Elizabeth Jenkins Place Aged Care Plus Centre

Performance Report

8 Homestead Avenue
Collaroy NSW 2097
Phone number: 02 9454 0407

**Commission ID:** 0414

**Provider name:** The Salvation Army (NSW) Property Trust

**Site Audit date:** 12 October 2020 to 15 October 2020

**Date of Performance Report:** 18 December 2020

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Non-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) | Non-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) | Non-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) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Non-compliant |
| Requirement 4(3)(e) | Non-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) | 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) | Non-compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

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

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

For example:

* They provided information about being treated with dignity and respect, and that their identity and diversity is valued by the staff.
* Some provided information about culturally safe care being provided to them.
* They are able to exercise some choices relating to their lifestyle and are supported to maintain relationships with family and with friends.
* Some consumer representatives are enabled to make decisions about the consumer’s care and services, but others are not. Consumers are also not being enabled to make decisions about their own care and services.
* Consumer personal privacy is respected and upheld by staff.

The Assessment Team found that consumers are not supported to take risk to live the best life they can. Staff were not able to provide any example where risk is identified and managed to support consumer choices.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

### Requirement 1(3)(d) Non-compliant

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

While many consumers are living the best life they can the service does not actively enable consumers to safely undertake a range of risks. Staff were unfamiliar with the concept of consumers having the right to take risk.

A consumer representative advised the Assessment Team that a consumer was previously repeatedly tilted back in a comfort chair looking at the ceiling. This prevented the consumer was even being able to watch television. In response to feedback about this the representative said a lap sash restraint was suggested, but management said this was requested by the representative. Refer to requirement 3(3)(a) for more information regarding physical restraint.

In relation to food a consumer representative explained that a consumer would prefer a regular diet rather than modified meals. They believe the consumer would be able to consume normal food if staff provided assistance and observation at meal times. A consumer representative also explained to the Assessment Team that consumers are allowed to consume alcohol but only if it is ordered by the doctor.

Lifestyle staff were unable to show how consumers are supported to take risks to live the life they can. When asked specifically about choices and risk a lifestyle staff member provided the example of organising the physiotherapist to assess a consumer’s ability to walk to a local newsagent. While the assessment as occurred the consumer has not yet been able to leave the service due to COVID-19 restrictions, but it remains a goal.

The lifestyle coordinator said they rely on advice from the Chaplain regarding many aspects of service. For example a consumer was concerned about the game bingo, which may be considered gambling as there are prizes such as chocolate. A consumer also wanted to clarify about the playing of cards in the chapel. They said the chaplain did not have any issue with this. They said Melbourne Cup is celebrated with a party but there is no gambling. They also said there is no alcohol allowed on site and consumers understand this. Catering staff were unaware of a request about a consumer’s food preferences. They said they do not change meal requirements without registered nurse direction.

The resident handbook states no alcohol is able to be brought on site including small amounts purchased by family. The handbook states “behavioural problems arising from un-prescribed alcohol consumption may result in suitable alternate accommodation being sourced for you”. The resident handbook states “in line with the Salvation army values and principles gambling or the selling of raffle tickets is not permitted at any time on the premises”.

Consumers were observed congregating in the communal areas of the service, interacting in a friendly and companionable manner.

I find this requirement non-compliant.

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Overall sampled consumers and representatives did not confirm that they feel like partners in the ongoing assessment and planning of their care and services, though they did consider they were involved in aspects of their care. For example, a representative said they would be given a copy of the consumer’s care plan if they asked.

When discussing the care provided to them consumers (and representatives on their behalf) gave examples that led the Assessment Team to consider that assessment and planning is not always focused on optimising health and wellbeing in accordance with a consumer’s needs, goals and preferences.

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

## Assessment of Standard 2 Requirements

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

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

Care planning documents demonstrate comprehensive assessment and planning for the consumer’s sampled. Despite this they did not always demonstrate alignment with consumer needs, goals and preferences, and were inconsistent with documented care and evidence of regular assessment and review in accordance to the service’s processes.

While the service has a New Admission and Care Assessment Flowchart to guide staff in completing assessments on entry that assist in the development of care plans the process is not always followed. Consumer files reviewed show assessments are not completed in relation to the services schedule nor are risk assessment always completed.

The ‘New Admission and Care Assessment Flowchart’ tool is designed to guide compliance with the assessment process and lists a number of assessments and reviews to be completed each day during the first 28 days. Some assessments are to be completed on the first day including assessing immediate needs on entry, request Medical Officer complete medication chart, completing a nutrition and dietary profile and creating a care plan and completing a pain profile. The Assessment Team found some assessments are not done until the consumer has been in the service for eight days, including the personal hygiene and skin integrity profiles. This means they do not assess needs like skin integrity until the consumer has been in the service in the service for more than a week.

The service offers respite care and during the audit three consumers were identified on the Current Residents List as receiving respite care. Review of consumer files showed they had not had all assessments completed and had limited information in their care plan to inform the delivery of safe and effective care on entry to the service. This has left the consumer and staff in a vulnerable position.

The Assessment Team heard a consumer calling out in their room and found them alone in the toilet requiring assistance, including pulling their clothes back on and to mobilise out of the bathroom. Staff came when the call bell was pressed and assisted the consumer. While staff said they had recently checked on the consumer they did not go into the room to assist them with toileting as they had been agitated. The staff member said they were unable to assist the consumer earlier as they had been the sole staff member in the household for 20 minutes and did not feel safe solely assisting them. The Assessment Team noted that the consumer has had repeated incidents of agitation which present as verbal and physical behaviours of aggression. This is not identified in their mobility, continence, pain or sleep care plans.

Another consumer, who is unable to mobilise without assistance, is restrained in a tub chair. While their mobility and movement care plan includes the restraint, a lap belt, in the interventions stating this was requested family, it does not provide instruction regarding the risks of this restraint or for use and monitoring of the lap belt. The restraint authorisation has been completed by the Medical Officer and a Registered Nurse and explains risks of this restraint. The restraint form also states that the lap belt is to be released every two hours for 10–15 minutes and staff to monitor if it is too tight. The Assessment Team observed that care staff had released the lap belt on one occasion while the consumer was being assisted with his lunch during the site audit.

A consumer with a cognitive, hearing and visual impairments requires scheduled colostomy care. It is noted that this consumer care be uncooperative to care and will attempt to change or empty their colostomy bag independently. Though with some difficulty. Wound charts relating to the care of the consumer’s stoma completed by registered nurses indicate the consumer looks after the stoma them self.

The Assessment Team found minimal progress note entries about the support provided or assistance required by another consumer with a profound visual impairment. There was no visual assessment and their care plan states “communication and sensory loss does not require assistance; cares for aids independently; staff are to assist and supervise cleaning of glasses”. Consumers (and representatives on their behalf) told the Assessment Team that a consumer has experienced many falls as they are not always supervised, had many urinary tract infections, and has been observed calling for help while on the toilet.

Care staff said they read the care plans and use them to inform how they deliver safe and effective care. For example, they know about consumers’ preferences with staff delivering care.

The service has an Admission Process Flowchart, this is included in a folder handed to the registered nurse with the introduction of a new admission. It includes a risk and safety assessment. When risk is identified, further assessment of a particular identified risk is conducted. The assessments transfer to the care plan. For example, the admission risk form alerts staff to complete a consumer risk form for an electric scooter if a consumer has one upon admission. Strategies to manage the risk are then reviewed and put in the consumers care plan and include a Psychogeriatric Assessment Scale. An occupational therapy assessment is also done and uploaded into the care documentation. An example of strategies includes staff to monitor for skin tears and bleeding.

I find this requirement non-compliant.

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

### For the consumers sampled, assessment and planning does not always identify and address the consumers specific needs and preferences including advance care planning and end of life planning.

### The Assessment Team identified consumer information in care plans does not consistently demonstrate individualised observations and goals, but more personalised goals were identified under the interventions section of the plan. In some cases, information in the care plan is inaccurate or confusing, and inconsistent with other documentation. When advance care plans are completed, a record is kept in the consumer’s paper folder and identified on the electronic documentation system. Each consumer’s profile indicated if they had a completed advanced care plan or not.

