Edenfield Family Care - Ramsay

Performance Report

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**Commission ID:** 6039

**Provider name:** El-Jasbella Ramsay Pty Ltd

**Review Audit date:** 17 November 2021 to 20 November 2021

**Date of Performance Report:** 24 January 2022

# Performance report prepared by

Michelle Glenn, 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** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Non-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) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | 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** | **Non-compliant** |
| Requirement 6(3)(a) | Non-compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-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) | 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 Review Audit; the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others
* the provider’s response to the Review Audit report received 11 January 2022
* the Assessment Team’s report for the Assessment Contact – Site and Desk conducted 2 November 2021 to 5 November 2021
* the Performance Report dated 13 May 2021 for the Site Audit conducted 9 February to 11 February 2021.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

In relation to Requirement (3)(b), the Assessment Team were not satisfied the service demonstrated care and services are culturally safe, staff always identified consumers with different cultural needs or addressed the cultural needs, including language and religious needs, for one consumer. The Assessment Team have recommended Requirement (3)(b) in Standard 1 Consumer dignity and choice not met.

In relation to all other Requirements in this Standard, the Assessment Team found overall, sampled consumers considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. The following examples were provided by consumers during interviews with the Assessment Team:

* staff are aware of their preferred daily routines and supported their efforts in maintaining independence;
* described how they are supported to take risks;
* receive information to help inform decisions; and
* most staff are respectful of their privacy and take steps to show respect and promote dignity.

Consumers are treated with dignity and respect, with their identity, culture and diversity valued. Most staff spoke of consumers in a kind, caring and respectful manner and demonstrated awareness of consumers’ background. Consumers are supported to take risks to enable them to live the best life they can. Where consumers choose to undertake and activity which includes an element of risk, risk assessments and risk management plans are completed in consultation with consumers and/or representatives and reflect identified risks and mitigation strategies.

Information provided to consumers is current, accurate and timely. Information is made available to consumers through newsletters, meeting forums and noticeboards. Staff were observed to deliver care in a way which promoted and respected consumers’ privacy and personal information is kept confidential. Consumers and representatives described involvement in care and decision making processes. Entry processes include collection of information relating to consumers’ life story and personal preferences which is used to inform care delivery. Staff sampled described consumers’ preferences for daily care and how they support consumer choice and independence. Staff also identified key relationships for consumers.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) and Compliant with Requirements (3)(a), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice. I have provided reasons for my finding in the specific Requirement below.

## 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) Non-compliant

*Care and services are culturally safe.*

The Assessment Team were not satisfied the service demonstrated care and services are culturally safe, staff always identify consumers with different cultural needs or have addressed the cultural needs, including language and religious needs, for one consumer. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer A

* Consumer A is from a culturally and linguistically diverse background and speaks a minimal amount of English. The care plan indicates religion is important to the consumer and they have religious, spiritual and pastoral care routines and customs, traditions and cultural considerations relating to leisure, lifestyle, and well-being routines. Three specific cultural celebrations the consumer likes to celebrate are noted.
* What the customs, traditions, or cultural considerations entail or explanation of the differences in dates, which are different to the Christian calendar celebrations, for two of the cultural celebrations which staff may not be aware are not identified.
* The care plan does not identify specific days of importance for one of the celebrations to Consumer A or the importance of the days within their culture.
* Care staff stated Consumer A is connected to their cultural heritage through watching a culturally specific television station. One stated Consumer A either watches television all day, or spends time with their family. The staff member stated they do not need to do much for the consumer following their shower.
* A Coordinator indicated Consumer A can understand some key English words and for more complicated matters, rely on family to translate. A trial communication tools was unsuccessful.
* The Coordinator indicated they spoke to Consumer A’s family who declined their offer to arrange something for a specific cultural celebrations. However, the consumer watches church services on television in their room to meet their religious needs.
* Consumer A’s representative indicated:
* Consumer A has not left their room for three months, seems no longer keen to do much at all and has lost the desire and interest in going out for the day with the family.
* Family visits are the main means for Consumer A to communicate and ongoing lockdowns have impacted the information the consumer receives.
* Consumer A is still aware of dates, and remembers cultural celebrations. It is important to Consumer A to understand the dates. The representative stated they can’t do much about them (staff) not celebrating it.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team as well as supporting documentation. The provider’s response included, but was not limited to:

* The Assessment Team’s report states the family have declined to celebrate any cultural special days for Consumer A. As the family explain, the consumer has also declined going out with family. It is Consumer A’s choice to sit in their room and keep to themselves. This is a resident choice.
* The Lifestyle coordinator regularly visits with Consumer A and understands their requests.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit the service did not demonstrate culturally safe care and services, specifically for Consumer A.

In coming to my finding, I have considered that the service has not sufficiently recognised or supported Consumer A’s cultural identity. Care plan documentation outlines the consumer’s connection to religion, cultural customs, traditions and considerations, and family indicated cultural celebrations are important to the consumer. However, the care plan lacks detail to guide staff on how to support the consumer to maintain these connections and customs. The provider’s response indicates the family have declined to celebrate any cultural special days for Consumer A. However, there is no indication to suggest that this is the consumer’s choice.

I have also considered feedback from staff demonstrated a limited understanding of what culturally safe care is. Staff indicated Consumer A’s cultural heritage is met through watching a culturally specific television station all day. This has not ensured improved outcomes for Consumer A’s care and services have been achieved with representatives indicating Consumer A has been isolating in their room, is no longer keen to do much and has lost the desire and interest in going out.

### For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) in Standard 1 Consumer dignity and choice.

### 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-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

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

The Assessment Team have recommended Requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met. The Assessment Team found the service was unable to demonstrate:

* assessment and planning, including consideration of risks to consumers’ health and well-being informs the delivery of safe and effective care and services, specifically in relation to behaviour management strategies and individualising goals and preferences; and
* care plans are consistently reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals, or preference of the consumer.

In relation Requirements (3)(b), (3)(c) and (3)(d) in this Standard, the Assessment Team found that some consumers sampled considered that they feel like partners in the ongoing assessment and planning of their care and services. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* two representatives stated they had been provided a copy of an advance care plan prior to entry providing the family to talk about the topic;
* described occasions where they had been consulted in relation to assessments, reviews, and changes to consumers’ care and service needs following allied health visits; and
* are aware of care plan documents and stated staff have discussed care plans with them.

Care files sampled demonstrated consumers’ needs, goals and preferences, including in relation to advance care planning and end of life planning are identified and addressed. End of life discussions are revisited during regular care plan review processes and in response to deterioration in consumers’ health.

Care plans sampled demonstrated consumers and/or representative and allied health specialists are involved in assessment and planning of care and services on entry and on an ongoing basis. Entry processes enable consumers to nominate who they would like involved in their care, including in relation to assessment and reassessment processes.

Care plans are developed from information gathered through assessments and consultation with consumers and/or representatives and are made available to consumers and/or representatives on entry and on request. Staff have access to care plans to assist them in the delivery of care and services. Progress notes demonstrated consultation with representatives occurs following monthly care reviews to discuss changes to consumers’ care needs and to identify where a copy of the care plan has been provided.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirements (3)(a) and (3)(e) and Compliant with Requirements (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers. I have provided reasons for my findings in the specific Requirements below.

## 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 were not satisfied the service demonstrated assessment and planning, including consideration of risks to consumers’ health and well-being informs the delivery of safe and effective care and services, specifically in relation to behaviour management strategies and individualising goals and preferences. The Assessment Team provided the following information and evidence relevant to my finding:

* Environmental restraint assessments and care plans for all 10 consumers in the memory support unit use the same core wording with minor differences for alternative strategies and preferences. Information is not personalised and is set in a generalised statement.
* Chemical restraint assessments and care plans for eight of 10 consumers include the same wording to describe alternative strategies to be used prior to the administration of chemical restraint with only minor differences noted.

Consumer B

* A Behaviour support plan has not been updated in response to increased behaviours, change in mobility and does not include personalised preventative strategies. Staff did not demonstrate knowledge of personalised strategies to assist with management of Consumer B’s behaviours.

Consumer C

* An Initial assessment included inconsistencies in information relating to mobility, personal care and repositioning.

The provider’s response outlined actions taken to address the deficiencies identified as well as further information to clarify evidence presented in the Assessment Team’s report. The provider’s response included, but was not limited to:

* Acknowledge Behaviour care plans are not personalised. This is now part of the Plan for continuous improvement.
* The electronic Restrictive practice assessment includes drop down boxes where you can only choose from specific words or phrases. The only free text box is under care details which for each resident assessment is personalised and care plans are created from an assessment.
* Chemical restraint assessments for two consumers have been updated. An as required psychotropic medication for one of these consumers has been ceased.
* Acknowledge Consumer B’s assessment should have been updated. The Behaviour support plan has been updated to reflect changes.
* On entry, Consumer C’s representative indicated the consumer needed encouragement to change position frequently.

I acknowledge the provider’s response and the associated documentation provided. The service has taken appropriate actions to address the deficits identified by the Assessment Team at the Review Audit. However, I find at the time of the Review Audit, the service did not demonstrate the assessment and planning processes were effectively implemented to ensure assessment and planning was personalised and reflective of consumers’ current needs, specifically in relation to restrictive practices and behaviour management.

I have considered that information documented in restrictive practices assessments and care plans was similar in nature for all consumers residing in the memory support unit. I find that this has not ensured each consumer’s care plan is tailored to their specific needs or informs how, for each consumer, care and services are to be delivered. In relation to Consumer B, the care plan was not reflective of the consumer’s changed needs, including in relation to behaviours, and staff sampled were unable to describe any personalised behaviour management strategies for Consumer B.

In relation to Consumer C, supporting documentation included in the provider’s response demonstrates initial assessments are reflective of the representative’s requests. Additionally, the Assessment Team’s report states staff were knowledgeable of Consumer C’s care and service needs.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

### Requirement 2(3)(e) 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 were not satisfied the service demonstrated care plans are consistently reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals, or preference of the consumer. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer D

* The care plan did not reflect the consumer’s changed needs following a clinical event. While some clinical care areas had been reassessed in a timely manner in response to the consumer’s changed needs, some had not been completed until approximately two months after the event. This included assessments relating to malnutrition, skin, pain and personal hygiene. Reassessment of other clinical areas had not been undertaken in response to the consumer’s changed needs, including falls risk, cognition and depression. Additionally, continence and communication and sensory care plans had not been updated to reflect Consumer D’s current care needs.
* Care staff advised they relied upon care plans and verbal handovers to understand consumers’ needs and changes. Those sampled were aware of the consumer’s current care requirements relating to activities of daily living.
* Four weekly progress notes for September and October 2021 included information which was not in line with the consumer’s current care needs. Clinical management advised it was possible that staff would copy and paste previous notes for the weekly review, and they would review further and address with staff.

Consumers B and E

* Required chemical restraint was administered to Consumer B on 11 occasions over a 17 day period November 2021 and Consumer E on six occasions in October. Behaviour assessments and care plans for both consumers had not been reviewed since September 2021.
* The Restrictive practices/Restraint minimisation policy states the care plan requires review, including when the residents condition changes. The policy does not identify the requirement to review following use of chemical restraint as legislated.

The provider’s response indicates they do not agree with aspects of the Assessment Team’s recommendations and commentary to refute assertions made by the Assessment Team as well as supporting documentation. Additionally, the provider’s response outlined actions taken to address some of the deficiencies highlighted as well as further information to clarify evidence presented in the Assessment Team’s report. The provider’s response included, but was not limited to:

In relation to Consumer D

* The assessment tool used rates pain at a particular time, therefore, there were no interventions required. The consumer’s pain is effectively managed. Regular analgesia is prescribed, therefore, pain is moderate. No as required pain relief is charted or requested. The provider’s response did not include supporting documentation to support these statements.
* The consumer was reviewed by the Physiotherapist in September 2021. There were no differences in care.
* The Communication and sensory assessment have been updated.

In relation to Consumers B and E

* The *Quality of Care Principles 2014* amendments do not state a requirement to review care plans following use of chemical restraint. Legislation requirement states if there is a change to a chemical restraint medication order, the Behaviour support plan requires review/change.

I acknowledge the provider’s response and the supporting documentation provided specifically for Consumer D. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not care and services are regularly reviewed for effectiveness in response to changes in consumer’s care and service needs.

In relation to Consumer D, I have considered that while the consumer’s care and service needs had changed following a clinical event, the care plan for some areas of care had not been updated to reflect the consumer’s changed needs, goals and preferences. Following the clinical event, assessments for some areas of care were not initiated until up to two months later or not at all. I acknowledge the Assessment Team’s report indicates care staff were knowledgeable of the consumer’s current care needs. However, I have also considered that care staff sampled indicate, they relied on care plans to understand consumers’ needs and changes.

For Consumers B and E, I acknowledge the provider’s response. However, I have considered that Behaviour assessments and care plans have not been reviewed in line with legislation which indicates to review and make necessary revisions after any change in the consumer’s circumstances. I find that this did not occur for Consumer B following an as required psychotropic medication being prescribed in November 2021. The Behaviour assessment and care plan were last updated in September 2021, prior to the medication being prescribed.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team have recommended Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e) and (3)(g) in Standard 3 not met. The Assessment Team found the service was unable to demonstrate:

* non-pharmaceutical interventions are used prior to administration of as required medications, behavioural management strategies and medication administration are in accordance with best practice principles, or that consumers are provided a diet in accordance with their assessed needs;
* effective management of high impact or high prevalence risks associated with the care of each consumer, specifically wound care and consumers at high risk of pressure wounds;
* the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved
* deterioration or change of a consumer’s mental health, cognitive or physical capacity or condition is recognised and responded to in a timely manner;
* documentation and communication of Medical officer instructions, changes of care requirements or clinical indications when commencing new medications; and
* minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection or practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Assessment Team recommended Requirement (3)(b) not met at an Assessment Contact conducted 2 November 2021 to 5 November 2021 where it was found the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically relating to pressure area care and management of pressure area wounds. A finding of compliance for the Assessment Contact was not made with the Assessment Team’s report for the Assessment Contact conducted 2 November 2021 to 5 November 2021. However, I have considered the evidence in my finding for Requirement (3)(b) in Standard 3 for the Review Audit as it is relevant. At the Review Audit conducted 17 November 2021 to 20 November 2021 the Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer in relation to wound care and consumers at high risk of pressure wounds. The Assessment Team have recommended Requirement (3)(b) not met.

In relation to Requirement (3)(f) in this Standard, Clinical staff sampled described how referrals are initiated and staff informed of changes to consumers’ care and service needs. Care files sampled demonstrated consumers had been referred to a range of allied health specialists with recommendations and/or directives incorporated into consumer care plans.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report, the provider’s response and the Assessment Team’s report for the Assessment Contact conducted 2 November 2021 to 5 November 2021 and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) and Compliant with Requirements (3)(c) and (3)(f) in Standard 3 Personal care and clinical care. I have provided reasons for my findings in the specific Requirements below.

### 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 were not satisfied the service demonstrated non-pharmaceutical interventions are used prior to administration of as required medications, behavioural management strategies and medication administration are in accordance with best practice principles, or consumers are provided a diet in accordance with their assessed needs. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer B

* As required psychotropic medication was administered on 11 occasions over a 17 day period in November 2021 for agitation and calling out. Progress notes and wound charting on the dates the medication was administered indicates the consumer presented with an itchy rash.
* Documentation shows staff administered psychotropic medications when a prescribed cream was ineffective. Alternative strategies trialled prior to administration of the medication were only documented on one occasion.
* A skin rash appeared two hours after the first administration of an oral psychotropic medication. The medication was noted to be administered on a further six occasions.
* Progress notes do not show a medicated cream prescribed for the rash was applied prior to administration of additional psychotropic medication.
* Investigation into the cause of the rash could not be demonstrated. Staff could not explain actions taken in regard to the rash or actions taken by the Medical officer to assess the cause. Email correspondence with the Medical officer regarding the rash was evident, but did not demonstrate the Medical officer had reviewed the rash or taken any further actions apart from prescribing creams.
* Staff confirmed the consumer’s rash persisted at the time of the Review Audit and behaviours continued.

Consumer E

* As required medication was administered on six occasions over a 14 day period in September 2021 and six occasions in October 2021 for wandering behaviours. Three staff confirmed administration of psychotropic medications prior to trying non-pharmacological interventions.
  + Of 61 behaviour monitoring entries, strategies were noted to be effective on 29 occasions. While interventions were noted to be effective on 29 occasions, staff had noted the consumer was ‘still calling out’.

Behaviour management

* Four staff and/or representatives indicated bedroom doors of consumers in the memory support unit were being locked during the day and at night after they are settled into bed to ensure Consumer H did not enter their bedrooms.
  + Five consumer bedroom doors were observed to be locked at approximately 12.30pm on day three of the Review Audit restricting them going into their rooms when they wanted.
  + At approximately 8:00pm on day three of the Review Audit, four consumers’ bedroom doors were found to be locked with the consumers observed to be in bed. Two of the four consumers locked their own doors by choice. Doors for the other consumers were locked as a behaviour management strategy to prevent Consumer H from entering their rooms.
  + Two staff indicated further doors would be locked throughout the night to manage Consumer H’s behaviour.
  + Behaviour charting in September 2021 for another consumer, not Consumer H, indicated the consumer had entered another consumer’s bedroom. A progress note by a Registered nurse in response directed staff to ‘also lock other residents' room to avoid access.’

Medication management

* While consumers can tolerate oral medications, a Medical officer has prescribed an injectable psychotropic medication on an as required basis for agitation and anxiety.
* Three consumers had been administered injectable psychotropic medication. Medication charts for the three consumers did not clarify if staff are to attempt to administer oral medications as the first option prior to administration of the injectable. Progress notes did not demonstrate staff had attempted to administer any other as required medications prior to administration of the injectable medication.

Dietary requirements

* Care plans for Consumers G and B indicate both require a lactose free diet. Representatives for both consumers indicated staff always provide normal dairy products.
* Food charting in November 2021 indicated Consumer G had been receiving formula and ice cream that contained lactose in days prior to the Review Audit.
  + Consumer G had been identified as experiencing loose bowel motions, and was isolated due to the outbreak.
* Consumer G was reviewed by a Dietitian in November 2021 in response to weight loss. Food charting commenced five days later for a 10 day period. The charting had not been completed on four of the 10 days.
  + Progress notes do not reference review of a further weight loss recorded 12 days later.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations and includes commentary to refute assertions made by the Assessment Team as well as supporting documentation. Additionally, the provider’s response outlined actions taken to address some of the deficiencies highlighted as well as further information to clarify evidence presented in the Assessment Team’s report. The provider’s response included, but was not limited to:

In relation to Consumer B

* Behaviours of calling out and agitation have been a long standing pattern since entry in January 2021. A specialist consultation occurred in February 2021 and behaviour management strategies included in the Behaviour assessment and care plan. These strategies are used before use of any as required medication.
* The consumer has been more agitated more recently due to the rash and a specialist appointment is being sought.
* Registered staff have communicated with the Medical officer several times about the rash, behaviours and general well-being. Emails (included in the provider’s response) prove the consumer is regularly reviewed and family are communicated with.

In relation to behaviour management:

* “Resident doors locked on the 19 November” is a vague statement and was not discussed with management on the day to allow further investigation.
* In the evening, there were three residents’ doors locked not four. One consumer was sitting in the lounge room when the Assessment Team identified their door was locked as evidenced by camera footage.
* One of the four consumers may have been in the room but is capable of locking their door and staff have keys to access every room. There is a window to all residents’ rooms that allow staff to monitor residents.
* When questioned by management, the staff member stated they did not say they lock residents in their rooms. They said that some residents lock their own rooms, but the staff member checks on them through their windows. This staff member has signed a statutory declaration to prove that their statement is correct and true.
* The progress note stated to “lock other residents doors to avoid access”. The Registered nurse gave this direction during a consumer’s increased agitated behaviour only. No residents are locked in their room, it is only to lock the bedroom door during this increased agitation.

In relation to medication management

* A conversation relating to the dangers of chemical restraint has been undertaken with the Medical officer. Following a review of the psychotropic register, medications for the three consumers highlighted have been ceased.

The response did not address the evidence relating to Consumer E or dietary requirements.

In coming to my finding for this Requirement, I have also considered evidence documented in Standard 3 Personal care and clinical care Requirement (3)(b) relating to behaviour management for Consumer H, falls management, use of an antiseptic solution and insufficient stocks and supplies. While the provider’s response outlined actions taken in response to Consumer H, which I have considered in my finding, the response did not address the issues relating to other areas highlighted.

I acknowledge the provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service had not ensured each consumer was provided safe and effective personal care and/or clinical care that was best practice, tailored to their needs and optimised their health and well-being.

I have considered psychotropic medications, used on an as required basis, have not been prescribed or administered in line with best practice or that consumers’ health and well-being has been optimised through administration of these medications. Alternative strategies trialled prior to administration of psychotropic medications was not consistently documented. Additionally, while Consumer B was identified with a skin irritation following an initial dose of a psychotropic medication, there was no evidence that the cause had been investigated or the Medical officer had reviewed the consumer. The psychotropic medication was noted to have been administered on a further six occasions. I have also considered that while consumers are able to tolerate oral medications, injectable psychotropic medications have been prescribed and administered to consumers for the purposes of managing behaviours. I find this practice does not optimise the health and well-being of consumers and is not in line with best practice as less invasive administration methods have not been attempted prior to the administration of injectable medications.

In relation to Consumer G, I find the service has not consistently ensured care has been tailored to their needs or has optimised their health and well-being. The consumer has been receiving a diet which is not in line with their assessed needs. Additionally, food and fluid monitoring processes were not consistently implemented or monitored following a Dietitian review for weight loss. A further loss in weight was identified 12 days later.

I also find use of an antiseptic solution has not ensured wound management is being conducted in line with best practice care. Insufficient stocks and supplies, including in relation to wound care, nutritional supplements and continence aids has resulted in consumers not receiving care, which is best practice, tailored to their needs and optimises their health and well-being.

In relation to Consumer H, I have considered that while charting has been ongoing over a five month period to monitor the consumer’s behaviour, this information has not been used to review and/or develop new management strategies to optimise the consumer’s well-being and ensure the safety of the consumer and others. I have also considered that staff were not able to describe personalised behaviour management strategies for Consumer H. However, one staff member did describe locking other consumers’ bedroom doors as a strategy to manage Consumer H’s behaviour. In relation to this practice, I have considered that the evidence presented relates to deficiencies associated with providing an environment for consumers which is safe and enables them to move freely, including indoors. I find the evidence provided aligns with Standard 5 Organisation’s service environment Requirement (3)(b) and, as such, have considered it with my finding for this Requirement.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### 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 were not satisfied the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer, specifically wound care and consumers at high risk of pressure wounds. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer E

* Wound charting included inconsistencies relating wound sizes or size details not documented, number of wounds and which wound was being attended at each treatment. The same wound chart was being used for all three wounds with documentation not clarifying which wound was attended to or which wound sizing documented referred to.
  + Management confirmed each wound should have a separate wound treatment plan and wound dressing chart.
* Eleven staff confirmed repositioning does not always occur due to staffing levels, not having enough time to complete repositioning and most days, pressure area care is not completed.

