Management were unable to readily provide information to the Assessment Team regarding consumers and clinical processes during the Site Audit.

Clinical indicator data did not include information pertaining to pressure injuries that required ongoing care. The organisation is not monitoring the number of ongoing pressure injuries, their assessed stages and progress of healing or deterioration.

Management advised additional support will be provided to the Clinical coordinator upon their return from leave in relation to their role and responsibility and to monitor their performance.

Management provided the Assessment Team with several planned actions in response to the Assessment Team’s findings. These included updating the service’s psychotropic medication register, engaging in case conferences with all relevant consumers and/or their substituted decision makers to obtain their informed consent regarding the use of restrictive practices and completing relevant behaviour support plans. Further to this, mandatory training will be delivered to staff by the end of December 2021.

The approved provider in its response provided an action plan to address the deficiencies identified by the Assessment Team. Actions include a review of the roles and responsibilities for the Residential service manager, the Clinical coordinator and Registered nurse and additional education and support is planned to be provided for the Clinical coordinator. Further to this, the approved provider accepts that assessment information had not been consistently reflected in care plans and as a result, processes have been reviewed to ensure this occurs. Additional daily processes have been implemented to improve communication between allied health staff and the service’s clinical management team.

I acknowledge the approved provider’s response however, I am satisfied at the time of the Site Audit the service did not have effective clinical governance systems and processes in place that aligned with the organisation’s clinical governance framework, policies and procedures.

Therefore, it is my decision this Requirement is Non-compliant.

# 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.

* The service is required to ensure that staff have the knowledge and are competent to undertake their roles effectively.
* The workforce is trained and supported to deliver the outcomes required by the Aged Care Quality Standards and mechanisms are established to ensure staff complete those elements of the education program that are deemed mandatory.
* The service is required to ensure the outcomes of assessment and planning are documented in a care and services plan and are available to support staff in the delivery of care and services.
* The service is required to ensure consumers receive care that is tailored to their needs and optimises their health and well-being.
* The service is required to ensure that high impact and high prevalence risks associated with the care of the consumer are identified and managed effectively.
* The service is required to ensure that the workforce is competent and that members of the workforce have the required knowledge to perform their roles.
* The service is required to ensure that the workforce is trained and is supported to deliver the outcomes required by the Aged Care Quality Standards.
* The service is required to ensure they have effective governance wide systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.
* The service is required to ensure they have effective risk management systems and practices, including but not limited to the management of high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.
* The service is required to ensure where clinical care is provided a clinical governance framework, including but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure.