Coffs Harbour Grange Care Community

Performance Report

50 Lakes Drive
COFFS HARBOUR NSW 2450
Phone number: 02 6659 4800

**Commission ID:** 0823

**Provider name:** DPG Services Pty Ltd

**Site Audit date:** 30 November 2021 to 2 December 2021

**Date of Performance Report:** 12 January 2022

# Performance report prepared by

Melissa Buhagiar, 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) | Non-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) | Non-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** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Non-compliant |
| Requirement 8(3)(b) | Non-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 conducted 30 November to 2 December 2021, 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 7 January 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

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

The Assessment Team found that overall consumers and their representatives considered that consumers are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

The Assessment Team interviewed consumers and representatives who confirmed they were encouraged and supported by the staff to do the things they enjoy such as gardening or going on outings.

The Assessment Team interviewed staff who had a good understanding of consumers’ cultural identity and provided examples of how this was put into practice for consumers to make them feel valued and respected.

Consumers and representatives confirmed their relative’s personal privacy is respected.

The Assessment Team reviewed care planning documents which generally included up to date information regarding consumers’ choice and preferences including about maintaining relationships.

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

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

The Assessment Team interviewed consumers and representatives and overall, they considered that they feel like partners in the ongoing assessment and planning of the consumer’s care and services. The majority confirmed they are involved in the care planning process, such as through the annual case conferences, face to face discussions and phone conversations with the RNs. The representatives said they generally have discussions with the RNs when their relative’s health needs change or when an incident occurs. Three representatives said they are always notified when there is a change in their relative’s care and when incidents occur.

However, a representative said from visiting their relative at the service they are aware of linen and waste skips in their room but have not been told why these are needed. A representative said they were notified of an incident, although the outcome or evaluation was not discussed with them. Some representatives said while they are informed of incidents their relative has been involved in, they are not told what is being done to try and prevent future incidents.

The Assessment Team found a representative of a respite consumer was not satisfied with the initial assessment and entry process, they said it was not thorough enough to ensure the consumer was able to be appropriately managed at the service. The Assessment Team identified the organisation’s consumer admission pathway for a respite consumer was not followed as directed.

The Assessment Team identified that the consumers’ care and services are generally reviewed when circumstances change, however the management team and registered staff are not following the organisation’s policies and procedures when an incident occurs. The incidents are not being investigated to try and understand the contributing factors and develop strategies to prevent a re-occurrence.

The Assessment Team found that it was not demonstrated the organisation’s incident management and reporting policies and procedures more broadly are being followed for some consumers. It was not demonstrated the organisation’s policies and procedures for consumer care and clinical assessment are being followed. Assessments and care plans do not include all relevant information about the needs, goals and preferences of consumers or the risks associated with their 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 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 that for the consumers sampled their assessments and care plans include information about some risks associated with their care and related management strategies for staff to follow. However, for some consumers their assessments and care plans have not been reviewed and updated when new risks emerge or when risks escalate. Consumer incident investigation is not consistently occurring to inform the review and update of consumer assessments and care plans. It was not demonstrated for some consumers sampled that their assessments and care plans inform the delivery of safe and effective care.

The Assessment Team found that the assessments and care plans for some consumers sampled do not include details of current risks associated with their care or guidance for staff about how to manage those risks.

The approved provider responded to the Assessment Teams report and submitted additional documentation to support their compliance with this requirement. I have considered the additional information, however there is no record of when these documents have been updated and there is no evidence of pain monitoring records to further support the approved provider’s compliance.

I find that the approved provider is not compliant with this requirement at the time of the Site Audit.

### 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.*

The Assessment Team found that the organisation has policy, procedures, staff training and resources to support consumer advanced care planning. Review of records for the consumers sampled shows advanced care plans are being completed and reviewed as required. Feedback from staff and a consumer’s representative was consistent with this. The organisation has a documented process about the initial assessment and care planning for new consumers. However, this was not followed for one consumer who did not have most initial assessments completed within the specified timeframe or otherwise at the earliest opportunity. For some other consumers sampled their care plans did not include all information about their current needs, goals and preferences.

The Assessment Team reviewed the organisation’s consumer admission pathway, which includes that clinical assessment is to be completed within 24 hours of admission. This is to encompass a full head to toe clinical assessment including vital and neurological signs and details of about care needs and risks, such as in relation to pain, skin integrity complex health care and wandering behaviours. The information is then to be used to generate a summary care plan to guide staff practice. However, the Assessment Team noted that this was not followed for one sampled consumer when the consumer moved into the service and therefore do not show all of the needs were assessed and planned in a timely manner to guide staff practice.

The approved provider responded to the Assessment Team’s report and furnished additional documentation, this included an Initial Clinical Assessment with associated risks and Summary Care Plan. Neurological observations were also provided for the consumer following a fall.

I find that the approved provider is compliant with this requirement.

### 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) Non-compliant

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

The Assessment Team found that consumers’ care and services are regularly reviewed for effectiveness. However, they are not always reviewed when consumer incidents occur, including falls, behavioural and skin injury incidents. There is a lack of investigation to understand factors contributing to consumer incidents to inform care planning and prevent future incidents.

The Assessment Team reviewed care planning documentation and for one sampled consumer it was noted that the consumer had a fall and was not clinically monitored in accordance with the organisation’s policy and procedure for the management of unwitnessed falls and falls with head-strike. The incident report in relation to the fall does not have a complete description of the incident and does not include details as prompted about when the consumer was last seen and what the consumer was doing, or the actions taken by staff.

The Assessment Team reviewed other care and services records and identified a lack of incident investigation had occurred. It did not include information to show management or staff sought to understand the how or why this happened (the contributing factors). The records for many incidents lacked information about strategies to prevent future incident.

The approved provider responded to the Assessment Team’s report and submitted additional information with evidence that the consumer was regularly monitored by staff. It was however not evident in the information that was supplied that incident investigation was occurring or strategies implemented to prevent future incidents.

I find that the approved provider is not compliant with this requirement.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care and service records and interviewing consumers, representatives and staff about safe and quality care and service delivery. The team also examined other relevant documents.

The Assessment Team found that most consumers and representatives interviewed by the Assessment Team considered the consumer receives personal care and clinical care which is safe and right for them. For example, a representative of a consumer receiving end of life care gave positive feedback about the management of her mother’s care and the support given to the family. However, some consumer representatives provided feedback about the personal and clinical care needs and preferences of their relatives not being met.

The Assessment Team conducted a review of organisational policy, procedure, resources and interviews with staff which show there is support available for consumers nearing end of life. For one consumer sampled who was nearing end of life, review of their care and services records showed their comfort and dignity were maintained.

The organisation has policy and procedure to guide staff in recognising and responding to consumer deterioration or change in condition. Review of consumer care and service documents and interviews with staff shows this was well managed, in a timely manner for a consumer who had change in their mental health.

The Assessment Team reviewed documentation and conducted interviews with consumers, representatives and staff who showed information about the condition, needs and preferences of consumers is communicated among staff and with others where responsibility for care is shared. It also showed consumers are referred to appropriate services and specialists in a timely manner and in response to the needs of the consumers.

The Assessment Team identified that although the feedback from most consumers and representatives was very positive in relation to the care the consumers receive, the Assessment Team identified deficits in pain, wound and restrictive practice management for some consumers.

The Assessment Team also identified in the management of high impact and high prevalence risks associated with the care of some consumers. This includes consumer falls, skin and pressure injury risk and risks associated with behaviour of concern, including consumer assaults. Medical directives and the organisation’s policy/procedure have not been consistently followed. The consumers’ safety and comfort has not been effectively monitored by the staff.

There is organisational policy and procedure about infection prevention and control (IPC) and some consumers, representatives and staff provided feedback or input about the practice of IPC at the service. There has also been support for consumer and staff vaccinations to occur.

However, it was not demonstrated there is effective management of standard and transmission-based precautions to prevent and control infections. There are deficits in the management of a consumer returning from hospital who was identified as having a multi-resistant infection. Throughout the performance assessment poor practice in relation to staff mask wearing was observed. A consumer’s infection was not reported and there has been a lack of monitoring and review of service performance in relation to antimicrobial stewardship.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that although the feedback from most consumers and representatives was very positive in relation to the care the consumers receive, the Assessment Team identified deficits in pain, wound and restrictive practice management. Documentation reviewed and discussions with senior management show the organisation’s related policies, procedures and best practice guidelines are not being followed. For the consumers sampled personal and clinical care has not been tailored to their needs and has not optimised their health and well-being.

The Assessment Team identified for some consumers sampled who are chemically restrained, staff have not followed the Commission’s restrictive practices guidelines or the organisation’s policies and procedures. For example, chemical restraint given on a PRN basis has not been used as a last resort after all available alternative strategies trialled; and behavioural support plans are not comprehensive and current.

The Assessment Team identified for some consumer sampled the organisation’s policies and procedures and best practice wound management guidelines have not been followed. The early identification of skin breakdown is not consistently occurring, there are gaps in incident reporting and timely initiation of a wound chart, and wound charts do not show effective wound management.

The Assessment Team identified for some consumers sampled their pain has not been assessed and monitored in accordance with organisational policy and procedure and best practice guidelines about pain management.

The approved provider responded to the Assessment Team’s report and advised that the pain assessments are conducted formally or informally, however there was no supporting evidence of this or alternate strategies documented as being trialled prior to PRN medication being administered.

I find that the approved provider is not compliant with this requirement.

### 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 found that although the feedback from most consumers and representatives was very positive in relation to the care the consumers receive, the team identified deficits in the management of high impact and high prevalence risks associated with the care of consumers. This includes consumer falls, skin and pressure injury risk and risks associated with behaviours of concern, including assaults.

The Assessment Team reviewed care planning documentation and identified for behavioural incidents, there are details about the incident, the support offered to the consumer at the time of the incident, and the assessments and charts to be commenced post incident, however, the consumer’s care and service records do not demonstrate the assessments and monitoring charts were completed. For another consumer, a medical officer directive is for clinical readings twice daily at random times, however entries in the chart are recorded inconsistently and on the majority of times recorded once daily and at times has not been recorded for 4 days.

The approved provider responded to the Assessment Team’s report and provided additional information, however this information does not provide corroborating evidence that effective management of high impact or high prevalence risks associated with the care of each consumer has been demonstrated as there are gaps in monitoring records associated with consumers care.

I find that the approved provider is not compliant with this requirement.

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

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

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team interviewed care staff who said they were unsure why the yellow contaminated skips were in a consumer’s room, even though they are regularly rostered to this room, the staff thought they were for her incontinence aids, clothing and bed linen. One care staff member interviewed more generally about infection prevention and control thought that yellow contaminated waste bins were for cytotoxic waste disposal (the Assessment Team noting these are for clinical waste disposal). The RNs advised the management and precautions for infection would have been discussed at handovers. However, they were unable to demonstrate when this occurred and if it was discussed in particular with the cleaning and laundry staff.

The Assessment Team observed some poor staff practices for infection prevention and control. The Assessment Team observed 10 staff members with their face mask placed under their nose. When the Assessment Team discussed this with the acting care manager, she provided new masks to staff and reminded them to wear masks as per the NSW Health guidelines.

The approved provider responded to the Assessment Team’s report and advised that further education will be provided in relation to infection control practices.

I find that the approved provider is not compliant with this requirement.

# 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

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

The Assessment Team found that overall consumers considered they get the services and supports for daily living that are important for their health and well-being and which enable them to do the things they want to do.

The Assessment Team interviewed consumers who said they are supported to do the things they like to do. However, some consumers who use a wheelchair to move around expressed a wish to go on bus trips. They have been unable to participate in bus trips as a bus to accommodate wheelchairs has not been made available.

The Assessment Team found that most consumers said they are supported to keep in touch with their families and that this a priority for them. They feel they can participate in their community and have social relationships.

There are systems to record information regarding consumers’ needs and preferences and this is available to staff requiring access to the information.

Most consumers say that meals are adequate and nutritious but comments by consumers indicate that there has been inconsistency in the quality of the meals in recent months.

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,*

### 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 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team interviewed consumers and representatives who considered they/their relative feels they belong in the service and is safe and comfortable living there. Some shared information about what helps the consumer feel welcome and at home in the service, often mentioning the presence of animals/pets and the outdoor spaces. They all provided feedback that the service is kept clean and is well maintained.

The Assessment Team’s observations were that the service environment is welcoming and generally optimises consumer belonging, independence, interaction and function. Other observations made, documentation reviewed and interviews with the management team and relevant staff confirmed that overall furniture, equipment and fittings are kept safe, clean and well maintained.

The Assessment Team’s observations were that the service environment is kept clean and is well maintained. Documentation reviewed and interviews with the management team and staff confirmed this. However, there were hazards in the service environment, including some which pose a safety risk to consumers. These had not all been identified and/or addressed.

The organisation’s monitoring and review processes for Standard 5 were not demonstrated to be effective.

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

*The service environment:*

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

The Assessment Team found that the environment in the service is kept clean and well-maintained. It is comfortable and enables consumers to move freely inside the building and to access the outdoors. However, there are hazards in the service environment including some which pose safety risks for consumers. Effective monitoring and rectification processes were not evident, and some hazards have not been identified and/or addressed. The lack of effective monitoring and rectification does not appear to have been identified through the organisation’s quality assurance processes.

The Assessment Team observed a number of hazards in the service with potential risk to consumers and others. These included that the fire indicator panel (FIP) showed a detector was isolated in a room in the service. Clinical and cytotoxic waste bins were unlocked and the waste storage bay where they were located is able to be secured, but the door to the bay was open to the car park. This meant people coming into the service from the street could access the waste.

The Assessment Team also observed the door to the room housing the laundry chute is not lockable, the key was kept in the lock of the laundry chute door and the door to the chute was unlocked. This meant the laundry chute was accessible to consumers. Chemicals were accessible to consumers. The dirty utility room in Arrawarra was open. Inside the room were cleaning chemicals. The meant the cleaning chemicals were accessible to consumers.

The Assessment Team also observed the medication room was open with the keys in the medication trolley on one occasion and on 3 occasions a medication trolley was observed in the houses left unattended with the keys still in the lock and/or a drawer open. This meant the medications were accessible to consumers.

The approved provider responded to the Assessment Team’s report and did not agree that the findings of the Assessment Team posed a hazard to the consumers. I have found that although an incident has not occurred the hazards were evident and posed a potential risk to consumers.

I find that the approved provider is not compliant with this requirement.

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

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

# STANDARD 6 COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

The Assessment Team found that overall consumers considered they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Consumers and representatives said they are able to raise issues if needed and felt safe to do so.

The Assessment Team however found, it was not demonstrated there is documented guidance about how to manage complaints and the records provided about the complaints made lacked detail to show how complaints have been managed. However, consumers and representatives said that actions have been taken in response to complaints. The service general manager explained how complaints are managed in general and in relation to complaints made by consumers and representatives. Staff lacked knowledge of open disclosure, however the general manager had detailed knowledge of this and none of the consumers or representatives provided any feedback indicating a lack of open disclosure. Overall, it was shown that appropriate action is being taken in response to complaints and open disclosure is being practiced.

Consumers and representatives who had made a complaint or given feedback were satisfied with the resolution, including to bring about improvement for them/their relative. While there are organisational policies and procedures regarding complaints and feedback, there is a lack of evidence to show whether and how the feedback and complaints made by consumers at the service, or their representatives, has been used to improve the quality of care and services for consumers.

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.*

The Assessment Team found that consumers and representatives who had made a complaint or given feedback were satisfied with the resolution, including to bring about improvement for them/their relative. While there are organisational policies and procedures regarding complaints and feedback, there is a lack of evidence to show whether and how the feedback and complaints made by consumers at the service, or their representatives, has been used to improve the quality of care and services for consumers.

The Assessment Team found that some ongoing concerns of consumers and representatives are not documented, and it is unclear whether these have been discussed or are in process. There has been feedback about the lack of a bus for consumers who move around in a wheelchair to go out on scenic drives and a request from a consumer for table tennis equipment for those more able to play. These have not been addressed.