Consumer H

* Behaviour charting from July to November 2021 indicated Consumer H exhibited wandering behaviours and verbal and/or physical aggression towards other consumers. The behaviour care plan had not been reviewed.
* Care staff were unable to describe personalised behaviour management interventions for Consumer H as outlined in the care plan. Interventions described by one staff member included locking other consumers’ bedroom doors.

Falls management

* Staff and representatives indicated floor sensor mats, in line with consumers’ falls management strategies, are not always in place when consumers’ are settled into bed or when sitting in a chair in their rooms.
  + On day three of the Review Audit at approximately 8.30pm, The Assessment Team observed sensor mats for three consumers placed under the bed and not next to the bed.

The provider’s response in relation to the Assessment Team’s report for the Review Audit indicated they accepted the Assessment Team’s recommendation. Additionally, the provider’s response included actions implemented, specifically in response to information relating to Consumer H, including:

* Since the Review Audit, mandatory Behaviour management training has been held for registered and care staff.
* An additional staff member has been allocated for a four hour period in the afternoon in the memory support unit.
* Consumer H was reviewed by specialist services in December 2021 with recommendations added to the Behaviour assessment and care plan. The consumer is noted as displaying less aggressive behaviour.

The response did not address the evidence relating to falls management.

At an Assessment Contact conducted 2 November 2021 to 5 November 2021, the Assessment Team recommended Requirement (3)(b) not met as the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer, specifically relating to pressure area care and management of pressure area wounds. A finding of compliance for the Assessment Contact was not made, with the Assessment Team’s report and provider’s response being considered in the findings for the Review Audit. The Assessment Team provided the following information and evidence relevant to my finding:

* Wound care is not attended in line with best practice measures. An antiseptic solution has been used as a cleansing agent on three consumers’ pressure injuries from August to November 2021.
  + Management said the antiseptic solution should not be used on any wounds and this had not been best practice in wound care for about 15 years.
  + Two clinical staff indicated they had not been directed not to use the antiseptic solution, with one indicating wound care management plans direct them to use it.
* Seven clinical and care staff said they do not have sufficient time to attend to consumers’ pressure area care every two hours as directed.
* Four clinical staff said they did not feel confident managing complex wound care and do not feel they have had sufficient training to enable them to do so.
* Sufficient stock of medications and general supplies is not consistently maintained to ensure staff can provide safe and effective care.
  + Two staff said they do not always have sufficient supplies, including wound dressings, hand towels, handwashing soap and gloves. One staff indicted insufficient supplies of continence aids resulting in consumers’ being placed in an aid which is not appropriate for them. The staff member stated this happens about every two months.
  + Consumer 1 was prescribed a supplement to assist in wound healing. Medication charts for a six day period in September/October 2021, note staff did not administer the supplement due to stock not being available.

Consumer 1

* The consumer entered the service in August 2021 with stage one pressure area and unstageable pressure areas to the right foot.
* Two photographs and wound documentation completed over a six day period post entry note a stage one pressure injury, however, the area is consistent with a stage 2 pressure injury.
  + Eight days post entry, wound documentation still indicates the pressure injury is a stage 1, not healing well and is increasing in size. A photograph shows two areas, one indicative of an unstageable pressure area which was not identified as such by staff until a week later.
  + A cavity at the pressure injury site was noted 34 days after entry. Cavity depth was not recorded on 16 occasions over a 20 day period in September and 16 October 2021. The depth was first recorded five days after a cavity was visible. Wound measurements were not consistently recorded or an accurate reflection of the wound actual size.
  + Two clinical staff said the wound was expanding throughout October 2021, not decreasing in size as indicated by wound measurements documented in the wound charts.
* The representative was not satisfied with management of the consumer’s pressure area care, wound management or nurses’ knowledge regarding wound care. Nurses did not inform them of how bad the wound was and the manager would say it was getting better, right up until the day the consumer was referred to a specialist.
  + The representative indicated they visited Consumer 1 every day for up to eight hours a day and they had observed up to six hours between turns.
  + The consumer was transferred to hospital in October 2021 and has not returned to the service. The representative indicated since Consumer 1 has been in hospital the wound is progressing well.
* Progress notes in September 2021 show a care staff was concerned for the consumer, indicating they were not their usual self. Clinical staff reviewed the consumer and noted a change in the consumer’s clinical condition.
  + A neurological assessment was not documented despite difficulties with swallowing and facial weakness being identified. A significant change in pulse was also noted in documentation which was not identified by staff.
  + A hospital discharge summary indicated a urinary tract infection. The representative indicated the consumer was also diagnosed with dehydration. Management stated Consumer 1 did not have a urinary tract infection and refuted claims by the hospital and representative the consumer was “severely dehydrated” when transferred to hospital.
* The representative indicated vomiting was an issue for the consumer resulting from a lack of proper repositioning when staff assist with meals or give too much food at once. There has been no further vomiting episodes since the consumer has been in hospital.
  + The potential need for a Speech pathology review was not identified until 4 weeks after consistent episodes of vomiting were recorded over a 23 day period in September 2021 during or after meals and medications.
  + There is no recorded follow up by the Medical officer despite these episodes being referred.
* Progress notes in September 2021 indicate the representative was concerned about Consumer 1 and asked for a urinalysis to be taken. There is no documented follow up for this request. A day later, a notation indicates the Medical officer requested a wound swab to be collected the following day. The swab was not collected until a day after the Medical officer’s request, with the results received four days later.
  + The Medical officer did not review the pathology or commence antibiotics until nine days after the initial concern about a wound infection was raised nor was this followed up by clinical staff at the service.

Consumer 2

* A risk assessment completed in November 2021 indicates the consumer is at significant risk of developing pressure injuries and requires repositioning two-hourly during the day and four-hourly overnight. A Skin assessment dated September 2021 indicates two-hourly repositioning.
* A stage 1 pressure injury was noted to re-develop in September 2021. Fifteen wound photographs taken over a 44 day period in September and November 2021 show visible breaks to the area. Fifteen wound entries over the period show the wound was incorrectly identified as a stage one pressure area. Management agreed the photographs demonstrate the wound has always been a stage 2, not a stage one pressure area as documented by staff.
  + Depth of the pressure injury was only recorded on one occasion and wound edge descriptions were not noted on six occasions.
* The representative indicated repositioning is not happening. They are sometimes at the service for up to four hours and staff do not move the consumer.

Consumer E

* At the time of the Assessment Contact, a stage two pressure injury had been ongoing for 43 days and does not appear to be healing. No reviews have been undertaken by the service’s Wound specialist nurse.
  + Wound charts indicate wound edge descriptions were not documented on six occasions between September and November 2021, wound measurements or description of the wound were not documented on six occasions in October 2021 and dressings used when attending to wound care on these dates were not noted.

The provider’s response to the Assessment Team’s report for the Assessment Contact indicated ‘wound management is currently under Sanction at Ramsay’. No further information was provided in relation to the issues identified.

I acknowledge the provider’s response to the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, high impact or high prevalence risks, specifically in relation to skin integrity, wound management and changes to a consumer’s condition were not effectively managed for each consumer.

In coming to my finding, I have considered that for consumers highlighted in the Assessment Team’s report, wounds were not adequately monitored or assessed to enable effective monitoring to occur, deterioration to be identified in a timely manner and appropriate actions initiated. Consumer 2’s wound was noted to have been incorrectly classified over a 44 day period and while Consumer E’s wound had been ongoing for a period of 43 days and was described as not healing, referral to a Wound specialist had not occurred.

In relation to Consumer 1, I have considered wounds were not adequately monitored or deterioration identified. A pressure injury identified on entry deteriorated to an unstageable pressure injury over a 43 day period. Pressure injuries were incorrectly staged, wound measurements did not reflect the actual wound size and deterioration of pressure injuries was not promptly identified. While a cavity developed at a pressure injury site, this was not recorded as such until five days after identification and the depth of the cavity was not consistently measured and monitored. I find such practices have not ensured the effectiveness of current management strategies is monitored resulting in deterioration in pressure injuries to not be identified and acted upon in a timely manner. I also considered the service failed to identify and initiate actions in response to significant changes to the consumer’s condition health and well-being with appropriate assessment not being undertaken and prompt referrals to the Medical officer and/or appropriate allied health specialists not being initiated.

In relation to use of an antiseptic solution, insufficient time to provide pressure area care, lack of confidence to manage complex wounds and insufficient stocks and supplies I have considered that the evidence presented in this Requirement does not demonstrate the service has failed to effectively manage high impact or high prevalence risks associated with consumers’ care. Rather, the evidence presented specifically relates to best practice care, staffing, workforce competence and optimising consumers’ health and well-being. As such, I find the evidence provided aligns with Requirement (3)(a) in this Standard, and Standard 7 Human resources Requirements (3)(a) and (3)(c) and have considered the it with my findings for those Requirements.

In relation to Consumer H and falls management, I have considered that the evidence presented in this Requirement does not demonstrate the service has failed to effectively manage high impact or high prevalence risks associated with consumers’ care. Rather, the evidence presented specifically relates to deficiencies associated with the implementation of behaviour and falls management strategies in line with consumers’ assessed needs. As such, I find the evidence provided aligns with Requirement (3)(a) in this Standard and have considered it with my finding for that Requirement.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### 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.*

The Assessment Team were not satisfied the service demonstrated the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. The Assessment Team provided the following information and evidence relevant to my finding:

* Access to documentation for consumers who had recently passed was requested on day one of the Review Audit and an additional four times throughout the remaining three days of the Review Audit. Management stated they would have to contact IT to allow access to the files, however, this did not occur.
* Two staff and a representative stated consumers who had recently died were not provided adequate care and services during the end stage of life due to limited availability of staff to provide care.
* Staff described generalised care and services provided to consumers during the end stage of life, as well as documentation required to be completed. Staff said they did not have enough time to provide end of life care, including assessment and management of pain, repositioning and meeting emotional care needs.

The provider offered their apologies that information for a named consumer was not provided. The information related to the consumer was submitted as part of the provider’s response. The provider’s response did not address feedback provided by staff and representatives provided in response to this Requirement.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement.

In coming to my finding for this Requirement, I have considered information included in the provider’s response. The care file provided demonstrated appropriate management of a consumer at the end stage of life. A Palliative care assessment had been completed and identified the consumer’s personal, clinical and cultural and spiritual needs and preferences. Progress notes demonstrated the consumer’s condition, health and well-being were regularly monitored, pain had been managed, consultation with the representative and Medical officer had occurred and a referral to specialist palliative care services initiated. I have also considered information in the Assessment Team’s report indicating staff were knowledgeable of generalised care and services provided to consumers during the end stage of life, as well as documentation requirements to be completed during this phase.

In relation to feedback provided by representatives and staff relating to insufficient staff to provide care, I have considered this information in my finding for Standard 7 Human resources Requirement (3)(a).

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Compliant with Requirement (3)(c) in Standard 3 Personal care and clinical care.

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

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

The Assessment Team were not satisfied the service demonstrated deterioration or change of a consumer’s mental health, cognitive or physical capacity or condition is recognised and responded to in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer D

* A staff member indicated they entered the consumer’s room in August 2021 and found two carers attending Consumer D who stated the consumer was drowsy and they had decided to give them a wash in bed rather than a shower. The staff member stated the consumer was not drowsy but unresponsive, and this had not been identified by staff prior escalation to the Registered nurse.
  + Progress notes did not include any information describing the time of clinical event or clinical assessment of Consumer D. Neurological observations were not recorded and only one set of vital signs were noted. The consumer was transferred to hospital.
* Progress notes in October 2021 indicate Consumer D was found unresponsive at 10:30am. The progress note does not record how long the consumer was unresponsive.
  + There is only one progress note in relation to the event indicating a head-to-toe assessment was undertaken but the outcome of the assessment is not noted; vital signs and neurological observations were checked but the findings are not noted.
  + Progress notes record a phone call to the Medical officer; there is no record of the Medical officer attending the service to review the consumer.
* Progress notes indicated the consumer’s condition would continue to be monitored, however, only record one set of neurological observations undertaken at 10:30am, and two sets of vital signs at 10.30am and 6:32pm. There are no further progress notes and or indications of how Consumer D’s condition was monitored.
* Clinical management advised there is no specific policy or pathway to follow or guide staff in the event of clinical deterioration, as the service always has nursing staff available who are expected to use clinical experience and judgement.

