HammondCare - Woy Woy

Performance Report

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**Commission ID:** 0615

**Provider name:** HammondCare

**Site Audit date:** 27 October 2020 to 30 October 2020

**Date of Performance Report:** 23 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

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | 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) | Compliant |
| Requirement 8(3)(d) | Non-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; and
* the provider’s response to the Site Audit report received 25 November 2020.

# 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

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:

* Each consumer is supported to take risks to enable them to live the best life they can.
* Representatives sampled advised staff speak to their consumers respectfully and treat them with respect.
* Representatives sampled provided positive feedback regarding their consumer being supported to exercise choice and independence and to make decisions about their care and the way care and services are delivered.
* Representatives interviewed confirmed that the service values their culture and diversity and care and services provided are culturally safe.
* Representatives interviewed confirmed that the service respects consumers privacy and staff knock and wait for an acknowledgement before entering their bedrooms.
* Staff interviewed spoke about consumers respectfully and with regard for their identity, culture and diversity.

The Quality Standard is assessed as compliant as all 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.*

The Assessment Team found that consumers are supported to take risks to enable them to live the best life they can. Despite this they identified that there is no formal risk assessment process in place to risk assess activities for consumers outside of the service.

Most representatives advised that prior to COVID-19 there was more for consumers to do outside the service, for example bus trips, picnics, walks along the water and swimming. Since COVID-19 commenced consumers have been restricted to their cottage with less visits from family and volunteers, which limits their opportunities to take risks to live the best life they can.

Team Leaders described the areas in which some consumers want to take risks and how the risks are discussed with the consumer or their representative. Team leaders also described how consumers are supported to take risks. For example, team Leaders advised of external activities that consumers took part in outside the service before COVID-19. Group outings included picnics, and shopping trips for consumers.

Management advised that there was no formal process for risk assessing activities of risk outside the service to enable consumers to live the best life they can prior to COVID-19. The organisation had identified this, and a risk assessment form was developed in July 2020 for use across the organisation. The area residential manager provided a copy of the risk assessment form and advised the Assessment Team that the service had not implemented the form. The Assessment Team found risk assessments in place for consumers who smoke and that the service has a risk management policy and risk assessment forms.

In response to the Assessment Team’s findings the approved provider submitted additional information about the external risk assessment processes now deployed at the service. While the approved provider confirmed that prior to the COVID-19 pandemic there was no assessment of risks associated with consumers engaging in activities outside the service, a comprehensive risk assessment had been developed in July 2020. This has been rolled out to ensure that once external activities recommence there is a system to assess the risks to individual consumers.

The approved provider also clarified that they the service has not implemented the new assessments yet as no consumers have returned to external activities as yet. Prior to a consumer joining or returning to an external activity a risk assessment will be completed.

I find this requirement 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-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

Most sampled consumer representatives said they felt satisfied in relation to the ongoing assessment and planning of consumer care and services. However, the Assesment Team found that risks are not always effectively assessed at the service by staff and documented in the care plan. There were two new consumers who entered the service for respite who did not have assessments and risk assessments completed. Consumer representatives are involved with the assessment and care planning process though they are not offered a copy of the care plan.

There is a process for assessment and planning for consumers at the service including the completion of a risk screening tool and the completion of the care planning assessment tool.

Consumer representatives reported the care and services of consumers are reviewed when a change in condition occurs. All care and service plans reviewed by the Assessment Team had been regularly evaluated.

The organisation seeks input from various health professionals to ensure the consumer receives comprehensive assessment of their needs.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

Risks are not always effectively assessed at the service by staff and documented in the care plan. All staff are not aware of the need for a risk assessment. While there is a process for a falls risk assessment to be completed, registered nursing staff could not describe the risk assessment process to the Assessment Team. Consumers entering the service for respite recently did not have adequate assessments or interim care plans.

Care planning documents and progress notes sampled demonstrate consumers have access to medical officers, medical specialists involved in their care, podiatry, behavioural specialist services, mental health services, geriatricians, dieticians, speech pathologists, and palliative care team. Most consumer representatives are satisfied with the care and services provided and had no complaints in relation to assessment and planning.