The approved provider responded to the Assessment Team’s report and provided evidence of improvements initiated as a result of consumer requests. This included the pending purchase of a table tennis table and a wheelchair accessible taxi to be provided to consumers wishing to go on outings.

I find that the approved provider is compliant with this requirement.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Assessment Team interviewed consumers and representatives who considered they get quality care and services when they need them and from people who are knowledgeable, capable and caring. However, some thought there was not enough staff to meet their/their relative’s needs.

The Assessment Team observed staff are kind, caring and respectful to consumers.

The Assessment Team undertook a review of documentation and interviews with management and staff showed staff are being recruited and inducted in accordance with organisational policy/procedure. Staff core competencies are defined, staff performance is monitored, and staff say they feel supported in the work they do.

However, on most recent days shifts on the staff master roster have not been filled and on all days sampled the response to some call bells and sensor alerts has been excessive. Staff say at times there is not enough staff to complete their work. They say they absorb the impact of this by working harder or longer and/or there is impact on consumers. Staff say the service management team is trying to address the staff shortage and fill the shifts. Discussion with management and review of records confirmed this.

The Assessment Team noted that while some staff training, and competency assessment is being undertaken, for some mandatory topics the completion rate is lower and the service management team has identified this as an area for improvement. While staff were knowledgeable about all or some topics sampled, some staff lacked knowledge in some areas relevant to their role and responsibilities.

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) Non-compliant

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

The Assessment Team found that the service demonstrated the workforce is planned. In the context of staffing challenges generally in aged care and in the local geographical area, adjustments have been made to the master roster and recruitment has been ongoing to try to ensure there is sufficient staff. However, the workforce as deployed has not enabled the delivery and management of safe and quality care and services for some consumers. Some rostered shifts are not being filled and some call bells and sensor alerts are not being responded to by the staff within a reasonable time. Some consumers/representatives and staff provided feedback about lack of staff and the impacts of this, including on consumers. The Assessment Team’s findings across this performance assessment do not support there has been sufficient staff to meet the needs, goals and preferences of consumers or to address the risks associated with their care.

The Assessment Team reviewed a report named excessive response times for call bells and sensor alerts for a sample of 3 recent days: 22, 25 and 28 November 2021. There were 176 calls answered in more than 10 mins, 29 associated with a sensor alert and the remainder a call bell. There were many consumers for whom this occurred multiple times.

The approved provider responded to the Assessment Team’s report and advised the service in a regional area has been significantly impacted by the shortage of healthcare workers, however disagrees that this has impacted the care and service provided to the consumers. I have considered the information that has been provided however, I find that the excessive times to respond to call bells does impact on the delivery and management of safe and quality care and service to consumers.

I find that the approved provider is not compliant with this requirement.

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

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

### 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 reviewed the organisation’s policy and procedure and noted it is being followed in relation to staff recruitment. Staff orientation is occurring, and staff say they feel supported by management. While staff say they can and have accessed training relevant to their role and records reviewed show some staff training has been provided, completion rates for some mandatory training and competency assessments are lower than others. Some staff lacked knowledge in some areas relevant to their role and responsibilities. Some of the Assessment Team’s findings support a lack of knowledge by staff in some areas.

The Assessment Team reviewed 6 staff training topics (restrictive practice, SIRS/incident management system, BSPs, pain management, skin care/wound management, and falls prevention/management. While there has been training in these areas the Assessment Team’s findings are that in some of these areas there are gaps in staff practice.

The approved provider responded to the Assessment Team report and advised that several more staff had undertaken the training, however the attendance had not been updated in the records. I have considered the information provided, however find that the gaps that have been identified within this report, indicate that additional training is required, and it should be demonstrated in practice.

I find that the approved provider is not compliant with this requirement.

### 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

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (including as assessed through other Standards). The Assessment Team also sought feedback from consumers and representatives about whether they think the service is well run.