Consumer E

* In September 2021 at 6.41am, the consumer was yelling for help indicating they wanted to see the Medical officer. At 6:57am, the consumer is described as having difficulty walking, unable to stand straight and leaning to the side when mobilising. The consumer indicated they could not move as they had a problem with their leg. A witnessed fall occurred at 7.50am.
  + Neurological observations following the fall were undertaken recording a Glasgow Coma Score of 15 out of 15 on all but one occasion, despite progress notes at 7:20pm indicating the consumer was complaining of no sensation in the leg.
  + A Physiotherapist progress note at 6:10pm requests the consumer is transferred to hospital for further investigations. Nothing untoward was identified.
  + Pain charting and/or additional monitoring was completed following the fall at 10:39am, however, did not include information regarding mobility or pain assessments prior to review by the Physiotherapist 11 hours later.

The provider’s response outlined planned actions to address the deficiencies identified, as well as further commentary to clarify evidence presented in the Assessment Team’s report. The provider’s response included, but was not limited to:

In relation to Consumer D

* There was another progress note documented on the day of the clinical event by the Registered nurse indicating they had contacted the hospital to enquire about the consumer. This was not noted by the Assessment Team in the report.
* Staff will be provided training in January and February 2022 on how to recognise clinical deterioration.
* The source of communication between the Medical officer and registered staff is usually email. Registered staff will always send an email and the Medical officer will reply via this form of communication.
  + Examples of email correspondence were included as part of the provider’s response.

In relation to Consumer E

* As per the hospital discharge summary, they could not find anything clinically wrong post fall with Consumer E. Registered staff and the Medical officer have monitored and treated the consumer.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, for the two consumers highlighted, changes or deterioration in condition were not effectively recognised or responded to in a timely manner.

In relation to Consumer D, I have considered that two clinical events experienced by the consumer were not effectively managed. Progress notes relating to the two events were limited and did not demonstrate appropriate clinical assessment of the consumer occurred at the time a change in condition was identified. I find this did not enable to the consumer’s condition to be effectively monitored and for further changes and deterioration in the consumer’s condition to be promptly identified or an understanding of the consumers’ condition to provide and coordinate care. Additionally, while progress notes following the second event indicated the consumer’s condition would be monitored, how this would occur was not noted. Aside from one set of neurological observations and two sets of vital signs, there is no indication further monitoring occurred. I have also considered that not all clinical and care staff have the skills and knowledge to identify changes and deterioration in consumers’ condition. Two care staff, providing personal hygiene care to Consumer D, did not promptly recognise or escalate a significant change in the consumer’s condition.

In relation to Consumer E, I find that staff did not respond to a change in the consumer’s condition in a timely manner. I have considered that while the consumer requested to see the Medical officer early in the morning and changes in the consumer’s mobility were subsequently identified, further actions were not taken until 11 hours later in response to a Physiotherapist review. This is despite assessment of neurological observations indicating the consumer was experiencing a change in their clinical condition.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

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

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

The Assessment Team were not satisfied the service demonstrated documentation and communication of Medical officer instructions, changes of care requirements or clinical indications when commencing new medications. The Assessment Team provided the following information and evidence relevant to my finding:

Consumer H

* While a pathology test returned a negative result, progress notes indicated Consumer H had been commenced on antibiotics for an infection. Management and clinical staff were unable to indicate why antibiotics were commenced or provide any documented information from the Medical officer as to why the antibiotics had been prescribed.

Consumer B

* In November 2021, Consumer B was identified with a rash approximately two hours after an initial dose of an as required medication. Emails were sent to the Medical officer in relation to the rash on two occasions and the medication chart demonstrated creams for the rash had been prescribed.
* Progress notes were not clear as to when the Medical officer had reviewed the rash or if a cause for the rash had been addressed.
* Management were unaware if the Medical officer had reviewed the rash on site and clinical staff could not demonstrate if additional investigations had occurred prior to the ongoing administration of the as required medication.
* An antipsychotic medication was prescribed on a regular basis in January 2021, with a supporting diagnosis of a severe mental disorder. Progress notes did not include any entries by the Medical officer as to why the medication was commenced.
* Diagnoses in the care file and progress notes did not include the severe mental disorder. Staff were unaware of the diagnosis and were unable to provide evidence of this being documented within the Medical officer’s assessments, progress notes or clinical reports.

Consumer E

* An antipsychotic medication was prescribed on a regular basis in September 2021, with a supporting diagnosis of acute mania. Progress notes did not include any entries by the Medical officer as to why the medication was commenced.
* Staff were unaware of the diagnosis and were unable to provide any evidence of this documented within the Medical officer’s assessments, progress notes or clinical reports.
* Management indicated most consumers are under the care of the one Medical officer who refuses to document in progress notes or send communication about consumers.

While the provider submitted a response to the Assessment Team’s report, the provider’s response did not directly address the issues highlighted in the Assessment Team’s report related to Requirement (3)(e) in Standard 3 Personal and clinical care.

Based on the Assessment Team’s report, I find at the time of the Review Audit, information about consumers’ condition was not effectively documented and communicated. For Consumers H and B, I have considered that medications had been prescribed without being clinically indicated for Consumer H or in response to an assessment of Consumer B’s clinical condition. Progress notes did not include any commentary form the Medical officer relating to the treatment plans for either consumer. Additionally, reasons why psychotropic medications were prescribed for Consumers B and E were not documented and diagnoses to support the use of the medications were not known to staff. As such, I have considered that these practices do not ensure the workforce has sufficient information to enable delivery of safe and effective clinical care or an understanding of the consumers’ condition to provide and coordinate care.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

### 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 were not satisfied the service demonstrated minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection or practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. The Assessment Team provided the following information and evidence relevant to my finding:

* At the time of the Review audit, the service was in lockdown due to a gastroenteritis outbreak. An outbreak register included details of six consumers who became unwell between 18 and 26 October 2021.
* Lockdown was ended on 28 October 2021. A further consumer received pathology on 30 October 2021 despite the lockdown being declared over. The Public Health Unit was not advised as it was deemed an isolated event outside the outbreak.
* The service did not go into lockdown again until 8 November 2021, despite identifying three consumers with suspected gastroenteritis symptoms on 5, 6 and 7 November 2021. The outbreak register included this information under the original gastroenteritis outbreak. Given Consumer I was identified as the first consumer, this suggests the lockdown should have commenced at 9:43pm on 6 November 2021.
* A total of 19 consumers were identified with symptoms/possible gastroenteritis between 20 October and 17 November 2021. Four consumers did not have pathology collected when symptomatic.
* Pathology returned a ‘positive’, for one consumer but the pathogen is not identified.
* Consumer I has had ongoing positive pathology showing presence of norovirus in samples and has been in and out of isolation between 25 October and 20 November 2021.
* Consumer J experienced two episodes of loose bowels on 17 November 2021, however, was not considered as experiencing gastroenteritis as aperients had been administered prior to these episodes. Bowel monitoring charts for showed this was not the consumer’s usual bowel pattern. Pathology was not undertaken, and the decision to cease isolation was based on lack of symptoms.
* While Consumer G was identified as experiencing loose bowel actions, progress notes show this was not identified as potential gastroenteritis until three days later.

Consumer H

* Progress notes in October 2021 direct staff to collect a urinalysis as soon as possible due to an increase in behaviours. A sample was not sent to pathology until 10 days later. A course of antibiotics was commenced despite a negative pathology result. Progress notes did not indicate why it took 10 days to collect a sample or why antibiotics were prescribed when no infection was confirmed.

While the provider submitted a response to the Assessment Team’s report, the provider’s response did not directly address the issues highlighted in the Assessment Team’s report related to Requirement (3)(g) in Standard 3 Personal and clinical care.

Based on the Assessment Team’s report, I find at the time of the Review Audit, the service did not demonstrate effective practices to minimise infection related risks or to promote appropriate antibiotic use to reduce the risk of antimicrobial resistance.

In relation to a gastroenteritis outbreak, I have considered that the service’s infection management practices and processes have not been effectively implemented or applied, including in line with SA Health directives. Despite a consumer testing positive for a pathogen two days after an initial outbreak was declared over, this was not reported to the Public Health Unit, and instead considered an isolated incident outside of the outbreak. Furthermore, despite three consumers presenting with suspected gastroenteritis symptoms in November 2021, a further lockdown was not declared until 37 hours after it should have been implemented. This did not ensure the risk of transmission was minimised, placing consumers at risk of infection.

In relation to Consumer H, I have considered that a course of antibiotics was prescribed and administered without consideration of the consumer’s presenting condition or of pathology results indicating no presence of an infection. This practice is not in line with antimicrobial stewardship principles which assist to minimise the development and spread of antimicrobial resistance.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

The Assessment Team have recommended Requirements (3)(b) and (3)(c) in Standard 4 Services and supports for daily living not met. The Assessment Team found the service was unable to demonstrate:

* services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being; and
* services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do things of interest to them.

In relation to Requirements (3)(a), (3)(d), (3)(e), (3)(f) and (3)(g) in this Standard, the Assessment Team found that most consumers sampled considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* likes and needs are discussed regularly as part of the care plan review process and most staff know consumer preferences;
* most were happy with the quality, quantity and variety of meals and indicated they could provide feedback on food and access alternatives to meals provided if the meals were not to their liking; and
* most stated equipment provided is clean and consumers felt safe when using personal care equipment.

Care plans sampled included consumers’ personal history, how they like to spend their day, past interests and preferred activities and barriers to participation in activities, however, strategies to overcome identified issues were not identified. Goals for care were identified in care plans, however, some were noted to be generic, rather than personal. Lifestyle staff described how care plans are tailored to consumers’ needs, including following reviews conducted by external organisations.

Care files demonstrated information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility is shared. Care plans include information relating to consumers’ needs and preferences and are accessible to clinical, care, lifestyle and allied health staff. Staff demonstrated knowledge of the organisation’s referral processes and provided examples of referrals initiated for consumers in line with the focus of this Standard.

The service has processes to identify each consumer’s nutrition and hydration needs and preferences and communicate these to staff, including catering staff. Alternatives to meals offered on the menu are available. Care plans included information relating to consumers’ dietary requirements, food sensitivities, food texture and assistance required for meals. A four week rotating menu is in place which is changed twice a year and has been endorsed by a Dietitian.

Equipment provided was observed to be clean and well maintained. Monitoring processes, including Resident of the day and scheduled and reactive maintenance processes are undertaken by service staff and contracted services to ensure equipment remains fit for purpose.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(c) and Compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living. I have provided reasons for my findings in the specific Requirements below.