The service has a risk screening tool that needs to be completed on admission. This is done in conjunction with the Care Planning Assessment Tool (CPAT). The consequences and strategies to mitigate the risk are then documented. For example where falls have been documented in the indicent reporting system a risk assessment tool is then actioned. This triggers a referral to the Physiotherapist for a mobility assessment. Similarly where pressure injury risk has been identified and assessed the Assesment Team found that appropriate interventions such as a pressure relieving foam mattress have been put in place. Management reported that there were three consumers on anti-coagulant therapy (Aspirin). Alerts are included in the consumer records for these consumers.

One representative of a consumer who had recently entered the service said they were not happy with the care provided to their consumer but had been in contact with the team leader and the issues had been resolved. The representative of a consumer who had entered more recently for respite said they were concerned they did not have the opportunity to meet with staff and had organised a meeting with the assistant manager which was postponed. The representative followed up with care staff and the registered nurse to resolve concerns about diabetes management. The staff now have special dietary guidelines for the consumer displayed in the kitchen and staff are checking the consumers blood glucose level three times a day and reporting any high blood glucose levels to the registered nurse. Two consumer representatives said they were more than happy with the care provided at the service to their family member.

Care staff said when risks are identified for consumers they are reported immediately to the registered nurse but could not describe the assessment process. Registered nurses could explain how assessments are conducted to determine what type of care is needed for the consumer and what should be prioritised. The registered nurses said risks are assessed and incidents reported. They explained how reassessment occurred with changes in condition but could not provide information about how they assess risk following a fall. Referrals are made to allied health practitioners and others for further specialised assessment where indicated.

Care staff said they followed manual handling instructions that are an assessment of the consumer’s mobility needs. The staff said using the correct equipment such as sling lifters to transfer consumers who had reduced mobility needs must be adhered to if indicated. The physiotherapist interviewed was able to describe the process for referral following falls and deterioration in mobility.

The Assessment Team identified the service is not always following the organisational risk management policy with regard to formally assessing risk. There is evidence the service has a process for risk assessment, with the initial assessment checklist and falls risk assessment. However, the registered nurse when asked about the process following a consumer fall was not able to describe the falls risk assessment completed in the electronic risk management system and said that they would do an assessment and decide whether a referral was needed.

The organisation has an ‘admission pathway’ which is a guide for the completion of assessments during the entry process. The schedule of assessments provided by the service indicates assessments are conducted on entry to the service for consumers and reviewed every three months. Consumers entering the service for respite have assessment and interim care plan developed on entry.

Policies and procedures guide when assessments should be completed and reassessed for consumers. The care planning policy is called the ‘Case Management Approach’ August 2018, which links to a workflow document called the ‘Admission, Assessment and Care Planning Process’. The Case Management document states that care plans are reviewed at least every three months and more often if there is a significant change in the consumer’s condition. Additionally, every six months there is a case conference where staff review and compete another CPAT (Care Planning Assessment Tool). There is an annual clinical care review conducted by the registered nurse which includes a full physical assessment and mini nutritional assessment.

The care plans reviewed for the consumers sampled were mostly reviewed every three months. However, one consumer care plan in had not been reviewed for over six months and was due for a case conference to be organised. Two respite consumers did not have care plans in place.

The training schedule for staff did not offer staff risk management training, there is training for staff to use the electronic incident reporting system which requires staff to risk rate an incident.

The approved provider acknowledged the absecence of interim care plans and advised that these have now been implemented. They have also established a process to review the files of all new consumer admissions until they are satisfied that this is occurring as required at the service. In relation to risk assessment, the approved provider submitted that while care staff may not have articulated the risk assessment process, the actions and escleations taken by them indicate an understanding of this. Further the approved provider clarified that risk training is provided during induction training, along with additional guides available to staff and other training modules avaliale on their online training system.

Althgouth the approved provide’s response confirms that action has been immediately take to address the gaps identified by the Assesment Team, it remains that up to date assessment and planning, including consideration of risks for all consumers was not up to date at the time of the visit.

I find this requirement non-compliant.

### 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.*

Care plans at the service include one single goal for the consumers sampled. The goal is a statement about what the consumer or representative hopes will happen and does not relate to the needs and preferences of the consumer in specific domains. Care planning documents detail current care needs and preferences for the consumers sampled. Care plans including specific care domains are completed by the case manager following a case management meeting with the consumer and/or representative. Care plans sampled document individualised personal preferences for consumers such as personal care.

