Estia Health Kensington Gardens

Performance Report

421 The Parade   
KENSINGTON GARDENS SA 5068  
Phone number: 08 8331 8098

**Commission ID:** 6835

**Provider name:** Estia Investments Pty Ltd

**Site Audit date:** 3 August 2021 to 5 August 2021

**Date of Performance Report:** 04 November 2021

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

This performance report details the 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
* the provider’s response to the Site Audit report received 03 September 2021.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Overall, sampled consumers considered they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they choose.

* Consumers described staff as kind, caring and respectful and were satisfied with the information provided to them.
* Representatives and consumers described how the service worked with consumers and provided support to do what was important to them, even if it included risks.

Staff were observed promoting choice and independence to consumers as well as ensuring consumers’ privacy and confidentially was maintained.

Staff were able to describe what was important to consumers and how consumers were supported to maintain personal relationships. Staff outlined strategies in place for supporting communication with consumers to overcome language barriers.

Care plans and lifestyle documents included the cultural needs of consumers and generally reflected what was important to the consumers, including information about their background, hobbies and life experiences.

The service had a diversity and inclusion policy to ensure care and services were inclusive and meet the diverse needs of consumers.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Overall, sampled consumers considered they felt like partners in the ongoing assessment and planning of their care and services.

* Most consumers said they or a person of their choosing, was involved in care planning and had a say in the delivery of care and services.
* Most consumers advised staff were aware of their needs and preferences and these were generally met.
* Consumers expressed satisfaction with access to other providers of care and services.
* Representatives confirmed they were informed about incidents and provided frequent updates regarding outcomes of assessment and planning.

Staff were knowledgeable about care planning and assessment processes, including re-assessment. Staff said care planning and assessment documents were readily accessible on the electronic care system and provided enough information to guide individualised care and services.

Care documentation generally demonstrated each consumer had been assessed on entry and at three-monthly care plan reviews. In relation to advance care planning, sampled consumers had an advance care plan completed, which had been signed by the consumer and/or their representative and a medical officer.

Staff confirmed outcomes of care planning were communicated to consumers (and their representatives if requested), following a change in health status or medication.

The service had policies and procedures on the admission process to guide practice and staff reported they had access to policies on the intranet. Monitoring processes were in place, such as 24-hour progress note reviews by clinical management, to ensure documentation processes were completed.

The Assessment Team recommended one requirement not met in Standard 2 requirement (3)(a) due to assessment and care planning did not inform the management of a consumer’s behaviour. The Approved Provider submitted a response in relation to these matters. Based on the information before me, I have come to a different view to that of the Assessment Team and I find the service Compliant in Standard 2 requirement (3)(a).

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found the service did not demonstrate for one consumer that assessment and care planning informed the delivery of safe and effective care. The Assessment Team provided the following information and evidence relevant to my finding:

* Representatives of Consumer A advised the consumer walked around the service all day and would wander into other consumers’ rooms. Although some staff would redirect, the representative raised concerns about the lack of stimulation and considered the consumer’s wandering had contributed to their weight loss.
* During the visit, the Assessment Team observed the consumer to be mobilising throughout the service and staff redirected the consumer when they entered another consumer’s room. The consumer was also observed moving heavy furniture that resulted in a minor incident.
* Assessments used to support care planning documentation were not completed in order to reduce or mitigate the consumer’s intrusive/wandering behaviours, refusal of care and moving of heavy furniture.
* Staff were aware of the types of behaviours the consumer displayed and reported strategies used included redirecting or returning later. However, documented interventions to manage the consumer’s wandering and intrusive behaviours were noted successful on a limited number of occasions (between 14 to 27 July 2021). Although medical reviews had been conducted post medication changes during this period, the consumer’s wandering behaviours continued.

The Approved Provider’s response disagreed that the systems for assessment and care planning were not effective. Its response acknowledged that risk planning assessments were used by the service and were not limited to falls, pressure injury and pain risks. It reported assessments and subsequent discussions with consumers and representatives allowed the identification of risks for an individual consumer and strategies developed to mitigate these.

The Approved Provider submitted further information about Consumer A and the management of their behaviour. Specifically, it disagreed with the evidence reported by the Assessment Team and considered care to be appropriate. Its response included:

* The consumer had a fondness for walking which was something they enjoyed doing prior to the onset of their dementia and was exercising their right to move freely around the service. Its response considered the consumer’s movement was not directly related to lack of activities or due to ineffective management of their weight.
* The Approved Provider asserted that if prevented this would be detrimental to the consumer’s overall health and well-being; the consumer was not distressed or agitated and did not have access to unsafe areas. Furthermore, the consumer had not been involved in any altercations and was happily guided back to their own room or common area by staff.
* It considered the substitute decision maker should have also been interviewed, as they had expressed satisfaction with the care and services provided.
* It had submitted additional evidence of other assessments that had been undertaken in order to consider if the consumer’s movement was related to an unmet need. In addition, during the second week, progress notes identified possible contributing factors and bowel and pain related medications were administered and noted to be effective.
* Furthermore, it reported the care plan referred to by the Assessment Team (December 2020) was not the most recent care plan, which had been developed/reviewed in February 2021. It asserted as the evaluations identified these were not effective, new strategies were implemented and evidence of the updated behaviour care plan (12 August 2021) submitted.

In coming to a view about compliance, I have considered the Assessment Team’s information and the Approved Provider’s response.

* I acknowledge progress notes provided some examples of other possible contributing factors to the consumer’s behaviour and the medical officer involvement to review and evaluate the consumer’s medication. Although I accept new strategies have since been incorporated into the care plan, the Approved Provider’s response did not provide evidence of comprehensive strategies in place at the time of the visit (February 2021 care plan).

Furthermore, I am concerned at the time of the visit, the December 2020 care plan had been updated with additional behaviour management strategies and the effectiveness of revised strategies have not yet been demonstrated. Whilst I am not persuaded appropriate strategies were listed in consumer’s care plan at the time of the visit, I am of the view this information is more relevant in Standard 3 requirement (3)(a) and does not demonstrate systematic failings in assessment and care planning under this requirement.

In addition, I have also considered other evidence under Standard 2 requirements which demonstrated assessment and care planning processes were overall in place as evidenced by:

* Assessment and planning documentation overall identified consumers’ current needs, goals and preferences, and detailed individualised strategies for meeting such needs.
* Care plans for sampled consumers showed assessment processes considered risk to most consumers and informed the delivery of care. These included validated risk assessment tools for falls, pressure injuries and pain.
* Staff were knowledgeable about care planning and assessment processes, including re-assessment, and confirmed care planning and assessment documents were readily accessible on the electronic care system and provided enough information to guide individualised care and services.
* Overall, sampled consumers considered they felt like partners in the ongoing assessment and planning of their care and services.

For the reasons detailed above, I find the service Compliant in this requirement.

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Most sampled consumers considered they received personal care and clinical care that was safe and right for them.

Staff generally demonstrated knowledge of consumers’ personal and clinical needs, could relay individualised strategies for managing some high-impact or high‑prevalence risks and described strategies for maximising comfort and dignity during palliative care.

The service had a range of policies and procedures to guide staff in best practice care delivery for falls management, palliative care and restrictive practice management.

Consumer files reviewed demonstrated a range of monitoring tools and assessments had generally been completed on entry and on an ongoing basis that were mostly used to identify and evaluate changes to consumers’ health, condition and abilities.

Where changes to consumers’ health were identified, documentation demonstrated further charting and monitoring processes had been implemented and referrals to medical officers, speech pathologists, dietitians and physiotherapists had been made.

Sampled care plans captured the needs, goals and preferences of consumers, including those nearing ends of life, and demonstrated that referrals were made to other providers of care and services in a timely manner.

The service demonstrated systems were in place to minimise infection related risks, including processes for prevention, control and appropriate use of antibiotics.

The Assessment Team recommended two requirements not met due to deficiencies in the effective management of high impact or high prevalence risks, as well as the safe and effective provision of care for consumers based on best practice, tailored to their needs and optimised their health and well-being. The Approved Provider submitted a response in relation to these matters.

Based on the information before me, I have come to a different view to that of the Assessment Team and find the service Compliant in Standard 3 requirement (3)(b). However, in relation to Standard 3 requirement (3)(a), I am not satisfied each consumer received safe and effective care that was based on best practice, tailored to their needs or optimised their health and well-being and, therefore, I find the service Non-Compliant.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service was not able to demonstrate each consumer received safe and effective clinical care which was best practice, tailored to their needs and optimised their health and well-being. The Assessment Team provided information and evidence relevant to my findings.

Nutrition and hydration/behaviour management

* Two representatives for Consumer A raised concerns with the consumer’s, wandering behaviours, their ongoing weight loss and the way this was being managed. They reported due to the limited options of vegetarian meals, additional food was being brought in and consumer was assisted by a family member at lunchtime as they were not confident there was enough staff.
* Documentation showed the consumer had experienced ongoing weight loss since January 2021, losing 10kgs in seven months and their risk of malnutrition had increased (medium risk).
* The consumer had been reviewed on three occasions, between February and June 2021 by a dietitian. Whilst the dietitian review in February 2021 identified strategies and recommendations, food and fluid charts had not been completed (over a three-day period) on two occasions as per the dietitian instructions. The Assessment Team did however observe during the audit, the requirement for monitoring the consumer’s intake between 5 to 9 August 2021.
* Staff were not consistently aware of the consumer’s dislikes and the Assessment Team observed meals served/offered were not consistent with documented dietary requirements (as referenced in Standard 4 requirement (3)(f)).
* In relation to behaviour management, documentation identified strategies and interventions to manage the consumer’s wandering and intrusive behaviours recorded by staff, were identified as being ineffective and were only successful on 9 out of 60 occasions (during the two-week period in July 2021). Although ongoing review and evaluation of medications during this time, the care plan reviewed by the Assessment Team and subsequently updated by the service during the visit, demonstrated limited strategies for managing these behaviours and the effectiveness of these were still yet to be determined.

Wound management

* Consumer B entered the service with pressure injuries to both heels in August 2020. Both wounds were identified as stage two pressure injuries and remained stable. While photographs were taken of the wounds, the photographs were not taken from the same angle and the measuring tape was not consistently positioned to enable comparison of the wound.
* Management advised weekly reviews were to occur and consumers were not referred to a wound specialist but would be reviewed by the medical officer.

Falls management

* Consumer C experienced 14 falls from 2 April to 27 July 2021 and was on a regular anticoagulant/antiplatelet medication. The consumer was noted to sustained skin tears following each fall and had not sustained any major injuries.
* Post fall, the consumer had been reviewed by the medical officer and neurological observations had been carried out, including head to toe assessment, pain assessment and baseline observations. The service’s policy stated consumers on anticoagulant or antiplatelet therapy who had a fall should be sent to hospital for a CT scan (i.e witnessed head strike or any unwitnessed fall). However, there was no documentation to support the decision not to transfer the consumer to hospital post each of their fourteen falls (including a risk assessment).
* During the visit, management provided a progress note entry (dated 5 August 2021) which recorded the family did not want the consumer sent to hospital for an unwitnessed fall or witnessed head strike.

The Approved Provider’s response predominately refuted the Assessment Team’s findings and provided further evidence and clarifying information in respect to each of the consumers.

In relation to Consumer A

* The Approved Provider asserted the views of the consumer and substitute decision maker should have also been obtained, who expressed their appreciation for the ongoing efforts provided in relation to the consumer’s care.
* It accepted a food chart was not used as per the dietitian’s recommendations, however, outlined this was being documented in the progress notes and weekly weight records. Progress note entries for 11 and 20 June 2021 were provided which demonstrated staff had noted the consumer ate well or had their meal.
* It also outlined the consumer had been reviewed on four occasions in 2021 by a dietitian, including on 28 July 2021 and the challenges of the consumer gaining weight was attributed to their advance medical conditions and desire to walk. It asserted the absence of a food chart did not impair the dietician’s assessment and since the visit the consumer had gained 2kgs.
* A copy of the consumer’s clinical documentation was provided to demonstrate the consumer required assistance with meals, staff provide assistance but will refuse and eat independently. It asserted the dietitian was aware of their refusal and had prescribed supplements.