## 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.*

The Assessment Team were not satisfied the service demonstrated services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being. The Assessment Team provided the following information and evidence relevant to my finding:

* Nine consumers and/or representatives raised concerns about the isolation being experienced by consumers due to ongoing lockdowns.
* Consumer K indicated they cope with difficult days by turning to their faith. They rarely get visits from family and feel lonely but feel staff are too busy to bother with this.
* Assessments included information about ‘how I cope on difficult days,’ but do not capture potential for the provision of emotional support through the service. Progress notes identified visits from Lifestyle staff for one-on-one time, however, did not include comments by lifestyle or clinical staff on assessment and monitoring of consumers’ emotional well-being.
* The Lifestyle coordinator advised there are currently some challenges with providing emotional support, including involvement of religious services.
* Care staff did not identify if other avenues were available for emotional, spiritual, or psychological support. One care staff said they had always believed it was part of their role to spend quality time with consumers, but in the general areas there just was not time for this.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team as well as supporting documentation. The provider’s response included, but was not limited to:

* Consumer K has a cognitive impairment and cannot always recall the past occurrences. The consumer has a lot of friends in the facility and attends activities regularly. The family picks them up and takes them out as per progress notes that should have been noted by the Assessment Team.
* The lifestyle team visited consumers during each lockdown and spent one-to-one time with each consumer. The lifestyle team clearly documented each visit to consumers and ensured emotional well-being was met during this time.

Based on the Assessment Team’s report, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. I acknowledge feedback provided by consumers and representatives relating to isolation being felt by consumers in response to the lockdowns. However, I have considered the evidence presented does not indicate consumers’ emotional, spiritual and psychological well-being has been compromised.

In coming to my finding for this Requirement, I have considered information in the Assessment Team’s report indicating care files sampled demonstrated one-to-one visits to consumers were occurring, with consumers in isolation prioritised. While care staff did not identify other avenues available to support consumers’ emotional, spiritual and psychological well-being, they did say that where they identify a consumer was low or needed additional emotional support, they advise clinical staff. These actions are within their scope of practice.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Compliant with Requirement (3)(b) in Standard 4 Services and supports for daily living.

### Requirement 4(3)(c) Non-compliant

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

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

The Assessment Team were not satisfied the service demonstrated services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment, have social and personal relationships and do things of interest to them. The Assessment Team provided the following information and evidence relevant to my finding:

* Activities are scheduled on the weekend to be done individually, initiated by care staff. Four care staff stated they did not have time to coordinate activities on the weekend. One stated they were so busy with physical care they did not even get time to talk with consumers who may be lonely or isolated.

Consumer D

* Current activities do not align with the consumer’s care plan, reflect participation within the service’s community or demonstrate regular activities are offered. Twenty-six activities are recorded over a 48 days period, including five occasions where the consumer was noted to be sleeping and two occasions where the consumer asked Lifestyle to leave them to rest. One-on-one conversations with lifestyle staff were documented on 16 occasions, however, the duration of the visit was not noted.
* The lifestyle care plan has not been reviewed or adjusted in response to a clinical event which occurred in August 2021.
* Care staff advised the only ‘activity’ they see for Consumer D is visits from family, otherwise they lay in bed all day.

Consumer A

* Current activities do not align with the consumer’s care plan or demonstrate regular activities are offered. Thirty-three activities are recorded over 48 days, including 10 visits from the consumer’s family member, four relating to putting ice in the consumer’s drink and one involving speaking to the consumer’s representative during the period of lockdown and relaying a message to Consumer A. Eighteen visits are recorded for one-on-one discussion, however, duration of visit is not referenced.
* The Lifestyle coordinator said Consumer A can understand some English within discussions but did not comment further on the quality of the conversations.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations, however, the response included limited commentary to refute assertions made by the Assessment Team. Supporting documentation was not provided. The provider’s response was not limited to indicating that it is not the organisation’s policy or process to document the duration of a visit when Lifestyle visit a consumer. This has never been documented previously.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, consumers, specifically Consumers D and A, were not being assisted to participate in activities of interest to them. Progress notes relating to lifestyle activities undertaken for both Consumers D and A were not reflective of interests or activities identified through assessment processes. Activities described as occurring were not meaningful activities which would have an impact on the consumers’ well-being and quality of life.

In relation to Consumer D, I have considered that the lifestyle care plan has not been updated in response to a change in condition to reflect the consumer’s current interests and abilities. This has not ensured the consumer’s goals needs and preferences for social connection are being met. For Consumer A, I have considered that while one-on-one visits from staff have been documented as occurring, the consumer’s active participation in these interactions is not noted. Consumer A is noted as being only able to understand some English.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(c) in Standard 4 Services and supports for daily living.

**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-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Quality Standard is assessed as Non-compliant as one of the three specific Requirements has been assessed as Non-compliant.

The Assessment Team found the service was unable to demonstrate all the environment was safe, maintained, and comfortable or that consumers were able to move freely indoors. The Assessment Team have recommended Requirement (3)(b) in Standard 5 Organisation’s service environment not met.

In relation to Requirements (3)(a) and (3)(c), most consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. The environment was observed to be welcoming, easy to understand and navigate and optimised each consumer’s sense of belonging, independence, interaction and function. Communal areas are available for consumers to interact and have large windows to allow natural light and views of the garden. Corridors were noted to be unobstructed and handrails are available to assist consumers to move around the service safely. Staff described how they make consumers feel at home and consumer rooms were observed to be decorated with personal belongings, including photographs, furniture items and ornaments.

Internal furniture, fittings and equipment were observed to be safe, clean, well maintained and suitable for consumer use and consumers indicated they felt safe when staff use equipment to assist them with their daily activities. Staff described processes to ensure the environment is maintained and how maintenance tasks are identified, reported and actioned. There are preventative and reactive maintenance processes in place and contracted services are utilised to maintain aspects of the service environment and equipment.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) and Compliant with Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment. I have provided reasons for my finding in the specific Requirement below.

## 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 were not satisfied the service demonstrated all the environment was safe, maintained, and comfortable or that consumers were able to move freely indoors. The Assessment Team provided the following information and evidence relevant to my finding:

* At lunchtime on day three of the Review Audit, the Assessment Team found five consumers’ bedroom doors locked whilst the consumers were in the communal lounge/dining area. Staff in the memory support unit indicated consumers’ doors are locked to stop some consumers wandering.
* Three of 17 consumers and/or representatives indicated bedroom doors in the memory support unit are locked during the day. Further information indicated consumer rooms in the memory support unit are locked at night when the consumers are in their rooms.
* Four bedroom doors of consumers residing in the memory support unit were found locked with consumers in their rooms at approximately 8.00pm on the third day of the Review Audit.
* Staff in the memory support unit confirmed the rooms are locked and would lock more doors as the consumers settled for the night. Staff stated some consumers wander in and out of consumers’ rooms at night and take items from their rooms, so they lock their doors to prevent consumers walking in and disturbing their sleep.

The Assessment Team observed:

* An external courtyard did not include signage to identify the area as a designated smoking area, an ashtray or fire provisions situated in or readily accessible to the area.
* A large concrete pot plant placed in the garden near some dried tree leaves and garden debris with substantial amounts of distinguished cigarette butts.
* The nearest fire extinguisher was not readily accessible or in line of sight for staff outside in the external courtyard.
* Some outdoor furniture was weather faded, paint peeling, an armrest of a wooden bench was broken off, cushions on some chairs were dirty, a wooden table with broken slats, a vinyl chair armrest wrapped in duct tape and the other armrest with ripped vinyl.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations and includes commentary to refute assertions made by the Assessment Team. The provider’s response included, but was not limited to:

* There are no laws or regulations determining exactly where a fire extinguisher should be located near a smoking area as long it is part of the fire plan and displayed in the facility.
* Staff are trained to use fire extinguishers on an annual basis. Consumers are required to wear a smoker’s apron and all consumers who choose to smoke have been allocated an apron. Consumers also have a smoker risk assessment completed, which has this information included.
* All furniture in need of repair has been disposed of and new furniture will be ordered for the outside area.
* An Environmental audit conducted in October 2021, included as part of the provider’s response, identified the furniture was needing to be repaired, so the facility has recognised this and has been actioned.

I have also considered the providers’ response for Standard 3 Personal and clinical care Requirement (3)(a), relating to the locking of consumers’ bedroom doors in my finding for this Requirement.

Based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service environment was not safe or well-maintained and did not enable all consumers to move freely within the service environment.

In coming to my finding, I have considered feedback provided by consumers and/or representatives and staff and observations made by the Assessment Team indicates consumers are not able to move around the service environment freely, specifically at night. Consumer rooms in the memory support unit were said to be locked at night when consumers are in their rooms. This practice was observed by the Assessment Team. I acknowledge two consumers lock their doors by choice and restrictive practice assessments have been completed. I also acknowledge the provider’s response indicating another consumer was not in their room at the time the door was noted to be locked. However, I consider that feedback provided to the Assessment Team from consumers and/or representatives and staff, and the Assessment Team’s observations, including of one consumer being locked in their room, indicates this practice has been used as a strategy to manage consumers’ behaviour, and as such, places the safety of those consumers’ being confined to their rooms at risk.

I have also considered that outdoor areas of the service were observed to not be sufficiently maintained or safe. An external courtyard, used as a smoking area, does not have appropriate safety measures in place. Cigarettes were observed to have been inappropriately disposed near combustible material and fire suppressant equipment was noted to not be located nearby. I acknowledge the provider’s response, including that staff are trained in the use of fire extinguishers. However, I encourage the provider to consider that in the event of an emergency, staff may not be present and to consider if other visitors, including consumers and representatives are aware of the location of fire suppressant equipment for use in such an event. Additionally, while the provider asserts furniture in need of repair was identified through audit processes, the audit referred to was completed in October 2021. Further actions, including removing or disposing of the furniture were only taken subsequent to the Review Audit.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) in Standard 5 Organisation’s living environment.

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

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

# STANDARD 6 NON-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

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

The Assessment Team have recommended Requirements (3)(a), (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met. The Assessment Team found the service was unable to demonstrate:

* consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints;
* the system for managing and resolving complaints is effective; and
* feedback and complaints are effectively reviewed and used to improve the quality of care for consumers.

In relation to Requirement (3)(b) in this Standard, eight of 11 consumers and representatives indicated they know how to raise an issue and if they do not attend Resident meetings, minutes of the meeting are available to access. Consumers are provided information on entry relating to internal and external complaints mechanisms and language services. Information relating to feedback mechanisms, including external avenues and advocacy is provided on an ongoing basis through monthly newsletters. Internal and external complaints, advocacy and language service information was observed to be readily available within the service. Staff sampled described how they assist consumers, including those with cognitive impairments, to provide feedback.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirements (3)(a), (3)(c) and (3)(d) and Compliant with Requirement (3)(b) in Standard 6 Feedback and complaints. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 6 Requirements

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

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

The Assessment Team were not satisfied the service demonstrated consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. The Assessment Team provided the following information and evidence relevant to my finding:

* Six of 16 consumers and representatives said they were reluctant to give negative feedback or make a complaint for fear of impact/retribution towards consumers.
* Four of 17 staff said they knew they needed to speak up if things weren’t right, acting as an advocate for consumers. However, they were scared this would have repercussions from management.
* Two staff said the service had been without an Executive services manager for an extended period, and there was no management available within the service during this period to talk to if things weren’t right. One staff said a senior clinical staff was ‘too busy and stressed’ to approach, and it seemed inappropriate to call the Operations manager or Chief executive officer.
* Nine of 16 clinical and care staff expressed concern that feedback provided to the Assessment Team would be linked to them, and this would result in action from management.

The provider’s response questioned some of the statements made by the Assessment Team. The provider’s response indicated that if the Assessment Team had noted names of staff, residents or representatives and a particular issue or feedback, this Requirement would be easier to provide an answer and evidence that the Requirement is met. The provider also indicated an Executive services manager resigned from the service in August 2021 and staff were notified who to contact in their absence. A new Executive services manager commenced in September 2021. Memoranda to staff in relation to the Executive services manager resignation and commencement was the only evidence provider to support the provider’s response to this Requirement.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not effectively demonstrate consumers, representatives and others are encouraged and supported to provide feedback and make complaints. In coming to my finding, I have placed weight on feedback provided by consumers and representatives which indicated a lack of trust and confidence in the service’s feedback processes. Six consumers and representatives expressed a reluctance to provide negative feedback or make complaints for fear of impact/retribution towards consumers. I have also considered feedback provided by staff who despite acknowledging they have a responsibility to advocate for consumers, they were scared that speaking up, including to the Assessment Team, would result in repercussions.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(a) in Standard 6 Feedback and complaints.