The Assessment Team was advised by management at the entry meeting there were two consumers at the service who are currently at end of life, or on a palliative care trajectory. The service does not have a separate palliative care plan for the consumers on a palliative trajectory. Any changes to care are included in the care plan document.

Advanced care plans are in place for about half of the consumers at the service. End of life wishes are included in the plan of care and palliative care needs are included the care plan. The service gives all consumers and their representative information in relation to advanced care planning on entry to the service called ‘At the End of Life’. This is also reviewed at the case conference and when applicable, such as deterioration or transfer to hospital. End of life care decisions and preferences are documented for relevant consumers in the ‘Plan of Care’.

A consumer confirmed that only male staff assist them with their personal care as is their preference, and a consumer representative confirmed they were asked at the initial case conference about advance care planning and given information by staff.

Care staff could describe what was important to the consumers they cared for. The assistant manager talked about the specific behaviours of consumers and how they wander or became agitated. The assistant manager said consumers could dehydrate due to wandering so the staff ensure oral fluids are encouraged.

Management and registered nursing staff said not all consumer representatives are prepared to make decisions about advanced care planning on entry and respect and support the consumer in the process of decision making. Mechanisms are in place to monitor and review this such as regular care conference meetings, weekly review, review on transfer to hospital or at the time of other changes in condition for the consumer.

The head of residential care north said the organisation will be commencing a new care plan template which is goal orientated that included several goals that related to several consumer domains and that this would be commenced at the service over the next few months.

The Approved Provider submitted additional information in reponse to the Assessment Team’s findings. This includes information about how the service seeks to understand consumer specific goals and wishes, through a HOPE Assessment undertaken by the Pastoral Care Team. The approved provider advised they have asked staff to ensure this information is also recorded in consumer care plans.

In relation to end of life planning, the approved provider acknowledged that not all consumers have advance care or end of life plan. The approved provider clarified that these plans are in place for consumers or representatives who wish for this to be in place. The additional information provided by the approved provider shows how individuals’ goals and preferences are obtained (including in relation to the creation of advance care planning) and that this information will be more clearly documented.

I find this requirement 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) 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

Consumers said they felt at home and most representatives are satisfied with the care and services received for consumers. Most representatives said the staff were kind, caring and they had no complaints. Most sampled consumer representatives also considered that the consumers receive personal care and clinical care that is safe and right for them.

The Assessment Team found management at the service not aware of the definition of chemical restraint. The service demonstrated they were not aware of what a relevant diagnosis is for specific classes of psychotropics. The psychotropic register did not list relevant diagnoses for certain classes of prescribed psychotropics.

Medical authorisations for chemical restraint were presented on request. Pain management for consumers sampled was effectively assessed or reviewed for consumers sampled.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that care documents did not consistently reflect care that is safe, effective, best practice, tailored to consumer specific needs, and optimises consumers health and well-being.

Not all consumer representatives felt the care and services received by consumers optimised their health and wellbeing, although representatives discussed how they had raised and addressed these concerns with the service.

The assistant manager said there are risk assessments conducted for consumers on entry to the service and when consumers experience incidents such as falls. The Assessment Team found risk assessments were not always attended as outlined in relation to Standard 2 Requirement 3(a).

Registered nurses said concerns are also reported to the assistant manager. Care staff said they report all concerns about consumers to the registered nurse. Care staff talked about a consumer who had deteriorated and how mobility needs had changed. The consumer has been reviewed by the physiotherapist and is now using a walking aid.

Best practice resources are available on line for all staff to access. Registered nurses said that they access the information on line and clinical policies reference best practice organisations in the document. The organisation has policies and procedures to provide guidelines and resources for the delivery of care that is safe and effective. Staff have access to on-line education and consult with other professional services to ensure information is current.

Monthly clinical indicators are used to provide feedback to staff and are presented to the board. The service was able to demonstrate how clinical indicator data is used to trend clinical incidents and benchmark the service against the organisation’s other services. The psychotropic use register was not up to date and did not always provide details about the reason for the use of medication. The assistant manager commenced updating the register during the visit.

Some consumers who are prescribed an antipsychotic medication for the treatment of behaviours had not been identified as being on a chemical restraint. Despite this in all cases the medication has been reviewed by a medical officer every three months and representatives have been consulted about the use of the medication.