In relation to the consumer’s behaviour management, I have considered the Approved Provider’s response outlined in Standard 2 Requirement 3(a).

In relation to Consumer B

* The Approved Provider reported it did refer consumers to wound specialist if the wound was noted to be chronic or deteriorating. It reported the consumer’s wounds were stable, the general practitioner was satisfied with their current management as evidenced by a progress note in June 2021. It reported other risk factors which can potentially impact upon wound healing (such as diabetes) had been considered and effectively managed.
* It acknowledged the wound photographs should have been taken from the same angle and measured using measuring tape. It would discuss with staff but did not consider this failing to have negatively impacted the consumer. Furthermore, it described an appropriate dressing type was being used and frequent pressure area care provided.

In relation to Consumer C

* The Approved Provider asserts the consumer’s falls were appropriately assessed and managed, falls were not all unwitnessed and the policy was not a directive. The reasons for not transferring to hospital whilst on an antiplatelet medication was based on appropriate clinical assessment and in accordance with the request of the family. In addition, the medical officer had continued prescribed an antiplatelet medication and submitted evidence of neurological observations completed in response one fall in April 2021.

I have considered the Assessment Team’s report and the Approved Provider’s response. However, in coming to a view about compliance, I have considered the following:

* I acknowledge the Consumer A had been reviewed multiple times during 2021 by the dietitian and the current advancement of their medical condition and goals for maintaining weight.
  + However, the service at the time of the visit did not adequately demonstrate the consumer’s food and fluid intake had been effectively monitored. The consumer was at risk of malnutrition, continued to lose weight and their representatives interviewed were concerned about the management of their intake and was bringing in additional food items.
  + While I accept that progress notes or alternative methods can be used to record this information, I am not persuaded by the Approved Provider’s response that this had been systematically undertaken to support effective monitoring and that allied health directives had been followed. Furthermore, whilst a weight gain had been reported, this had occurred following the visit and evidence of this had not been provided.
  + As referenced under Standard 4 requirement (3)(f), I am concerned that there was conflicting information about the consumer’s dietary requirements, staff knowledge and the observations of meals being served/offered to the consumer.
* Regarding Consumer A’s behaviour management, I acknowledge the involvement of the medical officer to review medications, examples of follow up in response to possible contributing factors as recorded in progress notes and the consumer’s care plan has since been updated 12 August 2021. However, I am not persuaded that there were effective behaviour management strategies in place for the consumer, based on:
  + behaviour monitoring and charting identified strategies had limited success in their effectiveness and representatives raised concerns about the consumer’s ongoing wandering behaviours, such as entering consumers’ rooms.
  + although the Approved Provider reported a February 2021 care plan was in place at the time of the visit, evidence of this had not been submitted. Furthermore, during the visit, the Assessment Team reported additional strategies were incorporated, however, not all behaviours, such as the movement of furniture and risks had been captured.
  + although I accept new strategies have since been incorporated into the care plan (for August 2021), the effectiveness of behaviour management strategies was not yet known or been demonstrated.
* While I note the wound had not been measured or photographed to support effective wound monitoring, the evidence does not persuade me that the wound was not effectively managed. While I acknowledged the Approved Provider provided subsequent evidence (a progress note dated June 2021) by a medical officer that the consumer’s wounds were progressing well, I have not placed significant weight on as it was reported two months prior to the audit. Although it does highlight staff practice was not consistent with its policy to support best practice and to potentially identify changes in a timely manner, wounds were stable at the time of the audit.
* In relation to falls management, the Approved Provider submitted limited evidence about each of the falls and considered appropriate clinical assessment had been undertaken. I accept the consumer’s medical officer had been involved and observations of the consumer was undertaken.
  + In relation to recording of the representative’s decision or discussion of risk relating to the use of anticoagulant/antiplatelet medication, I note the Assessment Team did interviewed the representative who had expressed satisfaction with how the service managed the consumer’s falls and evidence of a subsequent progress note had been completed during the visit, outlining not to transfer the consumer to hospital.
  + However, I am not persuaded by the Approved Provider’s response that consultation and outcomes of these decisions had consistently been undertaken or captured following each of these falls and that staff practice was consistent with its policy.

Based on the reasons outlined above, I find the service Non-Compliant in this requirement.

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

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

The Assessment Team found the service was unable to demonstrate effective management of high-impact or high-prevalence risks associated with the care of one consumer at risk of choking. The Assessment Team provided information and evidence relevant to my finding:

* Consumer D had experienced multiple episodes of choking during 2020.
  + In June 2020, the consumer was reviewed by a speech pathologist as they were observed to be coughing when eating. Strategies to manage the risk had been identified, incorporated into the care plan and communicated to relevant staff.
  + In November 2020, the medical officer reviewed the consumer and noted issues with choking were due to progression of their diagnosis and nil treatment available for condition. On the same day, the consumer had an incident of choking, although it was not known if this had occurred before or after the medical officer review.
  + In December 2020, the consumer had another choking episode, and was subsequently transferred to hospital. An obstruction was removed, and the consumer treated for aspirational pneumonia. An internal investigation was conducted, which confirmed the staff member assisting the consumer did cut up the meat.
* The representative felt procedures and standards were not in place for basic needs and skills and following the choking episodes, had lost confidence the service would provide adequate supervision and would attend daily during meals to ensure the consumer was not put at risk.