### All care plans reviewed had generic goals for each consumer which were the same in all care plans with the name of the consumer changed. While these consumers had varied levels of mobility there were no specific or individualised goals. For example observations identified some consumers required assistance but there were gaps in the documentation of their level of insight or ability to notify staff if they need support.

### There is no skin integrity care plan in the suite of care domains provided in the consumer care plans. Skin assessment and care is documented in the complex and specialised care domain. Information regarding the observation of current wounds with goals and interventions is not consistently documented. The Assessment Team also identified gaps in the documentation of pain for consumers.

### In relation to advance care planning the service acknowledged that 65 percent of consumers have an advance care directive. They said the directives take some time to be signed by family and the medical officer. They have made a tracker to monitor the completion of directives for all consumers. The Assessment Team also found that some end of life preferences have not been adequately documented and that a consumer was not kept pain free consistently during end of life care.

A representative told the Assessment Team that the most important thing to them is that the consumer can have social contact and receive pain relief as isolation increases the consumer’s pain symptoms. A clinical nurse consultant suggested that the consumer would benefit from being transferred into a tub chair with pressure relieving overlay for short periods during the day. The representative said this did not occur every day due to a lack of tub chairs and because staff could not easily change to consumer’s continence aid. The Assessment Team observed the consumer engaged with their surroundings in a tub chair on one occasion. Management advised there are enough tub chairs for all consumers who need them.

Another representative expressed concern with the high number of falls and urinary tract infections the consumer has experienced while at the service. The representative felt there were not enough staff, especially on Sundays, that leads to increased falls because consumers are not supervised adequately. While the consumer’s care plan informs staff they require the assistance of one staff member for mobility there are conflicting observations and interventions recorded.

### Care staff were able to tell the Assessment Team that consumers’ families were important to them. They also knew the preferences of consumers in relation to the gender of staff to provide care and they will call staff to assist. Care staff said the registered nurses discuss end of life care and advanced care directives with consumers. The Care Manager said palliation is discussed at Family Case Conferences. Department of Health, and palliative care team pamphlets were available in reception regarding grief and palliative care resources, which can be accessed by families. Mandatory staff palliative education was conducted in January, approximately 80 staff attended.

### Pain and palliative care plans were completed in clinical files for all six care plans reviewed though a consumer’s pain and palliative care plan had two generic goals and no observations or interventions.

### I find this requirement non-compliant.

### 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.*

While the service has a system of regular reassessment and incident recording these processes are not used to determine the effectiveness of planned care. When incidents occur, they are not always reviewed to consider their impact on the needs, goals or preferences of the consumer. For example, the Assessment Team found a consumer’s care plan nor their complex and specialised care plan were reviewed following their changed circumstances.

Similarly, the service used discretion not to report an incident involving consumers due to one of them having a diagnosis of dementia. A behaviour profile was completed by the Clinical Care Manager noting that the consumer had been transferred to hospital on the day of the incident for behavioural issues. At the time of the visit the consumer’s care plan had been reviewed or updated since the incident.

The registered nurse said care plans are reviewed annually. Management confirmed this and that assessments are reviewed to ensure effectiveness, with care plans updated every time an assessment is done. Care plans due are notified on tasks in the consumers computerised clinical file. Despite this the Assessment Team found care plans are not always reviewed or updated as required and that not all assessments are undertaken when needed.

I find this requirement non-compliant.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Most sampled consumer representatives considered that consumers do not receive personal care and clinical care that is safe and right for them. For example, some representatives expressed concerns due to the history of high impact and high prevalence falls and care management for consumers. Consumer representatives interviewed confirmed that their consumer has access to a doctor or other health professional when they need it.

When discussing the care provided to them consumers gave examples that led the Assessment Team to consider that safe and effective personal care, and clinical care is not always delivered in accordance with their needs, goals and preferences. They do not receive effective personal care and clinical care tailored to their needs and that optimises their health and well-being, in relation to pain management, wound care, identification of deterioration in condition, nutrition and hydration and management of agitation and urinary tract infections.

The service has some systems in place to manage high impact high prevalence risk to consumers, however the systems are not effective in identifying key concerns that are leading to deficiencies in care and oversight of consumers with high falls risk and consumers who are at risk of pressure injury. The needs, goals and preferences of consumers nearing the end of life are not always managed effectively.

Consumer information is communicated within the service and with others involved in their care though information about consumers is not always available or recorded and reported accurately.

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

### Assessment of Standard 3 Requirements

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

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

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

For the consumers sampled, observations of consumers and staff responses, care planning documents and progress notes did not consistently demonstrate that consumers receive safe and effective care that is best practice, tailored to their needs, and optimised their health and wellbeing. While the service has processes in place to guide staff regarding the tasks required to meet consumers clinical and personal care daily, these processes and tasks were not always being followed for the consumers sampled, in particular pressure area care, falls and post incident management, nutrition and hydration management, behaviour and wound management.

There has been high incidence of falls. Wandering behaviours have not been managed and staffing availability and performance negatively impact on falls management. There has been high rate of injury following falls. There is high incidence of skin integrity incidents including pressure injuries. Wound care is not demonstrated to be best practice. Consumers have been dehydrated and there is high incidence of urinary tract infections.

Post incident management has not been provided according to the organisational directives including review, observation and notifications, some of which have not occurred.

Representatives raised concerns with the provision of clinical and personal care, and some representatives said their family member does or has not had their needs met and they have not felt their family member is safe.

Progress notes did not consistently document the care provided to consumers at the service. Review of progress notes, observation of staff and consumers, wound charts, care plans, handover and interviews with consumers and staff does not reflect individualised care that is safe, effective and tailored to the specific needs of each consumer.

Management said they have organisational policies and procedures to ensure best practice care delivery. Changes to policy or best practice are emailed to all clinical staff. The Clinical Governance Procedure has information on all clinical policies updated and other policies provide supporting documentation. The Falls Management care pathway was last updated July 2019.

Complaints documentation shows concerns have been raised with care provision and clinical oversight, including: clinical deterioration not being well managed or identified; delays in arranging medical attention post falls; bruising and rough handling; wandering/intrusive behaviours of other consumers; and staff conduct. The Assessment Team also observed an issue with a consumer’s oxygen concentrator not being set at the right flow rate though staff corrected this during the visit.

Management said the service’s approach to restraint is to minimise restraint as much as possible and to have restraint authorisation in place if utilised. For every restraint in place family are informed of the risk involved. Environmental restraint authorisation forms have been documented for consumers who live in Long Reef which is a secure unit. Eleven forms of seventeen consumers have been completed with signatures of the medical officer and the family.

The service maintains a self-assessment tool for recording consumers receiving psychotropic medications, initially the Assessment Team was provided with the tool dated 9 July 2020 and later in the visit a further tool dated 30 September 2020 was provided. From this documentation the Assessment Team determined that 75% of consumers are prescribed psychotropic medication. This has increased since July 2020 when there were 73.3 % of consumers’ prescribed psychotropic medication. As required medications are reviewed individually, for example, if the consumer has not used an antipsychotic during the last three to four months, the medical officer is asked to review the need to continue or cease the order. Medications are also reviewed and changes made by the psych geriatrician.

Medication Advisory Committee meetings attended by pharmacy are held where related clinical indicators and medication incidents are discussed. Minutes from the meeting held 11 August 2020 were reviewed by the Assessment Team. The number of residents on psychotropic medications was discussed and the pharmacy was requested to provide data to the service on percentage of ceased psychotropic medications monthly and include ceased medications in a monthly psychotropic graph. Residential Medication Management Reviews are done which suggest reduction in psychotropic medications at times.

In relation to skin integrity management advised that every consumer has a head to toe assessment on admission by a registered nurse. This also done on return from hospital to identify skin tears or bruises. National quality Indicators for skin integrity are done three monthly. All skin tears, bruises and wounds are reported as an incident report, completed by the registered nurse. A wound chart and wound monitoring is commenced as needed. Wounds are reviewed every seven days at minimum, for example, a bruise, the registered nurse makes a decision about how often to check, depending on wound dressing and type.

Care staff reposition residents according repositioning chart depending on mobility and all consumers have moisturiser applied or available to them. Wound charts and wound assessments are documented in the consumers’ computerised clinical file.

The service has a nurse practitioner who will review chronic wounds and provide second opinion for care manager and are involved in complex wounds. The BRACE team is contacted for wounds which are not healing. Clinical indicators are collected, and every wound is reviewed. The data is trended and analysed. The clinical Indicators are discussed at a Compliance meeting with the area manager and actioned. Previous actions are reviewed at the meeting.

For pain management the service has three physiotherapists working Monday to Friday. Physiotherapists are involved in pain management. They provide therapeutic massages for pain and review and assess consumers after a fall, especially if there is a possible fracture. The service also employs a physiotherapy assistant who conducts daily exercise and massages. After falls, pain is assessed by chart or documented in progress notes.

A pain assessment is done on each consumer on admission by the registered nurse, asking for example the location of pain and what helps the pain. Physiotherapists also do assessments for people living with dementia and cognitive consumers on admission. They then make a plan using exercise and heat packs to manage pain and the service takes a non-pharmacological approach with a focus on mobility and repositioning. Consumers on Schedule 8 medications and strong analgesic are monitored for pain. PRN medication is discussed at family case conferences, palliative care focus on keeping the consumer pain free, and staff check pain each time they check a wound.

The physiotherapist assistant conducted a walking group before COVID-19 restrictions, they now do an exercise class in the mornings. This is added to the consumers care plan by the physiotherapist.

Although the Assessment Team observed some good practices at the service, gaps were still identified that indicate each consumer is not always consistently provided with safe and effective personal or clinical care that is best practice, tailored to them, or that optimises their well-being.

I find this requirement non-compliant.

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

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

The service demonstrated care planning, monitoring and trending of high impact and high prevalence clinical and personal care risks for consumers. Despite this the Assessment Team identified gaps in the monitoring and effective management of pressure injuries including pressure area care and prevention, wound management, falls prevention and injury minimisation and behaviour management. While the service has processes to monitor these trend risks, evidence does not support that all incidents have effective risk management strategies implemented in a timely manner.

Falls were identified as high risk high prevalence. There has been consumers with high numbers of falls, many with injury that have not been managed. Risk has not been effectively managed. Although recent improvements with the commencement of a falls committee has occurred falls and post falls and incident management continue to negatively impact on consumers.

Falls are recorded in the clinical indicators, then discussed and recorded in minutes at the monthly compliance meeting. The Area manager will escalate to his clinical and compliance team.

A falls committee meeting was started in June and meet every week. The committee includes the Care Manager, physiotherapist, physiotherapy assistant, one care staff and one registered nurse, the service manager and area manager. The Care Manager said they had put some interventions in place through findings at the falls meetings, for example:

* Staff checking chairs for safety before their shift and report any concerns.
* Falls trends are charted and placed in the staff room.
* Increased access to psychogeriatrician – to review medications to minimise as falls possibly caused by medications.

In addition to falls, the Assessment Team identified issues with behaviour management, wound management, and skin integrity for consumers sampled. They also considered that skin integrity incidents are high and that pressure area and wound care is not being adequately addressed at the service. There are currently nine active pressure injuries which have been identified at the service. These gaps were also considered in relation to requirement 3(3)(a).

Management acknowledged that falls and post falls management has been an area of deficit. They acknowledged some issues relate to staff understanding. Staff described aggression as being high impact and high prevalence risk at the service and identified this as the most significant risk for a consumer sampled. Staff reported that risks of aggression were increased due to their inability to supervise consumers, and that they have to leave consumers unsupervised in the lounge area while two staff attend other consumers. Management explained they have documented break times for staff so that staff are not left to work alone through the day.

The care manager trends and analyses falls, and behaviour incidents and skin tears and this information is reported at weekly falls meetings and monthly compliance meetings. Bed sensors, for high risk falls consumers, are often not responded to in a timely manner. The organisation’s Quality Team provide support visits and remote reviews of care notes. A report is given to the service by team providing feedback.

I find this requirement non-compliant.

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

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

While the needs and goals of consumers nearing end of life are recognised and addressed, their comfort is not always maximised. Risks to consumers at the end of their lives is not managed or mitigated, and consumers were noted to have had falls and skin integrity incidents in their final days.

Staff said comfort is the main thing along with love, dignity and respect. Staff said they observe the rate of pain and provide pressure area care, continence care, ‘feeding’ and observe swallowing. The registered nurse said they notify the medical officer for pain management and ensure care staff observe and document signs of pain.

The service has a Palliative Care Approach and Advance Care Planning policy. This ‘provides a focus on comfort care and a positive approach to reducing an individual’s symptoms and distress, while actively providing support to the customer and their representative’. Consumer can be commenced on increased pain medication as required and the medical officer reviews when there are increasing needs for pain relief. The medical officers work with the palliative care team who assess consumers after referral by the medical officer. The service sends documentation to the palliative care team including medication charts, and the team make recommendations to the medical officer.

Management advised that family case conference is conducted to involve family in decisions about care and end of life. Religious wishes are recorded at family conferences and involve the chaplain if preferred.

While the services has systems and processes in place to identify consumer end of life goals and preferences, the gaps identified by the Assessment Team in relation to issues that have impacted palliative consumers does not demonstrate compliance with this requirement.

I find this requirement non-compliant.

### 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.*

Consumers who experience a change of condition do not always have their needs recognised and responded to in a timely manner. For the consumers sampled, care notes do not show consumers who have changes in condition or who are deteriorating are recognised, and response is not timely with examples identified by the Assessment Team throughout Standard 3.

While one consumer representative said the service does respond appropriately when there is a deterioration in condition, health or ability of the consumer, more representatives provided negative feedback about this.

Staff gave an example of a consumer who had commenced on a new medication whose condition deteriorated; they became short of breath, with a decreased respiratory rate, and their mobility decreased. The medical officer and physiotherapist were notified and the consumer’s new medication was ceased, leading to a little improvement.

The Assessment Team examined policies and procedures relevant to the identification of deterioration and changes in a consumer’s condition, as well as staff training records. Although these guides are in place issues identified by the Assessment Team indicate that deterioration or changes are not always recognised and responded to in a timely manner.

I find this requirement non-compliant.

### 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.*

Although consumer information is communicated within the service and with others involved in their care, information about consumers is not always available or recorded and reported accurately. Progress notes provided limited information regarding the flow of the consumer’s current condition and management. Information in the care plans was limited and gaps and inconsistencies were noted by the Assessment Team and are also considered in relation to Standard 2.

A consumer representative told the Assessment Team that communication is the problem at the service. They would like to be rung every week with an update regarding the consumer’s condition and this was reported to management. Another representative said they were not sure if staff are letting them know about all incidents involving the consumer at the service. They said they are not always able to find staff at the service to discuss the consumer’s welfare. A consumer also said that they cannot get his messages across and that staff do not listen.

Handover between the morning shift and the afternoon shift registered nurses was observed by the Assessment Team. The handover was comprehensive, detailed, confidential, and effective. It included input from the physiotherapists at the service. Care staff said they receive a verbal handover from the previous carer and the registered nurse and that they read the shift report. Registered nurses said they email or phone medical officers when there are changes in consumers care and services.

Staff use a voice controlled badge system to communicate with each other within the service. One carer said they were unable to contact the registered nurse when they needed assistance with an agitated consumer.

While the Assessment Team observed some good practices within the service’s handover processes, other information considered does not demonstrate a comprehensive compliance with this requirement.

I find this requirement non-complaint.

### 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.*

Interviews with management, staff, consumers and representatives, review of documentation and some observations show the service has procedures and practices to support minimising infection related risks including an outbreak management plan for the COVID-19 pandemic. Despite this a registered nurse and carer interviewed could not locate the infection control policy and procedures on the services intranet.

Observations showed staff are not always following acceptable hand hygiene practices and staff were not always wearing masks when social distancing is compromised. This does not support infection prevention and control.

A review of consumers’ care and service records identified infections are treated but the reason for antibiotic use was not clear for four out of six consumers reviewed. The service was observed to have seven antibiotics in emergency stock to dispense if prescribed by a medical officer for a consumer. This is inconsistent with the standard maximum number allowable under New South Wales regulations.