While the service is seeking to reduce the use of psychotropic medication, current records indicate the use of psychotropic medication is high. The service has 75% (60 out of 81) consumers receiving psychotropics. There are medical authorisation forms for psychotropic medication for consumers did not always state a diagnosis for the use of the medication or recognise this as a chemical restraint. The service’s restrictive practice policy clearly defines chemical restraint as “the use of a medication or chemical substance for the purpose of influencing a person’s behaviour other than medication prescribed for the treatment of, or to enable treatment of a diagnosed mental disorder, a physical illness or a physical condition”. Management said there had been a reduction of psychotropic use at the service for consumers who entered the service who were already prescribed psychotropics.

As the service is for consumers with dementia there are environmental restraints in place for consumer safety. Consumers have full access to the garden and all areas within the cottage. Consumer representatives are informed and aware of this prior to the consumer entering the service. Environmental consent is in place for all consumers at the service with signatures from consumers and representatives. This is completed on a separate document when entering the service and forms part of the contract.

A review of skin and wound management identified wound assessments and dressings are completed and wounds are healing. Registered staff review all wounds weekly. Wounds are photographed regularly for comparison and measurement documented. Best practice wound products are utilised by clinical staff and kept in the treatment room. Pain management for consumers sampled has also been effectively assessed or reviewed.

The service stores medication in locked medication cupboards within the cottage pantries. All staff working at the facility have access to the room and the room is used as a thoroughfare to each cottage. Specialist Dementia Carer (SDC) staff who have completed medication competency training give medications to consumers from a webster pack. The medication cupboard in the ‘Birchgrove’ pantry where medications are stored was found to be open and locks not working on 28 October and 29 October 2020. The management was notified on the 28 October by the Assessment Team. The medication cupboard remained open on the 29 October 2020 after a follow up check. Staff in ‘Birchgrove’ cottage reported to the Assessment Team member that one consumer demonstrated their ability to open the locked door to the pantry. Management was not aware of this when informed and no incident report or risk assessment was found.

In response to the Assessment Team’s findings the approved provider confirmed that risk assessments are completed following any falls using the Falls Risk Assessment Tool. They also provided evidence that an incident report was completed after a consumer was able to gain access to the pantry, and that there has been no reoccurrence. While the service fixed the lock to the medication cupboard identified as faulty by the Assessment Team, staff left it unlocked the following day, and this has been addressed with staff.

In relation to chemical restraint the approved provider acknowledges that not all consumers on a form of chemical restraint had been recorded as such. Despite this the approved provider said there have been no adverse outcomes, as all consumers have a current psychotropic authorisation form, have had consent provided to be on the medication and are monitored and reviewed every three months to ensure the ongoing suitability of their medication. While the Assessment Team confirmed that these processes are in place, there remains a need for the service to ensure that any consumer prescribed a medication as a form of chemical restraint has an adequate restraint review and monitoring plan in place to assess the ongoing need in addition to regular medical officer review. The approved provider has acted to address this since the visit.

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 Assessment Team found risks for consumers are not effectively assessed. The service was not aware that some consumers are chemically restrained and did not document a relevant diagnosis for the use of specific psychotropics in the psychotropic register presented. They also considered feedback about a consumer whose psychotropic medication had been ceased without their representative’s consent that had a negative impact on the consumer. There are medical authorisation forms for psychotropic medication for consumers. The service is dementia specific and management reported that 80 out of the 81 consumers have a diagnosis of dementia.

Care staff were not able to describe effective management for high impact risk such as pressure injury. Staff said a consumer had a pressure injury risk. Staff talked about rubbing the locations such as buttocks and heels to prevent pressure injury. Care staff could not describe best practice pressure area care interventions such as repositioning and pressure relieving devices. Staff also could not describe effective management for pressure injury risk for a consumer who had experienced a previous pressure injury.

Policies and procedures to guide staff are available on the intranet such as Infection Prevention and Control, Restrictive Practices, Behaviour Management and Falls Management. The first ‘Restrictive Practice’ policy presented to the Assessment Team did not have ‘restrictive practice minimisation’ included. Many of the policies provided to the Assessment Team were out of date and not congruent with recent legislation. Management was informed of this and updated polices were provided.