The Approved Provider’s response did not agree with the Assessment Team’s findings. It considered it had effectively managed the risk of choking for this consumer, reiterated the Assessment Team’s information regarding the follow up investigation and staff training and knowledge of the consumer’s needs. It also and provided clarifying information regarding the consumer’s care. This included:

* It considered the Assessment Team was incorrect and there was no choking episode on the 17 November 2020 which required further speech pathologist review, otherwise a review would have been arranged. It reinforced the medical officer had reviewed the consumer on the request of the representative and considered this to be related to the cognitive decline.
* The service had meet with the family following the incident and reassured them staff were aware of the risk, the correct diet types and need for supervision.
* It outlined follow up with the consumer’s family member in response to feedback and reported there had been no further incidents of choking since December 2020.
* It submitted evidence of three progress notes regarding the administration/evaluation of medication. It reported medications continued to be provided, otherwise these would have been updated if there was a concern about choking/swallowing risks.

In coming to a view about compliance, I have considered the Assessment Team’s report and the Approved Provider’s response. Based on the information before me, I have come to a different view to that of the Assessment Team and find the service Compliant in this requirement. My reasons are based on the following:

* While I am concerned that the consumer’s representative lacked confidence in the service’s ability to manage risk, I note:
  + There were no further incidents of choking reported since December 2020.
  + Staff had been provided with training to identify consumers at risk of choking and training was also provided to catering staff in relation to preparation of modified, textured diets.
  + All care staff interviewed were knowledgeable of the consumer’s need for assistance at mealtimes.
* Whilst the Approved Provider’s response submitted examples of progress notes regarding the administration/evaluation of medications, the recency of these progress notes, including the limited number of examples does not adequately demonstrate the Approved Provider’s position.
* However, I have also considered other evidence provided by the Assessment Team where high impact or high prevalence risks were being effectively managed. These included other examples of consumers where:
  + comprehensive management strategies for their challenging behaviours had been identified. Documentation demonstrated staff had utilised the strategies listed and followed up on their effectiveness. There was evidence of referrals to dementia specialists and geriatrician input.
  + high fall risks had been identified and strategies implemented.
  + there had been effective management of a consumer with diabetes.

For the reasons detailed above, I find the service Compliant in this requirement.

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and 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 consumers and representatives confirmed staff support consumers to do the things that were socially, spiritually, and emotionally important to them. They stated they were supported to attend social activities within and outside the service, maintain their identity and independence, assist with activities of their choosing and maintain relationships.

However, some representatives in the memory support unit were not satisfied consumers were provided enough support to optimise their health, well-being and quality of life. Representatives stated there were no stimulating activities to engage consumers residing in the unit and were not always satisfied the consumer was receiving a variety of well-proportioned and quality meals.

Staff described what was important to consumers, their needs and preferences, how they assist and support consumers to do the things they like and participate in the community, and how they provide emotional and psychological support when required. Lifestyle staff were able to describe how the assessment process identifies consumers’ needs/goals/preferences and explained how this information was used to optimise their health and well-being.

Care planning documentation showed consumers’ social and emotional needs, social activity preferences and what was important to them was documented and communicated with others where responsibility for care was shared. Care planning documentation also showed consumers were referred to external service providers when required.

Documentation and interviews with lifestyle staff demonstrated the activity schedule was reviewed regularly, includes activities of interest to most consumers and reflects consumers’ diversity, needs and preferences. The service’s activity calendar for August 2021 however demonstrated a reduction in lifestyle activities when compared to the May 2021 activity calendar.

Documentation showed consumers’ personnel equipment is regularly maintained and cleaned.

The Assessment Team recommended two requirements as not met and the Approved Provider submitted a response in relation to these matters. Based on the information before me, I have come to a different view to that of the Assessment Team and find the service Compliant in Standard 4 requirement (3)(a) and Standard 4 requirement (3)(f).

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

## Assessment of Standard 4 Requirements

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

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

The Assessment Team found the service was not able to demonstrate each consumer gets effective services and supports for daily living that meets their needs, goals and preferences and that these optimised their well-being or quality of life. The Assessment Team noted:

* Five representatives felt consumers residing in the memory support unit did not receive sufficient emotional support to optimise their health, well-being and quality of life. Representatives indicated there was not enough staff and was a lack of stimulating activities for consumers. They also reported they were not confident consumers were provided with adequate support for daily living. Of the representatives interviewed, two representatives provided feedback that:
  + In relation to Consumer A, they did not consider the service undertook activities of interest to the consumer and had not observed them participating in any activities.
  + In relation to Consumer B, they said there could be more staff and activities to occupy consumers as the consumer was left in their room with no stimulating activities or wandering around by themselves. They felt the consumer often appeared lonely and required more emotional support and said the consumer would benefit greatly with some one-on-one time with staff or volunteers to read to consumer.
* The Assessment Team noted a reduction in activities for August 2021 and that only sing a long was scheduled for the afternoon of each day in the memory support unit which most consumers were observed not engaging. Management reported consumers could attend the other activities, however, this was not observed by the Assessment Team.
* Review of two consumer care plans (Consumer A and Consumer B) within the memory support unit, identified activities of interest were recorded. In relation to Consumer B, staff were overall knowledgeable of their background and interests in reading book. Staff stated books had been provided, but these had been ripped up and felt this may be due to frustration.
* Furthermore, the Assessment Team had identified under Standard 7 other staff reported they did not have the time to do things that are important to the consumer, such as read, assist them with a puzzle or have a chat or spending quality time with the consumer.