The Assessment Team found that none of the consumers/representatives spoke of ways they are engaged in the development or delivery of care and services across the service or organisation. The service management team explained no one has agreed upon invitation to be involved in additional consultative forums or roles. The service’s staff said consumer input has been used to develop activity programs for consumers at the service. However, organisational policy/procedure about consumer engagement was not provided and there was limited information about how the organisation seeks to engage consumers in the development and delivery of care and services across the organisation. There are feedback mechanisms for consumer input into the evaluation of care and services across the service and the organisation. However, limited information was provided about this being in response to feedback from consumers at this service and how it has led to change for consumers at this service.

The Assessment Team found that the service demonstrated the governing body promotes a culture of safe and quality care and services. Consumers and representatives interviewed by the Assessment Team said the service is well run. Staff interviewed demonstrated an understanding of the expected organisational culture consistent with the strategic plan. The regional managers described how the governing body is accountable for the delivery of safe and quality care. Sufficient documentation was not provided to corroborate this. It was not demonstrated the governing body is accountable for the delivery of safe, inclusive and quality care.

The Assessment Team identified that none of the information gathered indicates any gaps in effective organisation wide governance systems for financial governance. There are gaps in the effective governance of continuous improvement and regulatory compliance and to a lesser extent, for information management. It was not demonstrated there is effective organisation wide governance in relation to the workforce or feedback/complaints.

The organisation has a documented organisational risk management framework (RMF) describing some aspects of the risk management systems and practices. An organisational risk register was not provided, and the service risk register relates to workplace but no other risks, and it does not include details to show the effectiveness of the risk controls. There are organisational policies and procedures about high impact and high prevalence (HIHP) risks associated with the care of consumers, consumer abuse and neglect, incorporating supporting consumers to live their best life, and about consumer incident management and prevention. This has been implemented at the service in relation to supporting consumers to live their best life. The policy and procedure have not been implemented at the service for effective management of HIHP risks associated with the care of consumers, responding to consumer abuse, or preventing consumer incidents. It was not demonstrated there has been oversight of this for effective risk management.

The Assessment Team identified that the organisation has a documented clinical governance framework (CGF) however it lacks specificity in some areas. Data about some clinical indicators is collated, reported and benchmarked each month, however this does not incorporate some relevant indicators including as specified in organisational policy and procedure. Effective clinical governance was not demonstrated in relation to AMS, minimising the use of restrictive practice or open disclosure. It was not demonstrated there has been oversight of this for effective clinical governance.

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

## Assessment of Standard 8 Requirements

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

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

The Assessment Team interviewed consumers and representatives who could not speak of ways they are engaged in the development or delivery of care and services across the service or organisation. The Assessment Team asked the service management team for the names of any consumers engaged in committees, working groups or in other ways which for input to the development of care and services across the service or organisation. The general manager explained at service level they have sought to engage some vocal consumers in additional consultative forums or roles, but those consumers have not been receptive to date.

The Assessment Team reviewed the continuous improvement plan which did not show any examples of consumer engagement.

The Assessment Team requested organisational policy and procedure relating to consumer engagement; none was provided.

The approved provider responded to the Assessment Team’s report and advised there had been several improvements as a result of consumer feedback, this has been captured in Requirement 6(3)(d). It was identified there was very limited consultation and engagement with consumers and no organisational policy and procedure for engaging consumers at the service in the development, delivery or evaluation of care and services across the organisation.

I find that the approved provider is not compliant with this requirement.

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

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

The Assessment Team found that overall it was demonstrated the governing body promotes a culture of safe and quality care and services. The Assessment Team interviewed consumers and representatives and while many consumers and representatives said the service is well run, some spoke of staffing shortages and the service management personnel turnover when asked about this. The regional managers described how the governing body is accountable for the delivery of safe and quality care.

The Assessment Team sought documentation (such as reports to or minutes from relevant meetings such as the clinical governance committee) to corroborate the information provided from the regional managers about the governing body being accountable for the delivery of safe and quality care. The charter for the clinical governance committee was provided and reflects the committee’s responsibilities include, but are not limited to, monitoring the effectiveness of the clinical risk management and quality and safety controls. The Assessment Team notes this is relevant to the assessment of performance against the Quality Standards. Other than records showing the approach to consulting consumers about the design of the upcoming significant refurbishment of the memory support neighbourhood, no more recent or detailed records were provided to enable corroboration of information that the governing body is accountable for the delivery of safe, inclusive and quality care. Additionally, there was a lack of information to show the governing body promotes and is accountable for a culture of inclusivity.