Not all high impact risks were found to not be recorded in the electronic risk management system. Consumers with high impact behaviours are referred to specialist behaviour services such as Dementia Support Australia (DSA) and to geriatricians. Referrals from specialists and/or their recommendations are noted to be followed by the staff and documented in consumer care plans. The service has a falls management policy to guide clinicians and it includes a falls risk assessment to be completed.

The service also has a physiotherapist who visits the facility twice a week who receives referrals and provides assessments in relation to changes in mobility and joint pain.

The service has an internal audit schedule in place with diabetes, falls, medication, and behaviour management audited six monthly. The service collects, trends and analyses clinical indicators monthly.

In response the approved provider advised that they have commenced the delivery of additional training to staff in skin integrity and pressure injury management to ensure staff understand best practice pressure area care and interventions. In relation to chemical restraint (a restrictive practice) the additional information submitted by the approved provider reflects that provider in response to Standard 3 Requirement (3)(a). Specifically, that while some consumers had not been identified as being chemically restrained, they all have a current psychotropic authorisation form, have had consent provided to be on the medication and are monitored and reviewed every three months to ensure the ongoing suitability of their medication.

The Assessment Team also found in relation to Standard 2 Requirement (3)(a) that not all consumers had current care plans or risk assessments in place, which are required to ensure that high impact or high prevalence risks are effectively identified and managed.

Although the approved provider’s response aligns with the Assessment Team’s findings in relation to the review of medications, it does demonstrate that the service is minimising the use of restrictive practices (chemical restraint) as expected under this requirement. Their response does indicate that actions have been undertaken to assess and identify high impact and high prevalence risk, though this occurred after the identification of gaps during the visit.

I find this requirement non-compliant.

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

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

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

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

### 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.*

Staff understood antimicrobial stewardship and the principles and management of general outbreaks of gastroenteritis and influenza, though the Assessment Team considered the service was not prepared for a possible outbreak of COVID-19.

Density signage for all communal rooms at the service was not evident. Some extra density signage was placed by management during the performance assessment. There was a lack of bacterial wipes at the concierge and in the service. Visitors were not instructed to sanitise their hands by the concierge when entering the service. Feedback was provided to management who distributed wipes to all areas of the service during the performance assessment and gave further training to volunteers in concierge.

Management said they had a corporate outbreak management plan. The assistant manager is responsible for infection control at the service and the public health unit was informed of all outbreaks and was the one who decided when the outbreak was over. The assistant manager was aware of the listings for all consumers and staff with symptoms that needed to be reported to the public health unit daily.

Management said they had been working with medical staff about the policy of antimicrobial stewardship at the service. Management said that the registered nurses have training provided by the pharmacist on antimicrobial stewardship. The assistant manager showed the Assessment Team what happened when consumers had infections. They demonstrated how they enter the information into electronic system, follow up the results and upload the pathology reports to the system.

The registered nurse and assistant manager said in relation to the prevention of urinary tract infections, they always direct the staff to ensure good hydration of all consumers as they were particularly at risk of dehydration and weight loss.

The assistant manager described the measures taken in gastroenteritis and influenza outbreaks such as isolation of consumers in their bedrooms, observations recorded, specimens taken, no dining room meal service, disposable plates and cutlery, care staff taking meals and food and fluids into the consumer.

Consumer representatives said swabs were taken for possible wound infections and antibiotics were prescribed in a timely manner after being seen by their medical officer when they were unwell. Vaccination records were presented. 100% of staff have received influenza vaccination. 95% of consumers have been vaccinated.

Care staff said there was water available in each kitchen to assist with hydration of consumers. The staff also talked about the importance of good hygiene in preventing infections such as urinary tract infection. Care staff were very aware of what steps they needed to take in the event of outbreaks for gastroenteritis and influenza and the importance of handwashing. Staff said they used personal protective equipment (PPE) during outbreaks and have received education in infection control, COVID-19 and knew about donning and doffing. Non-care staff at the service have also completed COVID-19 and other training. Staff are assessed for competencies relating to infection control such as handwashing, use of colour coded equipment and safe food handling.

Staff said that all shared equipment is wiped over between use but there were limited supplies of bacterial wipes available throughout the service at the beginning of the visit. The service has an infection control policy and an antimicrobial stewardship approach is in place. The Assessment Team observed the service has spills kits and staff were familiar with where they were stored.