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

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

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

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

The Assessment Team were not satisfied the service demonstrated an effective system for managing and resolving complaints. The Assessment Team provided the following information and evidence relevant to my finding:

* Five of 17 representatives said they have spoken out verbally about some concerns. However, if changes are made, they are not monitored or evaluated, and things go back to how they were before. They indicated feedback is not provided following their concerns being raised and are not satisfied and/or confident the service acts appropriately and promptly when responding to feedback and complaints. Concerns raised related to front door alert response and insufficient staffing in the memory support unit.
* One representative indicated the consumer is no longer involved in social activities and that concerns them. They indicated they had raised their concerns with staff and while there was improvement for a short period, these improvements have not been sustained and their concerns remain. The representative also stated they have not been contacted or had any communication from staff or management in response to these concerns.
* A representative stated they were frustrated that the service has not formally addressed or provided a response about their complaint lodged in January 2021. While there has been some communication through care reviews in relation to the consumer’s care, the representative indicated the initial concerns from January 2021 have not yet been addressed and they remain ongoing.
* Concerns from five representatives were not captured on feedback/suggestion forms or included on the complaints log. Verbal concerns have not been captured on the June and September 2021 Continuous improvement log which showed no complaints since July 2021.
* Concerns/complaints raised through monthly consumer meeting forums are not being captured in the complaint system in accordance with the service’s procedure. Complaints relating to food were raised at the meetings conducted in August and November 2021.

The provider’s response indicated it was difficult to respond to the information in the Assessment Team’s report as they were unaware of who and there were no specific examples to provide evidence to. Supporting information included in the provider’s response was limited to Resident of the day entries, a care plan consultation with the next of kin for the named consumer, feedback forms from Resident meetings for 2021 and a Plan for continuous improvement. The provider’s response included, but was not limited to:

* One representative, named in the Assessment Team’s report, has been contacted monthly since they lodged a complaint in January 2021. The have been no issues raised since. This have given the family at least 11 opportunities to raise any concerns through the phone calls they are receiving. The family also visit on a regular basis and communicate with staff. The consumer is able to raise their own concerns.
* Information relating to five representatives is not specific enough to respond to.
* The Lifestyle coordinator captures feedback at every Resident meeting through the feedback form process. This was logged and in the feedback form folder the Assessment team viewed.

Based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not demonstrate appropriate action is taken in response to complaints. I coming to my finding, I have considered feedback provided by five representatives who were not confident the service acted appropriately and promptly when responding to feedback and complaints.

I have also considered that verbal complaints are not consistently captured. While the provider’s response asserts feedback received through Resident meeting forums is captured through the feedback process and provided documentation to support this process, the examples of feedback from consumers at meeting forums, highlighted in the Assessment Team’s report, were not included in the documentation provided. I find that this has not ensured feedback is monitored for trends and used to improve care and services.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

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

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

The Assessment Team were not satisfied the service demonstrated feedback and complaints are effectively reviewed and used to improve the quality of care for consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* Only one of 11 consumers could give examples of improvements made in response to feedback.
* Five of 17 representatives said they feel they are not involved enough or kept informed in relation to any changes or asked to participate in forums to improve the quality of care and services provided at the service.
* Six of 15 representatives indicated actions taken in response to feedback were not monitored, reviewed, and evaluated to measure effectiveness.
* Resident meeting minutes for August 2021 included a complaint in relation to meals. Minutes for November 2021 also showed a complaint about the meal service time with no corrective actions recorded. The Continuous improvement log for June and September 2021 included only three complaints, all relating to food
* The Complaints/continuous improvement logs for June to October 2021 did not include feedback and complaints provided by consumers and/or their representatives from care plan reviews, incidents, or direct conversations.
* The Plan for continuous improvement updated in November 2021 showed Standard 3 Personal care and clinical care Requirement (3)(b) and Standard 7 Requirement (3)(a) with recent outcomes. An up-to-date Plan for continuous improvement demonstrating all the Aged Care Quality and Safety Standards was requested, however, this could not be produced at the time of the Review Audit. The manager who monitors the plan, was on extended leave and the plan could not be accessed electronically.
* Leadership and Executive management meeting minutes for September and October 2021 did not detail consumer/staff complaints, concerns, incidents, or continuous improvements detailed. Minutes for Risk and compliance meetings had no concerns relating to complaints, feedback or trends identified.

The provider’s response indicated the Assessment Team made statements that are very subjective and with no substance which does not allow for evidence gathering. Supporting documentation relating to this Requirement was not included as part of the provider’s response. The provider’s response included, but was not limited to:

* The provider questioned if the consumers sampled read the newsletter, attend Resident meetings or read meeting minutes. The provider also indicated were no specifics of who these consumers were or if they would be aware of improvements requested or completed.
* The service does not have a forum and this is another assumption of the Assessment Team. Consumers are involved in decision making and kept involved through meeting forums, newsletters, minutes of meetings and feedback processes.

Based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, feedback and complaints are not reviewed and used to improve the quality of care and services.

In coming to my finding, I have placed weight on information provided by representatives indicating actions taken in response to feedback are not monitored, reviewed, and evaluated for effectiveness. I have also considered that Complaints/continuous improvement logs for a five month period did not include feedback and complaints from consumers and/or representatives resulting from care plan reviews processes, incidents or direct conversations. Additionally, complaints made by consumers through meeting forums have not been consistently captured through the service’s feedback processes. As such, this has not ensured that all feedback is captured and documented to enable improvements to the quality of care and services to be identified and implemented.

In relation to feedback from representatives relating to being kept informed and participation in forums, I have considered this evidence in other Requirements which reflect the core deficiency associated with the evidence. I find the evidence provided aligns with Standard 8 Organisational governance Requirement (3)(b) and, as such, have considered it with my finding for that Requirement.

In relation to the Plan for continuous improvement and minutes for Leadership and Executive management meetings and Risk and compliance meetings, I have considered this evidence in other Requirements which reflect the core deficiency associated with the evidence. I find the evidence provided aligns with Standard 8 Organisational governance Requirement (3)(c) and, as such, have considered it with my finding for that Requirement.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# STANDARD 7 NON-COMPLIANT Human 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

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

The Assessment Team recommended Requirements (3)(a), (3)(c) and (3)(d) in Standard 7 Human resources not met.

Requirement (3)(a) was found Non-compliant following a Site Audit conducted 9 February 2021 to 11 February 2021 where the high number of feedback from consumers, representatives and staff indicated dissatisfaction with staff numbers and/or planning and were of the belief that consumer care has been impacted. The Assessment Team’s report for an Assessment Contact conducted 2 November 2021 to 5 November 2021 outlined improvements the service had made in response to the Non-compliance identified at the Site Audit. The Requirement was not assessed at the Assessment Contact conducted 2 November 2021 to 5 November 2021, therefore, a finding on compliance was not made. The Assessment Team’s report for the Review Audit outlined further actions the service had implemented to improve staffing levels and skill mix. However, at the Review Audit conducted 17 November 2021 to 20 November 2021, the Assessment Team were not satisfied the service demonstrated it currently has workforce numbers and range of skills to deliver safe and quality care and services. The Assessment Team have recommended Requirement (3)(a) not met.

The Assessment Team recommended Requirement (3)(c) not met at an Assessment Contact conducted 2 November 2021 to 5 November 2021 where it was found the service did not demonstrate clinical staff have sufficient skills and knowledge to effectively manage pressure injuries. A finding of compliance for the Assessment Contact was not made with the Assessment Team’s report for the Assessment Contact conducted 2 November 2021 to 5 November 2021 considered in my finding for Requirement (3)(c) for the Review Audit. At the Review Audit conducted 17 November 2021 to 20 November 2021 the Assessment Team were not satisfied the service demonstrated clinical and care staff are competent and have the knowledge and skills to effectively identify and manage pressure injuries and wound care, or identify, monitor and manage clinical deterioration of consumers. Additionally, staff were unable to demonstrate understanding of legislative changes relating to use of restrictive practices and management of challenging behaviours. The Assessment Team have recommended Requirement (3)(c) not met.

In relation to Requirement (3)(d), the Assessment Team found the service was unable to demonstrate it has adequately supported, monitored and reviewed staff performance to ensure they identify and respond to any deficits in staff competency, skills and knowledge beyond mandatory training. Additionally, the service could not demonstrate is has provided staff with sufficient training until recently to ensure staff are able to identify and respond to changes in consumers’ health and well-being in a timely manner. The Assessment Team have recommended Requirement (3)(d) not met.

In relation to Requirements (3)(b) and (3)(e) in this Standard, overall, consumers and representatives sampled were complimentary of staff describing them as friendly, caring, professional and respectful. Most staff interactions were observed to be kind, caring and respectful.

Regular assessment, monitoring and review of the performance of each staff member occurs. This includes processes for probationary and ongoing performance appraisals and performance management. Staff performance is monitored through a range of avenues, including incident data, feedback and competencies. A staff appraisal calendar is maintained and demonstrated all appraisals are up-to-date.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report, the provider’s response and the Assessment Team’s report for the Assessment Contact conducted 2 November 2021 to 5 November 2021 and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirements (3)(a), (3)(c) and (3)(d) and Compliant with Requirements (3)(b) and (3)(e) in Standard 7 Human resources. I have provided reasons for my findings in the specific Requirements below.

## 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 were not satisfied the service demonstrated it currently has workforce numbers and range of skills to deliver safe and quality care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Twelve of 17 consumers and/or representatives indicated some concerns with aspects of staff. Feedback included:
* Felt there were insufficient staff in the afternoons and during night shifts in the memory support unit, resulting in inability to manage consumer behaviours and often only one staff member to assist with meal services.
* Impacts described included staff are always rushed and don’t have time to spend with the consumers, especially for emotional support with all the recent lockdowns, feeling lonely, down and out as there are times consumers don’t see anyone for hours, showering preferences not being met, skin care not completed and receiving meals late
* Twelve of 21 nursing and care staff indicated staffing levels are not sufficient to support the effective delivery of care and services to consumers. Impacts were described as not being able to manage consumers’ behaviours or complete consumers’ needs appropriately or in line with their preferences, and inability to complete toileting, meal service and pressure area care leading to development of new wounds
* A new staff rostering platform commenced 15 November 2021, following feedback from staff that includes extra night, morning and afternoon shifts. Extra staff (floaters) have been rostered for the memory support unit to assist with meal services, activities of daily living and to support lifestyle activities.