Antibiotic stewardship is monitored in the service’s clinical indicators. The data on antibiotic stewardship shows the percentage of consumers prescribed antibiotics where the doctor has reviewed pathology within 72 hours of prescription is below 50% and has fallen from June to August 2020.

Three consumers and a consumer representative interviewed provided information about being kept updated with information about COVID-19 and visiting restrictions, and said the service environment is generally kept clean. Another representative said it would often take several days for staff to obtain a urine specimen if requested, when they observed the consumer to be unwell and suspected a urinary tract infection. Three consumers interviewed said that the staff had advised them to wash their hands frequently and to isolate if they displayed any signs or symptoms of infection.

One consumer voiced a concern to the Assessment Team about visitors not complying with social distancing and conducting visits in a common area. In response a registered nurse asked the visitors to move outside, and the concern was brought to the attention of the manager who informed the Assessment Team that a memo would be sent to all relatives reminding them of the Level four visitor restrictions currently in place, the need for visitors to wear masks when social distancing is not maintained, and for visits to occur outdoors or in the consumers room only, not in indoor common areas.

Two registered nurses and three carers interviewed were able to describe how they would recognise if someone has COVID-19. The two registered nurses interviewed understood the incubation period, means of transmission and complication risks of the virus. They would isolate a consumer straight away, notify the manager, next of kin and doctor, arrange for a COVID-19 swab test and keep the consumer in isolation until a negative result is received. The clinical care coordinator and two registered nurses also provided examples of how they would manage a staff member who attended work with suspected COVID-19.

The clinical care coordinator described how the service has two infection control coordinators who both report into the clinical care coordinator. The clinical care coordinator said the two infection control coordinators are not currently allocated additional hours to complete two infection control work and there was no evidence given of formal two infection control coordinators training or qualifications. When asked how infection related risks are minimised at the service, the clinical care coordinator and two registered nurses spoke of the pre-entry screening processes, hand hygiene and use of personal protective equipment.

Two registered nurses reported they encourage fluids, ensure pathology results are available prior to commencing antibiotics and undertake monitoring when consumers are prescribed antibiotics. They also described how they recently responded to an infection related risk at the service and three ways to minimise the risk of transmission to others. For example, a consumer with flu symptoms who was placed in isolation. The two registered nurses could describe physical changes such as changes in temperature or flu symptoms but they did not mention behavioural signs of an infection such as increased confusion, changes in behaviour.

Five care staff interviewed were aware of the need to prevent infection through good hand hygiene, wearing masks and social distancing between consumers. Staff said they have completed infection control training, practised donning and doffing of personal protective equipment and completed handwashing competencies.

Three contracted cleaners interviewed explained the cleaning schedule and they were able to complete all cleaning work within the allocated time and they have all of the equipment and supplies required to do his work. The cleaner demonstrated an understanding of infection control relating to cleaning generally and in the context of COVID-19. The three cleaners and two laundry staff interviewed had undergone infection control and hand hygiene training and were aware of the cleaning plan to be implemented if there is a COVID positive suspected or confirmed case at the service.

The contracted chef said kitchen staff wear face masks when they are out in the common areas and social distancing is compromised. The chef said that the catering team currently had two weeks of disposable trays and utensils in stock for use if required. Two lifestyle staff interviewed said they are aware of handwashing practices and have received training on infection control and personal protective equipment.

The registered nurses and manager stated they were aware of the risks associated with over prescription of antibiotics and the potential for antibiotic resistance. They said they work with the medical officers to ensure antibiotics are ordered following pathology. However, in relation to the low levels of compliance and the rise in consumers who was prescribed antibiotics without pathology from June to September 2020 the clinical care manager was unable to explain why this occurred.

Three carers were able to describe the risks of infections for consumers. Care staff said they managed consumers with infection by making sure consumers are drinking fluids, particularly if they have a history of urinary tract infections. The care staff said they routinely conduct observations on consumers for signs of infection and notify the registered nurse as required. However, the three care staff interviewed stated they have not been advised about minimising the need for antibiotics and what they can do in their role as care staff.

Hand hygiene practices were observed though these were not always acceptable as staff were not always observed to immediately perform hand hygiene upon entry to and exit out of consumers’ bedrooms or between changing gloves. The hand hygiene point at the entry to the service as well as other hand hygiene stations throughout the service were observed to be empty. Some areas in the service were also not clean. This does not support infection prevention and control.

Screening and temperature checks were conducted on all staff and visitors prior to entry to the service. Hand hygiene instructions were above each hand washing station however the hand sanitiser stations observed in the consumers room and dining areas did not have hand hygiene instructions posted. There are notice boards, signs and other sources of information for staff, consumers and visitors on infection prevention and control and COVID 19 awareness. Physical and social distancing were generally observed to be maintained by staff but at times were not practiced by catering staff or visitors who were not wearing a mask.

The service had a well-stocked outbreak management kit in storage, there was seven kits for the seven houses and including guidance and supplies, although these were not controlled. There were adequate cleaning supplies including detergent and disinfectant products.

The leadership team monitor any outbreaks including monitoring clinical indicators/incidents to understand trends/tracing in relation to track infections. The service has reported nil outbreaks since a gastrointestinal virus outbreak in December 2019.

The service has written procedures relating to COVID-19, an outbreak management plan infection control and practices to reduce the risk of resistance to antibiotics last reviewed 1st July 2019. A business continuity plan for the service came into place on the 12 March 2020 and was last updated 22 July 2020.

The service maintains a comprehensive spreadsheet for staff and consumers with increased risk factors for COVID-19 including staff that work at other hospitals, consumers who have experienced flu like symptoms, residents returning from hospital and new consumers.

The service has a COVID-19 workforce management plan which identifies key focus areas goals and actions using a traffic light system. It is centre specific and it shows the person assigned responsibility for conducting a daily assessment of staffing status and needs during the COVID-19 pandemic is the centre manager.

There is a well-planned floor plan and map for cohorting with residents to be comforted into the seven distinct houses with all consumers currently residing in single rooms with the exception of two married couples. The floor plan outlines don doffing stations in each house and three extra hand hygiene stations for each house in the event of an outbreak.

Records indicate 117 of the 120 consumers have been immunised for influenza. Three consumers did not give consent for vaccination, one consumer was reported in their electronic file as having a previous allergy to the vaccine. Records indicate 100% of staff have been immunised for influenza.

Training records show staff competency skills assessments including hand hygiene, donning and doffing personal protective equipment had been completed by 95% of staff by 2 October 2020. 100% of staff have completed the Department of Health online COVID-19 training. A COVID-19 outbreak prevention and risk management document developed in July 2020 outlines levels one to five in response. Restrictions and screening processes enacted at the service reflect the risk management level at the time.

Education has been provided on antimicrobial stewardship to registered nurses and two clinical care managers. The medical advisory committee meeting minutes May 2020 report five antibiotics were selected on the list was which was approved post discussion. In relation to antimicrobial stewardship the service has an infection control surveillance plan and manual. The surveillance plan includes a monthly review of antibiotic microbial stewardship. Information reviewed by the Assessment Team showed a decrease in compliance with medical officers’ reviewing pathology results within 72 hours of prescribing antibiotics.

I find this requirement non-compliant.

# STANDARD 4 NON-COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Most sampled consumers consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

Consumers and representative feedback shows consumers have been sad and worried at times and left without support. Although the feedback indicates staff are generally kind, communication was repeatedly raised as an issue. Although the lifestyle program is meaningful to some consumers issues were raised about activities in the memory support unit and for consumers who require one to one support. Spiritual, emotional and psychological support has not always been available to all consumes. Although many consumers value the chaplaincy services some consumers do not have access to spiritual support of their choice or as they need it.

Although some consumers have indicated they do not enjoy the food service others do. The catering service has engaged with consumers to improve their satisfaction and the food service processes. Consumer said equipment, when provided, is well maintained but there were some issues relating to inventory and laundry.

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

## Assessment of Standard 4 Requirements

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

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

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

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

Consumer and representative feedback indicates that consumers have been sad and worried at times and left without support. Although the feedback shows staff are generally kind, communication was repeatedly raised as an issue. While there is a chaplaincy service this appears to have been fragmented due to availability and capacity to support the large number of consumers at the service. Consumers with special needs, those in pain and following incidents have not had meaningful emotional support. Some consumers feel ignored.