The Approved Provider disagreed with the Assessment Team’s report and provided further evidence and information about the service’s activities program and support for both Consumer A and B. This included:

* The Approved Provider asserts the 4pm music therapy had been scheduled as a broader sundowner’s syndrome management program and considered it had been effective in reducing behaviours. However, it did not provide any evidence to support this position.
* Consumers could attend other activities as doors to the memory support unit were kept open to facilitate this.
* The Approved Provider did not consider the Assessment Team had explored individual consumer’s views and highlighted references within the report relating to the provision of emotional support for consumers considered under other Standard 4 requirements.
* As the service had recently appointed a new lifestyle coordinator, there was a planned increase for lifestyle support for the memory support unit which was to be implemented on 30 August 2021.
* For consumer A and B, the Approved Provider provided further evidence in relation to leisure activities, including emotional support provided by staff.
  + For Consumer A, lifestyle care plan review with the consumer’s family (26 May 2021) had occurred and noted the consumer’s satisfaction with the program in meeting their needs. Activities records for 8 June to 31 July 2021 identified although minimal activities were attended in June 2021 there were 22 activities recorded for the month of July 2021.
  + For Consumer B, their care plan identified they had a mobile library visit, participates in the sunshine program, liked to do activities on own and may refuse. A three-monthly care plan review conducted in February 2021 outlined positive engagement in activities and consumer was able to make their own choices. A follow up care plan evaluation (30 June 2021), identified it was meeting their needs and new activities implemented.
  + It advised staff were available to read to Consumer B if this was something they wanted and outlined reasons for not participating in activities during the visit was due to the consumer being unwell. It asserted lifestyle staff attended to their room to provide 1 to 1 activities during this time.

In coming to a view about compliance, I have considered the Assessment Team’s report and the Approved Provider’s response. I note the Assessment Team had received feedback from some representatives in the memory support unit regarding not receiving adequate emotional support, a lack of engaging activities and were not confident with the supports for daily living; there was one activity observed during each day of the visit in which most consumers were not engaged in.

I note the wording of the requirement focuses on the services and supports being safe and effective in meeting the needs, preferences and goals of the consumer. Of the two consumers identified, additional information submitted by the Approved Provider outlined the consumer’s and/or their representative’s involvement in the review of the lifestyle program confirmed these were meeting the consumers’ need and level of satisfaction.

Furthermore, in addition to the above two representatives specifically reviewed, I note there was an additional three representatives (total of five representatives) who had reported concerns with the adequacy of emotional support and lack of stimulating activities. However, I do not have any further information about these specific concerns or impact on the individual consumer, including their emotional wellbeing. I am therefore unable to come to a view about whether their needs, goals or preferences were being met and note that additional support in relation to activities was to be implemented by 30 August 2021.

In addition, I have also considered the totality of evidence provided in the Assessment Team’s report and I have considered evidence provided in relation to other requirements in Standard Four. This included:

* Most consumers and representatives interviewed confirmed adequate support was provided in relation to consumers’ emotional, physical and psychological well-being.
* Staff could describe how they provided emotional support to consumers. If concerns were raised, this was passed onto clinical staff to enable appropriate management and referrals.
* Four representatives said consumers can go outside if they wish and confirmed consumers residing in the memory support unit were able to access other areas of the service.
* Lifestyle staff were able to describe how the assessment process for identifying consumers’ needs/goals/preferences and explained how this information is used to optimise their health and well-being.
  + For the consumers’ sampled, information about the consumer’s condition, needs and preferences was reflected in their care plans, assessments and lifestyle activities plan.
  + Consumer attendance records were maintained to ensure consumers are not at risk of social isolation.
* Lifestyle and care staff said a library attends weekly to provide books, magazines, DVD’s and art/craft activities to consumers. The library provides one-to-one time with consumers who dislike group activities.
* Information about activities was displayed and announcements made over the service’s public address system.
* Activities were discussed at the monthly residents' meetings, and consumers preferences and ideas were considered and incorporated on to the monthly lifestyle activity calendar.
* The lifestyle calendar provided for cultural events, such as Australia Day, Carnevale and Chinese New Year celebrations. Cultural food events are also held, such as Greek, French and Italian luncheons.
* Consumers and visitors were observed using the shared areas for activities and morning coffee chats and a staff member brings their pet dogs in to work every day and consumers were observed interacting.

For the reasons outlined above, I find the service Compliant in this requirement.

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

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

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

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

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

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

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

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

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

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

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

The Assessment Team found the service was not able to consistently demonstrate meals were varied and of a suitability quality and quantity. The Assessment Team noted the following evidence and information relevant to my finding:

* Some representatives were not satisfied the consumer was receiving a variety of well-proportioned and quality meals and that consultation processes were effective.
  + Representatives of Consumer A reported not receiving suitable meals in line with needs and preferences, food was not presented well, there was limited options for vegetarian meals and commented the family often brings in food. The consumer was noted by the Assessment Team to have lost weight.
  + Representative for Consumer E reported they were able to select a four-week meal cycle however had not seen a menu for a few months. They brought in food as they felt the consumer was not getting enough to eat and was malnourished.
  + Representative of Consumer D advised due to a past incident choking incident, they would attend the service daily to assist the consumer with their meals to ensure they were not put at risk of receiving the incorrect food or textures.
  + Consumer F advised their family brought in Italian food as there was not a lot of Italian food choices. The Assessment Team noted Italian meals were provided at least three times a week.
* Interviews with management, administration staff and the chef identified there was not a clear process for consultation with the representatives to advise staff of the consumers’ preference if they did not have capacity. Management acknowledged there is a gap in the system and said they will follow up with representatives and introduce a process to ensure representatives are involved in meal plan choices for consumers who do not have a capacity to choose for themselves.
* Dietary information was not consistently known by staff or adhere to by staff.
  + During the visit, the Assessment Team observed Consumer A to be served a red meat dish, despite the consumer’s dietary information identified no red meat. Although the meal was not provided to the consumer, the staff member providing the meal was unfamiliar with the consumer’s dislikes.

Clinical staff advised the family had advised to give the consumer meat again to gain weight, however, could not identify where this had been documented and this change was not reflected on the dietitian review (end of July 2021).

The chef advised representatives will select meals for the consumer, however, the service was not able to demonstrate documentation about meal choices had occurred.

* + One catering staff member was not aware of diet codes and what they represented specially in relation to diet types (diabetic diet). However, dietary cards were reflective of the consumer’s needs.