Requirement (3)(a) in Standard 7 Human resources was found Non-compliant following a Site Audit conducted 9 February 2021 to 11 February 2021 where the high number of feedback from consumers, representatives and staff indicated dissatisfaction with staff numbers and/or planning and were of the belief that consumer care has been impacted. The Assessment Team’s report for an Assessment Contact conducted 2 November 2021 to 5 November 2021 outlined improvements the service had made in response to the Non-compliance identified at the Site Audit. The Requirement was not assessed for compliance at the Assessment Contact conducted 2 November 2021 to 5 November 2021. Additionally, the Assessment Team’s report for the Review Audit outlined further actions the service had implemented to improve staffing levels and skill mix. Actions taken to address deficiencies, including, but not limited to:

* Provided education to staff, including in relation to customer service principles and responding to call bells.
* The roster was reviewed, including start and finish times for all shifts and implemented an additional float shift was implemented for the afternoon shift in the memory support unit.
* Provided mandatory training to Catering staff relating to customer service, time management, resident choice, plating and presentation, taking and recording temperatures and duty statements.
* Reviewed clinical staff duty statements and workload.
* Implemented monthly call bell audits. Analysis of the audits identifies sensor activations, adverse events, staff activations, and over-ways placed on sensor mats.
* Ongoing recruitment of staff at all levels is ongoing. A casual pool of staff is being recruited to provide an available resource in a COVID-19 outbreak.
* Developed a new workforce allocation roster with additional staff which was rolled-out on 15 November 2021. The new staff allocation rosters include extra Personnel care workers (PCA’s) added for night shifts and floater PCA’s shifts added during the am and pm shifts.
* Appointed an organisational Quality and compliance officer to oversee wound practices and Engaged a Nurse consultant to oversee and monitor compliance with the Aged Care Quality and Safety Standards.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation and included commentary to refute assertions made by the Assessment Team. Evidence to support the provider’s stance was limited to feedback from a staff member relating to extra hours initiated for the night shift. The provider’s response included, but was not limited to:

* Resident acuity is discussed daily through meeting forums and staff are allocated in line with resident care needs. It is inconceivable to suggest that the organisation is failing to provide sufficient numbers of staff.
* There was no evidence provided to substantiate the claims that staffing is inadequate beyond allegations made by a small number of residents who, in the large, have diagnosed cognitive impairments, are disorientated in time and place and have no knowledge of sector staffing standards.
* Representatives are not present during the night, therefore, it is not understood how the assessment team can make this assumption on night duty. Residents in the memory support unit are not cognitive enough to pass these comments. The memory support unit is sufficiently staffed for the number of consumers who reside there.

In coming to my finding for this Requirement, I have also considered evidence documented in Standard 3 Personal care and clinical care Requirement (3)(b) relating to clinical and care staff indicating they do not have sufficient time to attend to consumers’ pressure area care in line with their assessed needs.

I acknowledge the provider’s response and improvement actions initiated to address deficits identified by the Assessment Team at a Site Audit conducted 9 February 2021 to 11 February 2021. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not effectively demonstrate there were adequate numbers and mix of staff to deliver safe and quality care and services.

In coming to my finding, I have considered that the service has had ongoing Non-compliance in this Requirement since February 2021, and while improvement actions have been implemented, they have not effectively addressed all deficits. There remains ongoing deficits in the provision of timely delivery and management of care and services to consumers. In coming to my finding, I have placed weight on feedback provided by the majority of consumers and representatives indicating insufficient staffing numbers to provide quality care and services which has resulted in impacts for consumers. Additionally, I have also considered feedback provided by clinical and care staff indicating staffing levels are not sufficient to support the effective delivery of care and services to consumers and the resulting impacts to consumers described by staff.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

### 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 were not satisfied the service demonstrated clinical and care staff are competent and have the knowledge and skills to effectively identify and manage pressure injuries and wound care, or identify, monitor and manage clinical deterioration of consumers. Additionally, staff were unable to demonstrate understanding of legislative changes relating to use of restrictive practices and management of challenging behaviours. The Assessment Team provided the following information and evidence relevant to my finding:

* Five of 11 representatives were not satisfied with the skills, knowledge and communication ability of clinical and care staff. Feedback included:
* Rather than manage consumers’ wandering behaviours, staff lock doors to consumers’ rooms at night-time in the memory support unit; staff rush to assist consumers with their meal services and don’t engage or reassure them; staff lack understanding of fluid and food intake.
* Staff did not appropriately identify wounds, including pressure injuries, changes to pressure injuries or clinical deterioration. Additionally, staff do not routinely record Medical officer directions for management following consumer reviews.
* All five clinical staff felt they need more guidance and training in relation to pressure injuries and wound management.
* Staff were unable to demonstrate understanding of legislative changes in relation to use of restrictive practices and management of challenging behaviours.

The Assessment Team recommended Requirement (3)(c) not met at an Assessment Contact conducted 2 November 2021 to 5 November 2021 where it was found the service did not demonstrate clinical staff have sufficient skills and knowledge to effectively manage pressure injuries. A finding of compliance for the Assessment Contact was not made, with the Assessment Team’s report and the provider’s response for the Assessment Contact conducted 2 November 2021 to 5 November 2021 considered in my finding for Requirement (3)(c) for the Review Audit. The Assessment Team provided the following information and evidence relevant to my finding:

* Two of three consumers/representative were not satisfied with the skills and knowledge of clinical or care staff regarding wound care.
* Care staff said they have not received formal training regarding early identification of pressure injuries but would let the clinical staff know if they saw anything different about a consumer’s skin condition.
* The Quality and Compliance manager said they had been overseeing Consumer 1’s unstageable pressure wound since early September 2021 and had identified deficits in clinical staff’s knowledge of pressure wound staging, however, had not reviewed any other consumer’s pressure areas.
* Management advised deficiencies in skills and knowledge have been identified since the engagement of the Quality and Compliance manager. Training implemented to address the competency of staff was commenced in October 2021 and has to date been attended by two of 11 Registered nurses and four of nine Enrolled nurses.
* Internal monitoring systems, including audits have identified deficiencies in clinical staff knowledge regarding staging of pressure injuries, incorrect and inconsistent measuring of wounds and completion of relevant documentation. Action has not been taken to address these deficiencies in a timely manner. Training, reflected as the remedial action to be taken to address these deficiencies, has not been undertaken.

The provider’s response indicated they accepted the Assessment Team’s recommendation. The provider’s response in relation to the Assessment Team’s report for the Review Audit did question how representatives know what a wandering behaviour is. In relation to the Assessment Team’s report for the Assessment Contact, the response indicated ‘the facility is currently under Sanction for wound management’. A Nurse adviser has been engaged and training has commenced for the Requirements that were found not met.

In coming to my finding for this Requirement, I have also considered evidence documented in Standard 3 Personal care and clinical care Requirement (3)(b) relating to clinical staff not feeling confident with managing complex wounds.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the workforce was not sufficiently competent or had the qualifications and knowledge to effectively perform their roles. In coming to my finding, I have considered the outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal care and clinical care.

I have considered evidence which demonstrates staff have not provided care in accordance with best practice processes, responded appropriately to deterioration in health or condition, or demonstrated appropriate management of challenging behaviours, restrictive practices, wound management and minimisation of infection related risks. I find this has resulted in negative impacts for some consumers highlighted in Standard 3 Personal care and clinical care.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(c) in Standard 7 Human resources.

### 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 were not satisfied the service demonstrated it has adequately supported, monitored and reviewed staff performance to ensure they identify and respond to any deficits in staff competency, skills and knowledge beyond mandatory training. Additionally, the service could not demonstrate it has provided staff with sufficient training until recently to ensure staff are able to identify and respond to changes in consumers’ health and well-being in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

* Management and 20 staff said until recently, within the last two months, the only training provided was mandatory training.
* Training records confirm prior to September 2021 there was no other training offered or undertaken. The development of specialised training has only commenced within the last two months in response to deficiencies identified by the Aged Care Quality and Safety Commission at an Assessment Contact conducted on 2 to 5 November 2021 and Non-compliance identified at another of the organisation’s sites.
* Management was unable to demonstrate training and education has been provided to staff in relation to key areas of clinical deficiencies identified during the Review Audit.
* Five consumers and representatives raised concerns with training in relation to infection control, mobility and repositioning, nutrition and hydration and challenging behaviours.

The provider’s response indicates they do not agree with the Assessment Team’s recommendations and included commentary to refute assertions made by the Assessment Team. Evidence to support the provider’s stance was not included as part of the response. The provider’s response included, but was not limited to:

* On 20 November 2021 at the feedback/exit meeting, the Assessment Team commented training had improved. This was the day the Assessment Team met with Administration staff and viewed training folders. No concerns were raised about training or staff concerns about training.
* Staff are compliant with all mandatory training. Due to COVID-19 restrictions and the gastroenteritis outbreak, training was focused on these topics at the time to ensure staff had the knowledge to deal with the outbreak.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not adequately demonstrate processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. In coming to my finding, I have considered that training opportunities outside of the service’s mandatory training program have not been provided until recently which has resulted in staff not being trained, supported and equipped to deliver outcomes required by these Standards. I have considered deficits identified in Non-compliant Requirements in Standard 3 Personal and clinical care demonstrating staff do not have the training to perform their roles, specifically in relation to management of behaviours, restrictive practices and infections.

I have also relied upon evidence and outcomes in Standard 3 Personal care and clinical care Requirement (3)(b) indicating deficits relating to management and monitoring of wounds which has led to negative outcomes for some consumers highlighted. Four clinical staff said they did not feel confident managing complex wound care and that they have had sufficient training to enable them to do so. Training in relation to pressure area care and wound management was only provided subsequent to the Assessment Contact conducted in November 2021 in response to deficiencies identified by the Assessment Team.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(d) in Standard 7 Human resources

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

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

The Assessment Team have recommended Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance not met. The Assessment Team found the organisation was unable to demonstrate:

* the governing body understands the requirements to ensure performance of the organisation against the Aged Care Quality Standards or effective monitoring and continuous improvement processes are in place at the site level for the governing body to meet its responsibilities under Requirement (3)(b) in Standard 8;
* effective governance systems relating to continuous improvement, workforce governance and feedback and complaints;
* effective risk management systems for managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents; and
* an effective organisational clinical governance system to ensure consumers are provided with safe and quality clinical care.

In relation to Requirement (3)(a) in this Standard, consumers are engaged in the development, delivery and evaluation of care and services through care plan review processes, meeting forums, and feedback processes, including surveys. Resident meeting minutes demonstrated consumers have input and provide feedback into care and service delivery. Consumers are also encouraged to provide their opinions and feedback about the service through feedback surveys, including in relation to food and activities.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) and Compliant with Requirement (3)(a) in Standard 8 Organisational governance. I have provided reasons for my findings in the specific Requirements below.

## 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) 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 were not satisfied the service demonstrated the governing body understands the requirements to ensure performance of the organisation against the Aged Care Quality Standards or effective monitoring and continuous improvement processes are in place at the site level for the governing body to meet its responsibilities under this Requirement. The Assessment Team provided the following information and evidence relevant to my finding:

* Prior to July/August 2021, the governing body did not have a structured governance system. Recent changes to the organisation’s governance framework were demonstrated, including implementing a range of reporting and communication mechanisms to ensure the Board is aware of undertakings at the service.
* The new structure has only been in place for two months and has not yet captured current shortfalls as evidenced in other Requirements identified at the Review Audit.
* Evidence that all members of the governing body structure have the breadth and width of knowledge and the right experience to govern and oversee the delivery of safe and effective clinical care was not demonstrated. A number of new staff members have been with the service for less than two months form the governing body.
* A Risk management framework was implemented in July/August 2021. Evidence that Board and staff had received training in relation to the new Risk and governance framework was not provided, although information had been disseminated about the new structure to staff.
* The organisation did not demonstrate effective governance in relation to consumer engagement, risk management, clinical governance and organisation-wide governance systems relating to, continuous improvement, workforce governance, feedback, and complaints.
* Sixteen of 26 consumers and representatives did not feel happy and/or confident the service is run in the consumers’ best interests.
* I have also considered evidence documented in Standard 6 Feedback and complaints Requirement (3)(d) relating to being kept informed and participation in forums in my finding for this Requirement.

The provider’s response indicated it was difficult to understand the Assessment Team’s not met recommendation when the organisation’s two other services have the same governance structures in place and were found fully compliant with this framework in February 2021. Supporting documentation, specific to the evidence presented in the Assessment Team’s report for this Requirement, was not included as part of the provider’s response.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the organisation did not effectively demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. I have placed weight on feedback provided by the majority of consumers and representatives indicating they were not satisfied or confident the service is run in the best interest of consumers. Additionally, not all representatives felt involved with or kept informed of changes or felt they were provided opportunities to participate in forums to improve the quality of care and services provided at the service.