Review of incident reports and care documentation identified consumers are often in pain following injury. The Assessment Team also noted a lack of information about increased support needs for a consumer with vision loss and that some consumers’ spiritual needs are not respected. Feedback was also provided by consumers and representatives about theft at the service.

The lifestyle coordinator said lots of Salvation Army officers previously visited for mass weekly. Church services have been put on hold due to COVID-19. The Major/chaplain usually has hymn singing and chapel and continued visiting houses during COVID. The lifestyle coordinator said in relation to theft, she had not heard of any issue and found staff to be honest. They said the previous day a staff member found a consumer handbag and handed it in.

Lifestyle staff said for people of other faiths they encouraged them to go out for their celebrations prior to COVID-19; the service has diverse staff who respect residents and used to have ministers of other faiths; they were not sure which faith but they were of other Christian faith.

The Assessment Team met with the chaplain/Major of the service who said the service provides regular religious services twice a week and also offer Anglican, Catholic, Uniting and Baptist communion services once a month. At the monthly service an open communion is provided, irrespective of denominational status. The Assessment Team asked the Major to describe the services they provided to the consumers who may not be of the faiths mentioned above. The Major explained to that they often has coffee with a consumer of a different faith after lunch and although they may not have the same religious views they are respectful of their opinions and faith. The Major said relatives were concerned about a consumer’s right to practise their religion and the Major spoke to the family and explained that they were able to accommodate the consumer’s personal faith.

The Major said there was a recent incident where a visitor was observed to offer religious counsel to other consumers. The Major said they have a busy schedule of one on one consumer visits and she also visits a different dining room in the seven houses each lunchtime as she likes to visit different houses and speak with all the consumers. During the COVID-19 pandemic the Major said they have been particularly busy and been unable to rely on support from a retired Major due to visitor restrictions.

The Assessment Team observed consumers enjoying morning exercise and mediation classes in the chapel followed by a religious service where consumers were seen to enjoy singing hymns. The Major was seen to assist consumer in and out of the chapel.

Although some supports are provided, feedback and information reviewed by the Assessment Team shows that not all consumers receive supports or service that promote their emotional, spiritual and psychological well-being.

I find this requirement non-complaint.

### 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 sought feedback from consumers and their representatives that indicates consumers do not all participate in their community, maintain social and personal relationships, or do things of interest to them. There is limited support for consumers who do not participate in the group or self-directed lifestyle program.

A representative said their family member is incapacitated completely and often in bed and their main concern is about supervision. Their family member had been attacked by another resident. Another representative said it was unusual that during the visit residents were seated with an activity. They said staff “claim 10am-6pm lifestyle cover and that there used to have someone in the unit but now they rarely came downstairs; have one DVD in bedroom they play on repeat”. They said they observe residents regularly with no activities, slumped in seats and family put the communal TV on as regularly they (consumers) are just staring at blank screen.

Review of consumer files found minimal evidence to support consumers who are not engaged in the group activities have meaningful engagement with staff including lifestyle staff. Consumers who are said to require one to one support do not appear to be engaged in activities of interest to them.

The lifestyle coordinator has worked at the service for a year and has a certificate in lifestyle. They said there are four staff in the lifestyle team none of the other three staff have a qualification pertinent to lifestyle but two have a certificate III in aged care. There are self-directed activities such as scrabble and mah-jong for consumers who are able to organise their own groups. One to one engagements are generally once or twice a week for about 15 minutes.

One lifestyle officer said it is a problem that not a lot of separate activities are held and they are hoping to have more individual house programs which they said worked better in COVID-19 times. Lifestyle staff provided some examples about consumer interests and how they are supported to engage in the community. The chaplain said they tried to see all consumers at least once per week, however did not have time to document this in progress notes.

I find this requirement non-compliant.

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

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

The communication of information was identified as an issue for several consumers and representatives. Issues include staff comprehension, accessing staff to provide information and also the handover of information when provided. This has caused frustration and concern for consumers and representatives.

A representative said staff are lovely and kind but there’s no follow through on matters and that often they need to make multiple requests before things are actioned. They said this was a particular concern during COVID-19 when the service has gone into lockdown and they could not visit to check on things. Feedback was also provided in response to other standards highlighting issues with communication and information within the service.

Although staff said assessments and care plans are regularly reviewed deficits were identified in the currency of some information. For example, not reflecting the new support needs of a consumer with vision loss or the impact of this on their ability to participate in activities they enjoy.

Consumer and representative feedback along with the documents reviewed by the Assessment Team show that consumer information is not always accurate and up to date, and therefore cannot be reliably shared within the service or with others involved in the care of consumers.

I find this requirement non-compliant.

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

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

Staff were unable to identify any service consumers might be referred to in relation to this requirement. They were aware no consumer has NDIS funding. The lifestyle coordinator said previously ministers of other faiths and volunteers visited the service although no detail about how this was arranged or how consumers were referred was provided.

I find this requirement non-compliant.

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The sampled consumers considered they feel they belong in the service and feel safe and comfortable in the environment, though several issues were raised around pest control. The service was observed to be welcoming with individual rooms decorated with memorabilia, photographs and other personal items.

The service consists mainly of single bedrooms and single bathroom facilities. The layout of the service enabled consumers to move around, with suitable furniture and signage to help consumers navigate the service. Consumers have access to quiet rooms and areas to meet with family and friends including the outdoor areas, and the central courtyard where consumers can freely access a consumer café and chapel.

Observations and feedback from consumers and consumer representatives identified in the complaints register showed several issues around the service’s environment, including cleanliness and an issue with pest control.

Information derived from the Assessment Team’s observations and other sources indicate that the service did not demonstrate that it adequately provides a safe, clean and well maintained environment for each consumer and also for their staff.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

The service did not demonstrate it understands the requirement to provide a safe, clean, well maintained and comfortable environment that enables consumers to move freely, both indoors and outdoors. Feedback from consumers and consumer representatives identified in the recent complaints register shows they have raised several issues around the service’s environment, including cleanliness and an ongoing pest control concern.

Observations made by the Assessment Team included that some areas of the service were not safe, clean and well maintained to enable movement, particularly in outdoor areas and balcony entrances. The central courtyard area appeared clean and free from clutter with corridors and consumer’s rooms spacious and generally clean. The service restricts access to certain areas to help create a safe service environment for consumers including the kitchen and medication rooms.

The Assessment Team found there was a clean tub of consumer clothing labelled cleaned, sitting adjacent and touching a tub of dirty curtains marked dirty parked in the service area corridor. A handwashing station in the clean section of the laundry was situated behind the exit door, it was empty and not readily available or accessible. There was a large full rack of lost clothing that was situated in the common outdoor area next to the chapel.

Hand hygiene points at the entry to the home, laundry and in a common area of the memory support wing were empty. There was no bin with lid at the exit of the service to dispose of used masks. The contaminated waste bins in the service area were unlocked and unsecured. A contaminated waste bin outside an isolated consumer’s room in Bilgola house was overflowing with three used blue aprons hanging out the bin. The dirty utility room in the Curl Curl house was unlocked and unsupervised.

A toilet near the dining room Bilgola house was covered with dirty toilet paper and a used urinary bottle situated on the mobility rail. The wastepaper bin in the public toilet next to the hairdressers was overflowing and was observed not to be emptied in two days.

A refrigerator labelled medication fridge in the Long Reef dining room area contained unlabelled sandwiches and drinks. The Long Reef dining room floor was very wet after mopping. There were four consumers sitting in the dining area during this time.

Staff were not always observed to conduct routine hand hygiene when they enter or leave consumer’s bedrooms. For example, a care staff member was observed leaving a bedroom with gloves on and removed the gloves without performing hand hygiene. Another care staff member was observed leaving a bedroom with gloves on and replacing the gloves with another set without performing hand hygiene in between changes. Two care staff wore the same pair of gloves while they were attending to multiple residents. During the lunch service a care staff member was seen to wear one pair of gloves whilst he touched two consumers, served two lunches and assisted one consumer back to their room after the lunch service. The care staff under observation did not change his gloves or use hand hygiene during this sequence of events.