The Approved Provider response disagreed with the Assessment Team’s findings. Its response included:

* It asserted that interviews with a broader range of staff could have provided evidence of how the service ensured and evaluated meals for consumers residing in the secure unit. It also reported that if consumers had been identified as lacking capacity, the service would have been able to describe how care was provided in consultation with the substitute decision maker.
* The service evaluates the variety, quality and quantity of meals through various feedback mechanisms with consumers and representatives and audits. The Approved Provider submitted evidence from April 2021 of a nutrition and hydration audit which demonstrated overall 90% compliance. For those consumers who are not able to communicate, it asserted weights were tracked and staff documented any reduced food intake in progress notes.
* The service had contacted all representatives that lacked capacity and who cannot indicate a meal preference. It advised that one representative had responded requesting the menu and refuted that they did not need to kept forms for meal choices, for consumers who could choose on the day.
* In relation to Consumer A, the consumer did not lack capacity and was able to make daily food choices. Given it was not an allergy, the service deemed this acceptable to provide meat as the consumer was able to exercise choice. There was also a range of vegetarian options available.
* In relation to Consumer E,
  + The Approved Provider agreed the representative was involved in the selection of meals for the consumer and asserts that there had been a miscommunication regarding the menu process. The representative was contacted to explain the process and apologised for the confusion.
  + It outlined the past medical history of the consumer and reported the consumer had been appropriately reviewed by the dietitian in May 2021 due to losing weight. Since the dietitian review, the consumer’s weight was stable. A copy of the consumer’s care plan and three-monthly care plan review completed June 2021, identified the consumer’s weight had slightly increased, regular reviews by the dietitian and strategies for promoting intake.
* In relation to Consumer D, the service’s response had been considered under Standard 3 and a further meeting with the consumer representative would be arranged to reassure them of the recommendations by the speech pathologist are being implemented by staff.
* In relation to Consumer F, advised the service catered to a diverse range of consumers. It acknowledged Italian food was available, enjoyed by Italian consumers and the consumer’s family was happy to provide this for them.
* It was expected catering staff to recall individual details of all consumers.

I have considered the Assessment Team’s report and the Approved Provider’s response. Based on the information provided, I have come to a different view to that of the Assessment Team and find this requirement Compliant. My reasons are based on the following:

* In relation to specific representative and consumer feedback, I note:
  + One representative’s concerns related to their lack of confidence in the service to meet these needs and I note other actions previously reported to have been implemented by the service and the follow up action that was planned.
  + For Consumer A, I have considered weight lost under Standard 3 and I have concerns regarding the conflicting nature surrounding the consumer’s choices for meals. I accept that consumers have the right to exercise choice with meals, however information reported by staff, representatives of the consumer and in dietary information and reviews does not consistently reflect a shared view about the consumer’s preferences or how these were being determined.
  + For Consumer E, although I note the consultation processes for representatives was not clear, further evidence submitted showed there had been previous consultation regarding meal preferences and this was included as part of the care plan. I also note regular reviews by the dietitian had occurred between, there was a slight increase in weight for the consumer during this period and strategies identified to support weight goals. Although the Approved Provider reported the weight was stable, it had not submitted further evidence to demonstrate more recent weights.
* The service’s processes regarding seeking consultation from representatives was not consistently known by staff especially for consumers who lacked capacity. I do not accept the Approved Provider’s assertion for the Assessment Team to provide the names of consumers who lack capacity in order to demonstrate their consultation process or a wide range of staff would have provided the evidence to support consultation had occurred. I am of view given the differences in response by staff and management regarding these processes and given some staff were not aware of the diet codes listed, there were deficiencies in staff knowledge of processes which require increased monitoring. In addition, I do not however have any further information other than from the feedback provided that other consumers were not offered choice.

In addition, I have also considered the totality of evidence reported by the Assessment Team under other requirements, which included:

* The Assessment Team interviewed a total of 31 consumers and representatives. Although some representatives raised concerns about the variety and quality of meals, most consumers reported satisfaction with the provision of meals.
* Consumers and representatives said they received information food choices and the daily menu was observed to be displayed in the dining areas.
* During the meal service, staff were observed asking consumers if they were happy with their choice of meal and staff said they seek verbal feedback from consumers after meals and activities.
* I also note other observations reported by the Assessment Team which identified meal service in the main dining room demonstrated consumers were offered a choice of the main meal, the dietitian reviews the menu, staff were knowledgeable of where to access dietary folders, food safety procedures were in place and food was a standing agenda items at meetings.
* In relation to the service’s monitoring of feedback and completion of audits, I acknowledged the service had provided evidence of a nutrition and hydration. Given this was completed approximately three months prior to the audit I have also relied on other information within the report under Standard 6 and 8 regarding the effectiveness of the service’s comments and complaints processes which identified annual surveys were in place, consumer feedback regarding meals were sought by staff, and consumers stated the service had made changes to meals in response to their feedback.

For the reasons outlined above, I find the service Compliant in this requirement.

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall, sampled consumers considered they felt they belong in the service, and felt safe and comfortable in the service environment. For example:

* Consumers said they felt safe, their family and visitors were made to feel welcome, and they have personalised their rooms to make it more homelike.
* Consumers and representatives confirmed the environment is safe, clean and well maintained.

The main dining areas were observed to have tables and chairs set up restaurant style with long material tablecloths, cloth napkins and decorative centre pieces. The main dining area has a pianola which plays tunes during meal services.

Communal and corridor areas were clean with plenty of space for consumers to move around, private nooks, with comfortable lounges, bookshelves and plenty of large windows to allow for natural light. Doors leading out to the internal courtyard areas were open, so consumers could move freely inside and outside. Outdoor secure courtyards were observed to have well-maintained garden areas, walking and chairs and tables for sitting.

Pets were welcome at the service; one staff member brings their pet dogs in to work every day and consumers were observed interacting happily and patting them as they walked past them in the corridors. Volunteers also bring their pets into the service and pet therapy was a regular activity on the lifestyle calendar.

Maintenance staff described how maintenance was managed through the use of preventative and reactive maintenance schedules and explained a range of external service providers to assist in the maintenance of plant and equipment. Observation of schedules and worksheets showed each month was different, including but not limited to; essential services, preventative building maintenance, security, lighting, equipment, fire provisions, window/carpet cleaning and garden areas.