The approved provider responded to the Assessment Team’s report and provided a copy of the cultural safety, diversity and inclusion policy and procedures and other clinical policies, however did not provide evidence of their strategy to improve the service culture, or meeting minutes detailing priorities and outcomes to demonstrate their accountability for the delivery of care and services.

I find the approved provider is not compliant with this requirement.

### 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 Assessment Team identified there are gaps in the effective governance of continuous improvement and regulatory compliance and to a lesser extent, for information management. It was not demonstrated there is effective organisation wide governance in relation to the workforce or feedback/complaints.

The Assessment Team interviewed staff who said they can readily access the information they need when they need it. They did not think they faced any major issues in accessing up to date information about consumers or recent staff communications. However, as noted, consumer care plans do not include all information about the needs, goals and preferences or the risks associated with the care of some consumers to guide staff practice.

The Assessment Team reviewed meeting minutes that reflect the service and organisation have identified many of the gaps found by the Assessment Team during this performance assessment and these are discussed at meetings. However, it was not demonstrated this has consistently led to improvement.

The results of internal quality audits are reported at the service quality meetings. While the minutes reflect the gaps and potential areas for improvement, they lack information about what is to be done and/or assignment of responsibility. Minutes of the next meeting do not show any related information.

The approved provider responded to the Assessment Team’s report and refuted the Assessment Team’s report, stating that the documentation contains risks and interventions to manage care and are appropriate. The provider also stated that their clinical indicators are primarily used to identify systemic issues and not one-off incidents, however do not include all skin injuries. I have considered the approved provider’s response, however find that the service does not demonstrate that there are effectiveorganisation wide governance systems in place in all areas.

I find that the approved provider is not compliant with this requirement.

### 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 found that the organisation has a documented organisational risk management framework (RMF) describing some aspects of the risk management systems and practices.

The Assessment Team requested organisational risk register/s: strategic, operational. These were not provided. A service risk register was provided however, related to workplace risks and does not include details about risks associated with other aspects of service operations, including consumer care. The register includes inherent risk ratings for the specific workplace risks and the status of current controls, but no residual risk rating or detail of the effectiveness of the risk controls to help understand if the risk controls in use require review. No other documentation was provided showing monitoring and review of organisation wide risk management relating to the Quality Standards.

The Assessment Team found the in relation to managing High Impact and High Prevalence (HIHP) risks for consumers, there is related organisational policy and procedure. However, the Assessment Team’s findings are that for some consumers sampled HIHP risks associated with their care are not effectively managed.

The Assessment Team found in relation to abuse and neglect of consumers being identified and responded to, review of the compulsory reporting folder provided included monthly registers, however did not include all incidents and for some incidents did not include the consumer name or had only their initials. The records in the folder behind the registers did not include details about all incidents.

The Assessment Team found in relation to incidents being managed and prevented, incident management and prevention systems are in place, these have not been consistently followed at the service.

The approved provider responded to the Assessment Team’s report and furnished policies and procedures in relation to high impact and high prevalence risks to guide staff. I have considered the information provided, however note that the policies have not always been followed and as a result there has been a lack of investigation and review of risk controls.

I find that the approved provider is not compliant with this requirement.

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

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

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

The Assessment Team found in summary, the organisation has a documented Clinical Governance Framework however it lacks specificity in some areas. Data about some clinical indicators is collated, reported and benchmarked each month, however this does not incorporate some relevant indicators including as specified in organisational policy and procedure. Effective clinical governance was not demonstrated in relation to AMS, minimising the use of restrictive practice or open disclosure. It was not demonstrated there has been oversight of this for effective clinical governance.

The Assessment Team found the organisation’s documented Clinical Governance Framework does not include the details of all of core elements at the organisation for implementation. For example, a core element of an effective Clinical Governance Framework is having measures of success for clinical quality and safety. The Clinical Governance Framework includes that the organisation is driven by information and data with lead and lag indicators which are quantitative and qualitative across safety and quality; and that there is a core set of measures across all services. The indicators and measures are not specified in the Clinical Governance Framework.