Consumers have some access to outdoor areas however there were observed hazards in the houses that impacted on safe and free access. For example mould on the main stairs leading to Long Reef house; the balcony area outside Curl Curl house was observed to have a recently spilt drink all over the tiles with no wet floor sign present; the entry door into Long Reef house has a sign stating “close the door gently” however the door is made of heavy wood and it is very difficult to close gently.

The outdoor path in Long Reef house was uneven around the herb gardens where there was a large gap between the edge of the concrete path and the grass area in large sections. In the Warriewood house the door to the balconies were being propped open with chairs.

Numerous pedestal fans and oil heaters were observed in the east facing houses. The fans and heaters were observed to be tagged and tested however these appeared to clutter rooms and could be seen as obstructions and trip hazards. Four consumers and one consumer representative sampled could describe how they felt safe and comfortable at the service, but two raised the issue of recent pest infestations and temperature control.

A registered nurse and two care staff sampled described the process to identify and report a hazard or safety issue however the notification of hazards and maintenance issues occurs through many different communication channels and not all care staff were aware of the current process or were able to locate the maintenance log book in their house.

The maintenance officer could describe how maintenance is managed at the service, how they identify an issue that requires attention and how you get approval to address this.

Three contracted cleaning staff and the cleaning supervisor provided an overview of the cleaning process at the service. It includes daily bathroom cleaning, daily touch point cleaning of common areas, daily routine checks, and full weekly clean of consumers bedrooms. The cleaning supervisor said three staff are regularly rostered on daily to perform cleaning duties including touch point cleaning during the COVID-19 pandemic.

The cleaning staff could provide a general overview of what they do at the service including cleaning areas using the colour coding guides however they could not clearly articulate the colour coding symbols used by the clinical and care staff for infection alerts. This was discussed with the cleaning supervisor.

On the 30 September 2020 resident and representative meeting, the issue of cockroaches was noted as an ongoing issue, actions taken included ongoing contracted pest services.

The maintenance log showed evidence of regular maintenance of the service environment or any outstanding maintenance issues that have been identified and reported to the maintenance officer. The issues identified by the Assessment Team under observations Long Reef were not registered on the maintenance log or in the hazard register. The maintenance officer provided written examples of regular internal reviews (environmental audits) against a comprehensive checklist undertaken to ensure the facilities are maintained, including hazards or breakdowns.

The local leadership committee meeting minutes September 2020 itemised an agenda item for a request for extra cleaning staff due to the COVID-19 restrictions however the minutes report this was not in the current budget allocation. The local leadership committee meeting minutes 10 September 2020 noted that fans and portable air conditioners were purchased, and a tender process was underway to replace the service wide air-conditioning. There was no documentation on the assessment of the suitability of the pedestal fans as a work around.

The contracted cleaners’ records indicate routine month cleaning audits occur at the service. Training records indicate that all staff attended infection control training including hand washing in 2020. The contracted cleaning policy states that all dirty linen is to be delivered into the Dirty area only.

While policies and procedures are in place and staff could generally explain their role in ensuring the service is safe and clean, and that consumers can move around freely, the evidence available does not support that this is always occurring.

I find this requirement non-compliant.

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers and representatives are aware of complaints and feedback opportunities and most indicated felt they could make complaints and felt safe to do so. Most sampled consumers consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Some consumers expressed frustration with the ongoing nature of concerns which negatively impact on their family members.

Management and staff spoke of a range of ways consumers can give feedback and make complaints and said that advocacy and language services are promoted. Documentation reviewed and observations made confirmed this information is promoted to consumers and staff.

Appropriate action has not always been taken in response to complaints. Although there is an open disclosure process it is not always evident when things go wrong.

There have been ongoing concerns raised without resolution. There have been ongoing complaints relating to staffing and clinical care provision which has not resulted in improvements for consumers.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

Appropriate action has not always been taken in response to complaints and although there is an open disclosure process, it is not always evident when things go wrong. Consumers shared feedback that staff’s favourite expression is “let’s do it tomorrow”, that staff do not listen, or take notice when they are told things. A representative expressed concern that an ambulance was not called when their family member was unwell, and another expressed dissatisfaction that there is a lack of accountability by care staff.

Several staff were unaware of the term open disclosure. When explained to them they indicated they would rely on management to deal with complaints and any follow up. Management indicated they utilise principles of open disclosure and apologise for any deficits identified. When asked for examples they said they believed open disclosure was used in a case sampled by the Assessment Team. They said they met with the family, apologised and acknowledged a delay in notifying the family.

The centre manager was asked if open disclosure was used when a manual handling incident of occurred. The incident was documented as a “near miss” although staff did not use correct manual handling practices and the consumer sustained a large bruise. The centre manager was unable to provide information about the use of open disclosure as the registered nurse had reported to family and there was no documentation about the conversation. An open disclosure policy was provided by management though most staff were unable to access policies from the intranet.

Review of a sampled consumer’s complaints and documentation found limited information about these concerns. It is evident staff did not believe the consumer’s report of theft. Consumer meeting minutes shows similar concerns are repeatedly raised. Some of these issues were further raised with the assessment team. Management have not resolved consumer concerns.

I find this requirement non-compliant.

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

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

Several consumers interviewed (and representatives on their behalf) provided information about not being satisfied with the outcome of their complaint or that their complaint has not been resolved. Refer to requirement 6(3)(c) for information about the ongoing nature of some complaints. Although some improvements are planned they have not yet been actioned or have not resulted in improvements for consumers.

Management explained a computerised risk system is the current online complaint system. The system issues an automated alert to managers when entered. The paper based system is logged into the computer by lifestyle staff. Feedback must be in system. Management was unsure of the timeframes for complaint response but said they expected an acknowledgement and risk assessment of the complaint in 24 hours and for the matter to be closed out in 10-14 days.

The organisation’s complaints and feedback policy/procedure includes that complaints trending and analysis will be undertaken and improvements made as a result of complaints, including any trends. The service’s Quality Standards self-assessment report includes complaints are analysed for trends and improvements are undertaken.

While the service does have a complaints management framework which staff are aware of, some complaints raised with the Assessment Team were not reflected in the complaints documentation. There have been ongoing complaints relating to staffing and clinical care provision which has not resulted in improvements for consumers.

I find this requirement non-compliant.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Some sampled consumers consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. While most consumers and representatives said staff are kind and caring some information including limited feedback about care documentation and complaints information shows at times staff are not kind or caring towards all consumers.

There was some negative feedback about staff skills and knowledge about consumer needs. Some consumers and representatives said there are insufficient staff particularly at night and on weekends.

The workforce is not planned to meet the needs of consumers ensuring the delivery and management of safe and quality care and services. Issues were identified relating to availability and skills of registered nursing staff for the provision and oversight of consumer clinical care, and the director of nursing has not been providing clinical oversight.

While there is a program of mandatory training, some staff have not completed some training. Other training has been provided for staff, but it has not been demonstrated this has enabled them to deliver care and services consistent with the Quality Standards. Management was unable to give an example of how feedback from consumers and performance reviews is used to identify staff training needs, but an annual staff training needs analysis has been undertaken.

While there is a staff performance management structure is has not maintained to monitor staff performance. It was not demonstrated that performance appraisals have led to development opportunities for staff or have been used to address staff performance issues, such as arising from a complaint about a consumer’s care and services.

The Quality Standard is assessed as non-compliant as all five specific requirements have been assessed as non-compliant.

## Assessment of Standard 7 Requirements

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

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

There has been a restructure of the leadership team resulting in a reduction of leadership positions. The previous structure was a centre manager, a care manager and two care coordinators. The current structure is a centre manager and two care managers.

There are insufficient staff to meet the needs of consumers. Consumers wait lengthy periods for assistance when they request it. Out of bed alarms for high risk consumers are not promptly responded to.

A family member said there are insufficient staff to feed consumers. They said this concerns them greatly. Another representative said food is generally unappetising, rarely a menu is apparent and there are not enough staff to assist with feeding. They also saw a consumer waiting for meal; staff put the meal on their walker and when the consumer got up the food went everywhere. Although staff did help the consumer but they did not replace the meal.