Management said the service has CCTV installed in some corridors and communal areas, as well outside entry points to the service for security purposes.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Most sampled consumers considered they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. For example:

* Consumers interviewed were aware of the various channels available to make a complaint or provide feedback and confirmed when they make a complaint, satisfactory action is taken. Consumers confirmed staff will apologies where appropriate.
* Consumers and representatives confirmed they were aware of how to access advocacy services.
* Five representatives confirmed meetings are held in relation to complaint resolutions and management and staff were open and transparent in their approach.

The service was able to demonstrate consumers, their family, friends, and others are encouraged and supported to provide feedback and make complaints. Mechanisms to provide feedback included feedback forms, consumer meetings, consumer surveys, and the care plan review process. Information about how the service seeks feedback and responds to complaints, compliments and suggestions was also available on the organisation’s website and information was also available in hard copies throughout the service.

The Assessment Team observed posters and pamphlets displayed with information for consumers and representatives as to how to make complaints and provide feedback both internally and externally. These include information about Older Persons Advocacy Network (OPAN) and ARAS.

Feedback, complaints and open disclosure policies, procedures and processes were in place which guides management and staff on how to identify, manage, escalate, document, and resolve complaints. Staff were knowledgeable of what open disclosure involves and understood the importance of following this when things go wrong.

Feedback and complaints were reviewed at a site and organisational level to improve the overall quality of care and services.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall, sampled consumers considered that staff are knowledgeable, capable and caring, for example:

* Most consumers and representatives said staff were kind, caring and respectful when providing care and services to consumers. They provided examples of how staff respected consumers’ identify, culture and diversity.
* Consumers and representatives expressed how open and friendly the staff are and one consumer stated, ‘it feels like home.’
* Most consumers and representatives interviewed are satisfied clinical and care staff have the skills to meet consumers’ care needs.
* Consumers and representatives said staff were competent in providing the clinical and personal care.

Interviews with staff and management, and documentation showed the service has a framework to guide management in onboarding, recruitment, performance appraisal and performance management.

Ongoing training is provided through various channels, which was managed at a corporate and service level. A training gap analysis was undertaken to ensure staff have adequate competencies to undertake their roles.

Performance appraisals were conducted annually, and performance improvement plans are implemented for underperforming staff, with disciplinary action undertaken when necessary.

The Assessment Team recommended one requirement as not met in Standard 7, requirement (3)(a) as some consumers and representatives including staff did not consider there was sufficient staff to provide care and services. The Approved Provider’s response was provided in relation to the above matters. Based on the Assessment Team’s report and Approved Provider’s response, I have come to a different view and find the service Compliant in this requirement.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

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

The Assessment Team found the service was not able to demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services, particularly in relation to the memory support area. The Assessment Team provided the following information and evidence relevance to my finding:

* Five representatives stated they come in every day and/or often during the week to assist with meal service, as they did not have confidence the service would ensure the consumer was appropriately nourished and hydrated.
* Three consumers commented on how busy staff were rushing around and attending to consumers who were wandering.
* Three representatives said they come in to assist with activities of daily living, such as showering and helping the consumer get into bed at night. One representative reported staff run around and there was not enough staff on.
* Other representative comments included:
  + Staffing on Sunday afternoons had been poor and sometimes only observes two staff who were often rushing to deliver care and to attend to consumers who wander.
  + There were concerns with nights and/or weekends and two consumers had on occasion experienced a delay in assistance for toileting or getting into bed.
  + Representative feedback relating to provision of emotional support and stimulating activities under Standard 4 requirement (3)(a).
* Staff reported they could meet the basic personal and clinical care needs of consumers; however, five staff indicated they either were not able to spend quality time with consumers, to do things of interest or had time for the ‘add ons’.
* One staff said the memory support unit needs more staff to supervise consumers who are at a risk of falling and considered two staff was not enough during 11am to 3pm to support consumers who wander.
* Management advised a master roster review had not been undertaken except on one occasion; they had some degree of flexibility in adjusting the roster on a temporary basis and call bell data was monitored for calls over 10 minutes.

The Approved Provider’s response disagreed with the Assessment Team’s findings. It reported it considered there was sufficient staff in the memory support unit to provide adequate care and support which include a lifestyle staff member throughout the day for 12 to 13 consumers residing in the memory support unit.

* In respects to representatives’ lack of confidence, the Approved Provider outlined there had been past incidents/near misses of choking for three consumers that had occurred; these were not as a result of inadequate staffing levels and/or the knowledge of staff. It asserted staff were in attendance, the incidents had been resolved and relevant health professionals involved. For another consumer, it refuted weight loss was as a result of inadequate staffing and reinforced this was linked medical condition and desire to walk.
* It outlined there were several consumer representatives that attended the service to partner in care. This was documented within individual consumer’s care plans and staff actively supported these relations. It refuted this was linked to staffing issues and provided examples of two consumers (Consumer B and E) where representative attendance/assistance was included as part of care documentation.
* It reported staffing levels had been modified in the memory support unit to include the additional presence of one staff member during mealtimes and additional lifestyle staff member after 1.30pm which was implemented in September 2020.
  + The Assessment Team observed three staff were available in the memory support unit during lunch service.
  + It also reported it was committed to continuing to monitor all meals services across the home.
* Its response also outlined an increase in staffing within the past 18 months and the implementation of additional staff/management positions. It also advised of the existing plans for increased lifestyle support due for implementation on 30 August 2021, in response to the recently appointed lifestyle coordinator.
* In relation to weekends and staff coverage, management advised they were not aware of this feedback and the only changes in staffing levels related to management, administration and maintenance team. It advised the service had not receive any feedback within the last six months regarding staffing levels. It would however, further review with consumers and representatives. In addition, since receiving the feedback, the service had also implemented signage on the visitor register on how to speak with the supervisor out of hours.
* It outlined the service’s replacement process for staff and collation of monthly clinical incident data to monitor care. It asserted incident data did not support that staffing between 1100 hours and 1500 hours was not sufficient.
* Furthermore, the service outlined other processes being used to ensure monitoring of falls and that there are effective prevention strategies, handover identify consumers who have fallen and monitors this to the end of the month. This included additional clinical reviews which was implemented in March 2021 for high risk and high impact consumers.