The approved provider responded to the Assessment Team’s report and contested the teams report. Additional information was furnished in relation to how the Clinical Governance Framework provides guidance and strategies to guide practices, however these strategies and practices were not demonstrated in relation to minimising the use of restrictive practice and monitoring and review of service performance in relation to antimicrobial stewardship.

I find that the approved provider is not 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.

### 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 approved provider must demonstrate:

* Assessments and care plans include risks associated with the consumers care and related strategies.
* Assessment and care plans are reviewed and updated when new risks are identified.
* Incident investigation is conducted and documented to inform the review of the care plan and to implement effective strategies for staff to prevent the incident reoccurrence.

### Requirement 2(3)(e) Non-compliant

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

The approved provider must demonstrate:

* Consumers’ care and services are regularly reviewed for effectiveness when consumer incidents occur, including falls, behavioural and skin injury incidents.
* Investigation to understand factors contributing to consumer incidents to inform care planning and prevent future incidents are conducted.
* Recording of incidents should include complete description and contributing factors of the incident, actions taken by staff and strategies to prevent future incidents.

### 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 approved provider must demonstrate:

* Consumers personal and clinical care is tailored to their needs and optimises their health and well-being.
* Medical officer directives are followed and documented.
* Medical officer directions are followed prior to administering chemical restraint PRN.
* Review and evaluation of alternative strategies must be conducted and documented if these strategies are found to be ineffective.
* Pain assessments are documented.
* Alternate strategies are documented as being trialled prior to PRN medication being administered.

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

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

The approved provider must demonstrate:

* Assessments and monitoring charts are completed following any incidents.
* Medical officer directive is followed for consumers and recorded consistently.

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

*Minimisation of infection related risks through implementing:*

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

The approved provider must demonstrate:

* All staff are informed of consumer’s requiring infection management.
* All staff have education in infection precaution and control.
* Buddies or spotters are in place to ensure that staff are wearing masks and if required additional PPE appropriately as per the NSW Health Guidelines.
* Monitoring and review of service performance is conducted in relation to antimicrobial stewardship (AMS).

### Requirement 5(3)(b) Non-compliant

*The service environment:*

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

The approved provider must demonstrate:

* Effective monitoring and rectification are identified through the organisation’s quality assurance processes.
* Hazards and potential risk to consumers and others is eliminated with regular review and compliance with locked waste bins, medication rooms, cupboards and trolleys and laundry that pose risks to consumers and others.
* Immediate maintenance to any isolation detectors is conducted if the fire indicator panel (FIP) detects an issue.

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

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

The approved provider must demonstrate:

* Rostered shifts are filled and sufficient staff are rostered to meet the needs, goals and preferences of consumers and to address the risks associated with their care.
* Call bells and sensor alerts are responded to by the staff within a reasonable time.

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

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

The approved provider must demonstrate:

* All mandatory training and competency assessment topics are completed.
* Staff have access to current training and can demonstrate that knowledge in their work.
* Attendance of staff training is updated in electronic records.

### 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 approved provider must demonstrate:

* Consumers are engaged in the development or delivery of care and services across the service or organisation.
* Organisational policy and procedure is developed for engaging consumers at the service in the development, delivery or evaluation of care and services across the organisation.

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

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

The approved provider must demonstrate:

* Accountability for the delivery of safe, inclusive and quality care and promotes and is accountable for a culture of inclusivity.

### 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 approved provider must demonstrate:

* The results of internal quality audits reflecting gaps and potential areas for improvement, detail actions for remediation and assignment of responsibility. Minutes of the next meeting do not show any related information.
* An effectiveorganisation wide governance system in place in all areas.

### 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 approved provider must demonstrate:

* An effective risk management system and practice to address risks to consumers
* Effective oversight of the risk management system to identify when risk controls need to be reviewed.
* Risk registers include all incidents and details about all incidents including investigation and actions taken.

### 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 approved provider must demonstrate:

* The Clinical Governance Framework effectively guides the practice of staff and staff can demonstrate these practices in their day to day work.