In relation to the restructure and reduction of leadership positions the general manager care quality and compliance and the general manager residential aged care provided the following information:

* The need for improved clinical oversight was identified and there is a plan to increase clinical oversight sitting in approval process.
* Experience in another state with a similar sized centre which had non-compliance and is now doing well has provided direction as to the restructure.
* They have reviewed what was not working and why issues were not actioned and sought feedback. Monitoring sits with the care manager and feedback from home identified clinical handover adequate especially post business hours.
* In relation to recruitment the service has a resident consumer on the recruitment panel.

Language (staff understanding and communication) is another issue raised regularly as an issue for consumers and families, and the face to face interview assists identification of potential issues. Management confirmed there has always been a face to face interview when asked why it would be a current issue in the workforce. 95% of staff speak English as a second language. They said the chaplain is reviewing a program for staff to enrol in to improve communication/language skills.

While the manager reviews staffing on a daily basis (specifically the staff skill mix and area of allocation), staffing numbers are fixed by head office. If it is identified that additional staff are required the manager would seek approval from the area manager although this has not occurred since May 2020.

The service’s household model means each of the houses has 18 consumer bedrooms. The Long Reef house is a memory support unit and care staff are rostered differently to the other six houses. Staff allocation and roster replacement generally shows staff are available for their rostered shifts. However frequently staff leave their rostered shifts early and are not replaced. For example:

Consumers wait lengthy periods for assistance when they request it. Calls for assistance above 10 minutes were reviewed from 14 August 2020 to 14 October 2020. The organisation believes a reasonable response time to be five minutes. There were in total 1,471 calls and out of bed alarms above 10 minutes. Out of bed alarms for high risk consumers are not promptly responded to. Out of bed alarms above 10 minutes were reviewed from 14 August 2020 to 14 October 2020. There were in total. The call summary shows:

* Alarms above 10 minutes and under 20 minutes: 457
* Alarms above 20 minutes and under 30 minutes: 146
* Alarms above 30 minutes and under 60 minutes: 170
* Alarms above one hour: 130

On night shift consumers wait for extended periods of time. In total there were 74 calls or alarms above 10 minutes on night shift, with 49 of those being out of bed alarms.

The information reviewed by, and feedback provided to, the Assessment Team does not show that the workforce is planned to enable safe and quality care and services.

I find this requirement non-compliant.

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

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

Overwhelmingly most feedback indicates the majority of staff are kind, caring and respectful towards consumers. However there was some verbal feedback about staff interactions which indicates at times some consumers feel ignored and not respected. Some staff documentation is not respectful or kind and caring.

A representative said staff are kind but they do not have the knowledge they need and that it is not kind that consumers get sores. There was positive feedback provided by consumers about individual lifestyle members and also the Chaplain. Another representative said staff interactions were generally pretty kind, though others and were impatient. This representative has experienced issues with staff lacking English skills.

In relation to this requirement feedback from consumers and representatives in response to Standard 3 has also been considered. For example, that staff do not always listen to consumers or believe them when they report concerns.

I find this requirement non-compliant.

### 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 workforce is not competent and staff do not all have the qualifications and knowledge to effectively perform their roles. There has been staff performance issues some of which have not been effectively managed. Staff have not completed mandatory training the organisation requires.

There was negative feedback about staff capacity which was also observed through review of consumer files as documented in requirement 3(3)(a). Consumers have had negative outcomes including injury and hospital admission due to lack of staff skills. A representative said staff are not adequately trained and not suitably trained for the role. They are all nice people.

The centre manager and human resource partner said:

* They were unaware three of the four lifestyle staff do not have qualifications relating to their roles.
* There are four new graduate registered nurses, later it was found there were five new graduate registered nurses.
* A carer who was involved in the incident was employed without experience, did not understand how to use the Vocera communication device, and was new to the service.

The area manager provided information about recent support and resources which have been provided to the service and registered nurses. The area manager provided some information about recent registered nurse clinical decision making and leadership skills training although the number of registered nurses who attended the training was not seen.

Consumer file review identified deficits in clinical skills including in recognising deterioration in mental health and physical status. Refer to requirement 3(3)(c) for further information.

Staff training records were reviewed, deficits were identified as described in requirement 7(3)(d).Staff performance has not been monitored and appraisals not maintained according to the organisational expectation. Refer to requirement 7(3)(e).

I find this requirement non-complaint.

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

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

Staff have not been trained or supported to deliver required outcomes which has negatively impacted on consumers and representative confidence. New graduate registered nurses have worked unsupervised in the service and have not had the mentoring or support to develop clinical decision making skills. Deficits were identified in staff skills and knowledge and there have been ongoing concerns raised about staff literacy skills. Refer to requirement 3(3)(a) for information about consumer personal and clinical care provision where deficits were identified with staff skill and knowledge.

The centre manager and human resource partner said:

* There are currently 17 registered nurses working at the service and another one was employed the previous week. There are four new graduate registered nurses employed at the service.
* Another new graduate registered nurse was later identified making the total five. A request was made to clarify the exact number of new graduate registered nurses although no further information was provided.

New graduate registered nurses have worked night shift where they are in charge and the sole registered nurse on duty for the 140 bed service. New graduate registered nurses have been rostered and work together without the supervision of a senior registered nurse on weekends and on afternoon shifts. For example two new graduate registered nurses have worked the Monday afternoon shift for the previous month and also work mornings on weekends together.

Although the training information indicates 75% of staff have completed online mandatory training the records show 96 of the 141 staff have at least one module overdue. Some staff have many gaps in their compulsory training such. A training needs analysis has recently been undertaken and a calendar for training has been developed. The management team is responsible for staff training.

I find this requirement non-compliant.

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

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

While the service has a performance framework it is evident staff have not had regular performance monitoring. The organisation has a process where annual staff performance appraisal is to be undertaken but this has not occurred at the service. In 2019 40 of the 147 staff completed a performance appraisal, and at the time of this visit in 2020 28 staff had completed a performance appraisal. The Assessment Team identified numerous issues in staff performance which have negatively impacted on consumers and others.

The general manager care quality and compliance said the organisation has developed the format for a graduate nurse program. The program has not yet been costed or funded as yet. There is no timeframe for the program.

The centre manager and human resource partner said:

* Organisation expectation is for annual staff performance appraisal.
* There has been a change to the human resource platform. This is the second recent change to the human resource system. The contracted centre manager had not prioritised this aspect of their role.
* The current system, Workday, requires the centre manager and care manager to complete staff appraisals.
* The Accountability framework have identified huge gap in this area and have a plan in place have initiated about 45 appraisals through Workday however the process is multi-stepped requiring management then staff involvement.

Review of staff files found most staff including new graduate registered nurses, new staff to the service and some staff where performance issues were identified have not had a performance appraisal or performance monitoring.

A family member said when the previous manager was at the service they came into the service during the night shift. One of the staff had put a chair up at the front door of a household, blocking the entry to the door, and had gone to sleep. The centre manager had to access the back door. The centre manager provided information about staff who have been performance managed following allegations of sleeping in night shift.

While there is evidence of some actions being taken in response to issues with staff performance, feedback provided to the Assessment Team throughout the visit shows that regular assessment and review staff performance does not occur.

I find this requirement non-compliant.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Most sampled consumers considered that the organisation is well run and that they can partner in improving the delivery of care and services.

While most consumers and representatives generally thought the service was well run, several representatives qualified their response. Some consumers have been engaged in the evaluation of care and services and have been supported in that engagement. For example a consumer sits on staff interviews.

A strategic plan and other plans are in place. There is a diversity plan.

Organisation wide governance systems are not in place or are ineffective, generally and in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

Effective risk management systems and practices are not in place relating to managing high impact or high prevalence risks associated with the care of consumers or identifying and responding to abuse and neglect of consumers. While governance systems and practices were not demonstrated relating to supporting consumers to live the best life they can, the Assessment Team found for the consumers sampled they were being enabled to live the best life they can with support from management and staff.

An effective clinical governance framework is not in place generally or in relation to antimicrobial stewardship, minimising the use of restraint, or open disclosure.