I have also considered that a number of members of the governing body are new. The findings of Non-compliance in relation to 20 Requirements across eight Quality Standards indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(b) in Standard 8 Organisational governance

### 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 organisation demonstrated effective governance systems relating to financial governance, information management and regulatory compliance. However, the Assessment Team were not satisfied the service demonstrated effective governance systems relating to continuous improvement, workforce governance and feedback and complaints. The Assessment Team provided the following information and evidence relevant to my finding:

Continuous improvement

* The Continuous improvement logs/register, generated from complaints/feedback, has limited improvements originating from consumers’ feedback, complaints, or suggestions.
* The service was unable to provide examples of continuous improvement initiatives derived from incidents, audits, or consumer care plan review processes.
* The Plan for continuous improvement (the Plan), updated in November 2021, included Standard 3 Personal care and clinical care Requirement (3)(b) and Standard 7 Requirement (3)(a). There were no other Quality Standards outlined in this plan with the plan being developed in response to the Non-compliance identified following a Site Audit conducted in February 2021, rather than opportunities identified from the organisation’s monitoring processes.

Workforce governance

* While a new workforce strategy was implemented in November 2021, the impact of these improvements has not yet been demonstrated. Information provided to the Assessment Team by consumers, representatives and staff indicated dissatisfaction with staffing levels.
* While a training framework in relation to mandatory training is in place, the service has only recently implemented processes to ensure specific training and education in relation staff knowledge and skills gaps has been implemented.

Feedback and complaints

* Not all consumer complaints and incidents have been captured, recorded, and outcomes of monitoring and evaluations provided back to consumer representatives. A culture conducive for consumers and staff feeling supported to provide feedback was not demonstrated.
* I have also considered evidence documented in Standard 6 Feedback and complaints Requirement (3)(d) relating to minutes for Leadership and Executive and Risk and compliance meetings in my finding for this Requirement.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, however, the response included limited commentary to refute assertions made by the Assessment Team. A Plan for continuous improvement, submitted as part of the provider’s response for Standard 6 Feedback and complaints was considered in the finding for this Requirement. Further documentation to support the provider’s stance was not included as part of the response. The provider’s response included, but was not limited to:

* The organisation has a comprehensive governance system to provide a framework and guidance to all staff in the home’s operations. This is reflected in the Assessment Team’s commentary that identified no issues with the organisation’s policies or procedures.
* One part of the report states a Plan for continuous improvement was not produced, then reference a Plan for continuous improvement updated in November 2021. This clearly shows the Assessment Team were provided a copy of the most recent plan.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the service did not demonstrate effective organisational governance systems, specifically in relation to continuous improvement, workforce governance and feedback and complaints.

In relation to continuous improvement, I have considered that while a Plan for continuous improvement is maintained, this was not sighted by the Assessment Team during the Review Audit or included as part of the Provider’s response. The Plan included in the response does not demonstrate improvements across all eight Quality Standards or that improvements are identified through a range of sources. Rather, improvement opportunities documented on the plan have been initiated in response to deficits identified through visits conducted by the Commission. Additionally, I have considered the findings of Non-compliance in relation to 20 Requirements across eight Standards indicates deficiencies with the governance processes associated with continuous improvement.

In relation to workforce governance, I have considered that evidence provided in the Assessment Team’s reports for both the Assessment Contact and Review Audit in relation to Standard 7 Requirements (3)(a), (3)(c) and (3)(d) demonstrate the organisation’s workforce governance systems are not effective. I find the organisation’s processes have not ensured the workforce is sufficient or supported to deliver safe and quality care and services to consumers.

In relation to feedback and complaints, I have considered the finding of Non-compliance in relation to Standard 6 Feedback and complaints Requirements (3)(a), (3)(c) and (3)(d) indicates deficiencies with the governance processes associated with feedback and complaints. I find the organisation’s processes have not ensured consumers and representatives are supported and encouraged to provide feedback, appropriate actions are taken in response to feedback or feedback is consistently captured, reviewed and used to improve the quality of care and services.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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 were not satisfied the service demonstrated effective risk management systems for managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents. The Assessment Team provided the following information and evidence relevant to my finding:

* The service does not have framework to prevent abuse and neglect. A Freedom of movement policy dated June 2019 provides direction for consumers to move freely within and without the service, however, states consumers residing in a secure memory support unit are excluded from this right.
* The Assessment Team identified staff practices within the memory support unit of locking consumers in and out of their rooms. Clinical and care staff did not identify this action as a form of abuse. Management only became aware of this practice following feedback from the Assessment Team.
* Policies and procedures to guide staff in relation to incident reporting and escalation and care and incident management systems for reporting and documenting consumer issues and concerns are in place. However, understanding and application of those processes for all consumer incidents, issues and concerns is not understood or applied by all staff.
* Some staff are not documenting consumer incidents or escalating, reporting, or involving consumers, consumer representatives in investigations of incidents or complaints in a timely accurate manner.
* A new risk management framework had recently been introduced and a governance and clinical governance structure implemented. Risk and clinical governance committees have been introduced to report and analyse data. However, other than change of a communication reporting and escalation structure this has not resulted in any changes within the service since implementation.
* Whilst meeting minutes demonstrate identification of some training requirements, they do not demonstrate identification of trends within clinical and non-clinical service delivery.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, and includes commentary to refute assertions made by the Assessment Team. The response also indicated improvements have been implemented in response to the Assessment Team’s report. Supporting documentation, specific to the evidence presented in the Assessment Team’s report for this Requirement, was not included as part of the provider’s response. The provider’s response indicated:

* The organisation has a well-defined governance structure with regular meetings to analyse data. In response to the Review Audit, additional reporting structures include two organisation wide committees relating to risk and clinical governance which meet monthly. The purpose of the committees will be to receive monthly data from all the services, provide an avenue for broader review and analysis, benchmark results and responses and enable areas of identified risk to be consistently responded to.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the organisation did not demonstrate effective risk management systems and practices. I have considered that while a new risk management framework has recently been introduced, this framework has not been effective in relation to managing high impact or high prevalence risks associated with the care of consumers or managing and preventing incidents

The provider’s response asserts the organisation’s two other residential services have identical systems and governance structures in place and the service was found fully compliant with this framework at a re accreditation audit in February 2021. However, organisations are expected to have systems and processes to assist to identify and assess risks to the health, safety and well-being of consumers and to identify and evaluate incidents. I have considered that for this service, the organisation’s risk management framework has not been effective in ensuring this occurs or that it has been implemented effectively.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to skin integrity, wound management and changes to a consumer’s condition as highlighted in Standard 3 Personal and clinical care Requirement (3)(b). I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care, specifically in relation to wound management. Additionally, in response to one consumer’s behaviour, other consumers’ bedroom doors are locked at night-time to prevent the consumer entering into their rooms placing these consumers at risk.

I have also considered staff have not demonstrated an understanding and application of incident reporting and escalation processes. Not all consumer incidents are being documented, escalated or reported. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are being minimised and/or eliminated.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### 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 were not satisfied the service demonstrated an effective organisational clinical governance system, specifically in relation to antimicrobial stewardship and minimising use of restraint, to ensure consumers are provided with safe and quality clinical care. The Assessment Team provided the following information and evidence relevant to my finding:

* The service does not have a policy to support staff to identify and manage clinical deterioration in consumer health.
* Clinical indicators for September and October 2021 identified the number of consumers prescribed antibiotics but does not identify infection type, location, or cause to enable effective trending analysis or reduction of infections and antibiotic use.
* A policy relating to restrictive practices defines the five types of restraint, however, does not include all legislative requirements and provide sufficient guidance for staff.
* The content for training provided to staff in October 2021 does not align with the current policy, or inform staff in relation to use of restraint as a last resort. This has resulted in inappropriate use of chemical restraint, failing to identify that all other strategies have been exhausted prior to use.
* Clinical incidents reported, discussed at meeting forums and escalated to the governing body are not reflective of the actual clinical incidents. For example:
* Infections or behaviour incidents are not consistently documented in the incident management system and/or reported.
* Verbal and physical assaults are not consistently reported through Serious Incident Response Scheme processes or documented in the incident management register/log.
* Consumers’ skin integrity and/or wounds are not consistently or accurately categorised and/or reported.
* Consumers’ clinical deterioration is not effectively identified, documented and/or reported.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, however, the response is limited to commentary to refute assertions made by the Assessment Team. Further documentation to support the provider’s stance was not included as part of the response. The provider’s response included, but was not limited to:

* The service does not use restrictive practices unless deemed necessary as a last resort and only ever in consultation with the consumer, representatives and the broader health care team.
* The organisation has a well-defined governance structure with regular meetings to analyse data.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Review Audit, the organisation did not demonstrate the clinical governance system was effective at ensuring staff practice and knowledge aligned with policy and legislative requirements relating to minimisation of restraint or monitoring processes effectively identified and analysed infections to ensure appropriate use of antimicrobials.

I have also considered that while clinical incidents are reported, discussed and escalated, the incidents were found not to consistently reflect the actual clinical incidents which were occurring. I find this has not enabled the organisation to identify improvements to clinical systems and practices.

For the reasons detailed above, I find EI-Jasbella Ramsay Pty Ltd, in relation to Edenfield Family Care - Ramsay, Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# Areas for improvement

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

**Standard 1 Requirement (3)(b)**

* Ensure consumers are:
* provided care and services which are culturally safe and values their cultural identity.
* Ensure policies and procedures in relation to culturally safe care and services are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to culturally safe care and services.

**Standard 2 Requirements (3)(a) and (3)(e)**

* Ensure consumer care plans are updated in response to consumers’ changing condition and clinical incidents.
* Ensure consumer care plans are personalised and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure care plans are reviewed in response to changes in consumers’ care and service needs.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g)**

* Ensure staff have the skills and knowledge to:
* provide appropriate care relating to wounds, restrictive practices and behaviours, nutrition and falls.
* recognise changes to consumers’ health and well-being, including clinical deterioration, implement appropriate management strategies and initiate referrals in a timely manner to Medical officers and/or allied health specialists.
* develop and/or implement appropriate behaviour management strategies and monitor effectiveness of strategies to ensure impact of behaviours on other consumers’ safety is minimised.
* ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* identify changes to consumers’ personal and clinical care needs and implement appropriate monitoring processes.
* implement standard and transmission based precautions to prevent and control the spread of infection.
* implement practices to promote appropriate antibiotic prescribing.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, personal care, restrictive practices, infection control and antimicrobials are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, personal care, restrictive practices, infection control and antimicrobials.

**Standard 4 Requirement (3)(c)**

* Ensure staff have the skills and knowledge to:
* identify things of interest to each consumer, implement activity programs in line with consumers’ preferences and engage them in activities of interest, including meaningful one-on-one activities.
* Ensure policies, procedures and guidelines in relation to leisure and lifestyle are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to leisure and lifestyle.

**Standard 5 Requirement (3)(b)**

* Ensure consumers, specifically those residing in the memory support unit, are able to move freely indoors, particularly at night.

**Standard 6 Requirements (3)(a), (3)(c) and 3(d)**

* Ensure consumers and others are encouraged and supported to provide feedback and make complaints.
* Ensure feedback and complaints, including those received verbally are captured and appropriately actioned.
* Ensure feedback and complaints data is regularly reviewed to identify trends and improvement opportunities to the quality of care and services.

**Standard 7 Requirements (3)(a), (3)(c) and (3)(d)**

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.
* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in all eight Quality Standards.

**Standard 8 Requirements (3)(b), (3)(c), (3)(d) and 3(e)**

* Ensure the governing body engages with consumers and representatives to assist to identify organisational improvements.
* Review the organisation’s governance systems in relation to continuous improvement, workforce governance and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to Non-compliance identified in Standard 3 Personal care and clinical care.