In coming to a view about compliance, I have considered the Assessment Team’s report and Approved Provider’s response.

In relation to feedback provided by consumers and representatives and staff, I have considered the collective nature of this feedback and evidence provided surrounding these concerns. Furthermore, I have also considered the totality of consumer and representative feedback, the weight of evidence provided as well as reference to care and services within the report.

After considering information before me, I have come to a different view to that of the Assessment Team and find the service Compliant in this requirement. My decision is based on the following:

* I note the Assessment Team interviewed 31 consumers and representatives and a mix of staff. Some representatives identified they were not confident that support would be provided to the consumer and would attend the service to assist with meals and/or care. While I am concerned that representatives lacked confidence in the service to provide these supports, based on the information and additional evidence submitted surrounding specific incidents, I note:
  + some incidents were historical in nature, and outcomes of investigations and other feedback provided did not directly evidence these were as a result of staffing levels.
  + although I acknowledge some representatives’ and consumers’ feedback about representatives attending the service or that staff were busy and rushing, based on the evidence and feedback provided there was not sufficient evidence to support these activities or observations were impacting on the consumer and were attributed to the adequacy of staffing levels.
  + staffing on weekends and evenings was noted to be a theme for some representatives in which two consumers had experienced occasional delays in assistance with toileting. Whilst this is not acceptable, other than a delay being experienced, I do not have sufficient evidence surrounding degree of impact and overall management of the consumers’ continence needs.

In relation to weekend coverage, I note information gathered by the Assessment Team over a one-week period showed other than registered nurses, there was minimal variation in enrolled nurses and care staff hours.

I also note the Assessment Team reported call bell data (including calls bells and sensor mats) was being monitored by management and the Approved Provider would review consumers’ continence needs in response to this feedback. and complaints information did not support this feedback.

* I have also considered staff feedback which identified they could meet the basic personal and clinical care needs of consumers, however were not able to spend quality time or to do the extra things with consumers. I have considered the feedback and have explored this further in respect to Standard 4 requirement (3)(a), including the additional evidence submitted by the Approved Provider.
  + In respects to this feedback, I do not have further information about the circumstances surrounding staff comments and degree of impact for consumers’ well-being more broadly.
  + I also note one care staff member (located in the memory support unit) provided examples of how they maintained consumers’ independence and undertake tasks of their choosing, such as supporting them to sort out their own clothes and make their bed.

While I am of a view there were some gaps and areas of improvement in relation to supporting consumers’ quality of life, such as activities, most consumers were satisfied in respects to Standard 1 and 4. I note the Approved Provider had already planned for an increase in lifestyle support by end of August 2021 and would implement additional measures to support the monitoring of staff levels.

Furthermore, I note the Approved Provider’s response which outlined its processes for replacement, monitoring and the implementation of additional positions and staff over the past 18 months, including other monitoring activities being undertaken. Its response, however, did not consistently include evidence of these and therefore I have placed weight on other information provided within the Assessment Team’s report which included:

* Overall, consumers and representatives reported the service was well run and consumers considered they felt like partners in the ongoing assessment and planning of their care and services.
* The effectiveness of the service’s complaints and feedback mechanism which did not identify concerns with staffing.
* In relation to Standard 4, most consumers and representatives interviewed confirmed adequate support was provided and staff were knowledgeable of consumers’ emotional support needs.
* The organisation’s governance systems showed it monitored and reported on clinical data and incidents and these were actioned. Although some aspects of care were not consistently provided to consumers (as outlined in Standard 3), other examples by the Assessment Team showed effective management of consumers’ high impact or high prevalence risks, such as falls and behaviours.

Based on the reasons detailed above, I find the service Compliant in this requirement.

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

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

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

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

### Requirement 7(3)(d) Compliant

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

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

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

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Overall, sampled consumers considered the organisation was well run and that they could partner in improving the delivery of care and services. Consumers confirmed they were involved in the development of care and services and have access to a range of feedback mechanisms, such as feedback forms, through the monthly resident meetings, and organisational surveys.

The organisation had a range of reporting mechanisms to ensure the Board was aware of undertakings within the service and is accountable for the delivery of services. All Board members have received training on the Standards.

The organisation had a range of policies and procedures to ensure effective governance systems and to guide staff when providing care and managing risks.

Management was able to describe how they manage high impact or high prevalence risks associated with the care of consumers through executive leadership, governance meetings and a range of staff meetings to ensure effective communication across all levels of the organisation.

Clinical management said they have completed training on Serious Incident Reporting Scheme and could explain how they use this information to help identify and respond to the abuse and neglect of consumers.

Staff described how they supported consumers to take risks to ensure they live the best life they can and were aware of the internal policies and procedures in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure.

The organisation demonstrated it had effective governance systems in place and there was a range of monitoring mechanisms to oversee clinical care which includes Board, Clinical Governance, Audit, Risk Committees and Quality Improvement Committees.

Furthermore, the service holds clinical care subcommittee meetings, such as wound care committee, staff committees and conducts handovers to ensure information is communicate at a service level.

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

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

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

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

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

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

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

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

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

# Areas for improvement

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

### Requirement 3(3)(a)

* Ensure each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and well-being by:
  + Ensuring there is appropriate monitoring of intake for consumers at risk of malnutrition and in accordance with allied health directives.
  + There is clear guidance on consumers’ dietary needs and staff are familiar with these.
  + Care planning documentation consistently guides staff and demonstrates there are effective behaviour management strategies in place.
  + Ensure there are effective processes for capturing and recording clinical decisions and consultation with representatives about clinical risks.
  + Ensure policies and procedures effectively guide staff practices and decision making specifically in relation to falls management.