The Salvation Army is a large not for profit, national, Christian organisation which predominant supporting vulnerable and disadvantaged in our community. TSA is governed by a board with various sub committees.

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

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

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

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

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

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

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

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

The general manager care quality and compliance attended the service during the audit to assist service’s team. The general manager residential aged care also attended, via phone, to assist in understanding governance of the service. They advised that the Mission Council is the Salvation Army division responsible for the oversight of aged care provision. The Mission reviews a traffic light risk format to identify gaps.

The service had been identified as a high risk service in the three areas (environment, clinical, operational). The said service came on the radar from a quality review a couple of months ago. A full review was undertaken and there is an action plan to improve outcomes. They said resources have been provided and there have definitely been improvement and progress. They provided feedback about some high level issues. They said improvements have been made but acknowledged there is still work to go. They said they believe right people in roles.

Information management

The organisation has a communication team who utilise express mail, newsletter, poster or memo. The organisation recently undertook a survey to identify what residents want from the centre manager. The survey identified people felt safe about the communication they receive. Management were not able to identify how the Mission directly interacts with consumer or representatives. The main communication is through the service or the advocate.

Although communication was repeatedly raised with the Assessment Team as an area of deficit there has been minimal action on this. The Assessment Team was told the chaplain is reviewing resources to improve staff skills. Staff repeatedly were unable to access policies and procedures on the intranet. Some said they would ask the registered nurse if they needed to. The centre manager and the human resource partner said they are working to get all staff an email account which will improve accessibility for staff.

Continuous improvement

The Assessment Team explored three specific scenarios with management to understand this: opportunities for continuous improvement are identified; how critical incidents are used to drive continuous improvement; and how the governing body satisfies itself that Quality Standards are being met.

Management advised that there is a continuous improvement plan and survey process; meetings with standing agendas; verbally the chaplain; consumers and representatives have direct access to the management an example provided was in relation to issues with the laundry.

A weekly call bell audit commenced following the appointment of the current service manager when it was noted response time needs improvement. The service manager said the commencement of the falls committee has highlighted this issue and there have been communications with staff relating to this.

In relation to the increase in clinical oversight the Centre manager and human resource partner told the Assessment Team was told it is sitting in the approval process and there is no current timeframe available.

Financial governance

Service management were asked how they seek changes to budget or expenditure to support changing needs of consumers. The general manager care quality and compliance and the general manager residential aged care said the organisation has funded and anticipated the royal commission findings. The organisation has a plan for a rapid gap analysis to identify issues; the recently appointed national manager, who has a legal background, is very committed to making and enabling improvements in aged care.

At the commencement of the pandemic the service quickly invested in computerised tablets to facilitate and support communication with family members. They also funded additional lifestyle support during lockdown.

In relation to workforce governance, including the assignment of clear responsibilities and accountabilities deficits were identified in all requirements relating to Standard 7 indicating this is not effective at the service.

Regulatory compliance

Management advised that legislative updates come through the clinical compliance team. The organisation is a member of a peak body. The royal commission has been monitored and discussed at high level. Risks are escalated to Mission. The Mission has approved the purchase of peak body policies and procedures, which has been budgeted. The Assessment Team was told there will be a roll out of changes that will provide oversight of policy/legislative changes and support the increased computerised reliance for developing benchmarking.

Staff at the service are able to access advice, by phone or email. The general manager care quality and compliance has introduced recent changes to improve process with a more hands on approach and expectations. Staff are encouraged to seek advice and have access to legal advice. The Mission actively seeks information and reporting systems provide commentary. The general manager care quality and compliance reports to the Mission as well as the Board.

While following changes to organisation’s restraint the policy has brought about monitoring of chemical restraint gaps were found in the practical application of restraint management as described in requirement 3(3)(a).

Review of complaints documentation also identified a potential allegation of assault which had not been identified or responded to. This is further reflected in the deficits identified in some aspect of the management of complaints outlined in Standard 6.

I find this requirement non-compliant.

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

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

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

Effective risk management systems and practices are not in place relating to managing high impact or high prevalence risks associated with the care of consumers or identifying and responding to abuse and neglect of consumers. While governance systems and practices were not demonstrated relating to supporting consumers to live the best life the can, the Assessment Team found for many of the consumers sampled they were being enabled to live the best life they can with support from management and staff.

An effective clinical governance framework is not in place generally or in relation to antimicrobial stewardship, minimising the use of restraint, or open disclosure. Management said policies have not been updated frequently although the quality principle are reflected in them and the purchase of the new system will improve visibility of the quality principles.

There has been inadequate identification and/or review of critical incidents. When the centre manager was asked they said there had been two critical incidents in 2020. They said the falls committee commenced in July 2020 has provided review of falls. Other incidents which may be considered critical incidents have not been escalated or reviewed as considered in requirements 3(3)(a) and (b).

The organisation has documented risk management framework, including policies describing how:

* High impact or high prevalence risks associated with the care of consumers is managed however it was acknowledged improvements are required. The recent Mission governance meeting identified high impact high prevalence notes choking risk, managing pain, managing delirium, managing hearing loss not currently captured in the data.
* The abuse and neglect of consumers is identified and responded to
* Consumers are supported to live the best life they can.

However, deficits were identified in each aspect of these areas of governance. Staff were also asked whether these policies had been discussed with them and what they meant for them in a practical way. Some staff had been educated about the policies and were able to provide limited examples of their relevance to their work. For example staff said they would ask the registered nurse if they had a concern about consumer interactions. Staff were also unclear about what constitutes physical restraint.

I find this requirement non-compliant.

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

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

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

There is a limited documented clinical governance framework including policies and procedures relating to antimicrobial stewardship, minimising the use of restraint and the use of open disclosure.

The organisation provided:

* a documented clinical governance framework.
* a policy relating to antimicrobial stewardship.
* a policy relating to minimising the use of restraint.
* an open disclosure policy.

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Some staff had been educated about the policies and some were able to provide limited examples of their relevance to their work. For example staff were unfamiliar with the term open disclosure.

Management were asked what changes had been made to the way that care and service were planned, delivered or evaluated as a result of the implementation of these policies. Management were not able to provide examples relating to service, although had examples where initiates have been successful in their other services. For example:

* Pacific Lodge, a collocated service engaged with the local geriatrician and have made big reductions in use of chemical restraint. Management said they hope to roll this project in other services and this is on the continuous improvement plan
* Post falls management at the service; deep investigation; post falls management chart changed as a result is in draft form currently; process when release a form; release goes to the centre with distribution list and dispersal and introduction process.
* The organisation has developed a new graduate support program which is currently being tabled at the national governance meeting. The program has not been costed or funded as yet and there is no timeframe for its implementation. The Assessment Team was told when approved there will be a pilot program, they said there has been COVID-19 focus in the organisation which has shifted timeframe.

I find this requirement non-compliant.

# Areas for improvement

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

**Standard 1 Consumer dignity and choice**

**Requirement 1(3)(d)**

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

**Standard 2 Ongoing assessment and planning with consumers**

**Requirement 2(3)(a)**

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

**Requirement 2(3)(b)**

*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)(e)**

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

**Standard 3 Personal care and clinical care**

**Requirement 3(3)(a)**

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

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

**Requirement 3(3)(b)**

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

**Requirement 3(3)(c)**

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

**Requirement 3(3)(d)**

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

**Requirement 3(3)(e)**

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

**Requirement 3(3)(g)**

*Minimisation of infection related risks through implementing:*

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

**Standard 4 Services and supports for daily living**

**Requirement 4(3)(b)**

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

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

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

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

**Requirement 4(3)(d)**

*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)**

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

**Standard 5 Organisation’s service environment**

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

*The service environment:*

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

**Standard 6 Feedback and complaints**

**Requirement 6(3)(c)**

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

**Requirement 6(3)(d)**

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

**Standard 7 Human resources**

**Requirement 7(3)(a)**

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

**Requirement 7(3)(b)**

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

**Requirement 7(3)(c)**

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

**Requirement 7(3)(d)**

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

**Requirement 7(3)(e)**

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

**Standard 8 Organisational governance**

**Requirement 8(3)(c)**

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

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

**Requirement 8(3)(d)**

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

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

**Requirement 8(3)(e)**

*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.*