The service has an electronic infection control risk management system. The assistant manager reviews infections and trends them monthly. Infection status for consumers is captured when entering the service, through care review and from return from hospital.

A special education program for residential service visitors has been developed. The online program provides foundational education and information on COVID-19 and infection control.

Medical advisory meeting minutes show there are discussions about antimicrobial stewardship, outbreak management, infection rates, medication incidents and COVID-19.

Outbreak kits at the service were inspected, included a contents list and all were stored securely in a locked room. One outbreak kit was not tied securely. The service has further stock of PPE available in locked store rooms on site. There were not sufficient foot coverings for 48 hours and there were no N95 masks on the site.

In response to areas for improvement identified by the Assessment Team the approved provider shared additional information. This included information about the assistance staff provide consumers with hand hygiene, cleaning of high touch services, use of signage within the consumer areas of the service, and access to personal protective equipment. The approved provider also submitted a copy of its COVID Preparedness Plan and information about the application of this at the service and across the organisation.

The approved provider’s response also addressed the risk of having hand sanitizer (alcohol based) freely accessible to consumers throughout the service, in respect to potential harm if ingested. This is a risk particularly for the service due to the dementia-specific consumer cohort. In relation to emergency supplies the approved provider also clarified that the organisation maintains its own emergency stockpile that can be distributed to any of its services as needed should any outbreak occur.

I find this requirement compliant.

# 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

Overall sampled consumers considered 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.

For example:

* Representatives interviewed confirmed consumers are supported to optimise their independence, health, wellbeing and quality of life.
* Consumers and representatives interviewed confirmed that consumers are mostly supported by the service to do the things they like to do. As a result of COVID-19 community activities have been cancelled, however substitutes to support the interests of consumers have been considered.
* Representatives interviewed confirmed that consumers are supported to keep in touch with people who are important to them.
* Feedback from consumers and representatives interviewed included meals provided are of a suitable quality, variety, and quantity and are provided in a safe environment.
* The service demonstrated they are providing sufficient religious and spiritual services for consumers. The staff have said they have difficultly due to COVID-19 with local community religious and spiritual clergy visiting.
* Emotional and psychological wellbeing of consumers is assessed or reviewed.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall sampled consumers considered that they feel they belong in the service, feel safe and are comfortable in the service environment.

For example:

* Representatives interviewed confirmed that they find the environment to be safe and well maintained. They are happy with the cleaning of the environment and their consumers room.
* Consumers interviewed said they are happy living at the service. They referred to it as home.
* Consumers are able to decorate their bedroom with personal items to make their home as comfortable as possible.

The Assessment Team observed the service has clear signage throughout, structural strategies to support most consumers to mobilise independently indoors and out. There is adequate lighting, heating and cooling, a comfortable atmosphere and appropriate noise levels and pathways around the service are level and safe.

The Quality Standard is assessed as compliant as all 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

Overall sampled consumers and representatives said they are encouraged and supported to give feedback, make complaints, and felt that appropriate action is taken.

For example:

* Several consumers said if they had any concerns or if they were worried about anything, they would just tell the staff and they would help them.
* Representatives said they felt comfortable to speak directly with staff and management if they had a concern or a complaint and were familiar with the other ways they could make complaints if needed.
* One representative who had a family member enter the service recently said they were not happy about the condition of the room. The representative complained directly to staff and said they were satisfied with the action taken and there has been no reoccurrence.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-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 and representatives said quality care and services were delivered when they need them and from people who are knowledgeable, capable and caring.

For example, representatives said they felt staff were kind, caring and respectful, and that staff were very capable given they had to do everything in the cottage for consumers. Some representatives thought there needed to be extra staff particularly for leisure and lifestyle activities.

The service was able to demonstrate the workforce was planned and that staff are competent and capable in performing their roles. Consumers and representatives said staff are kind, caring and respectful of each consumer’s identity, culture and diversity and have been trained and equipped. Despite this the Assessment Team found that the regular assessment and review of performance of each member of staff has not been undertaken.

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

## Assessment of Standard 7 Requirements

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

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

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

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

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

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

The Assessment Team found that the regular assessment and review of the performance of each member of staff has not occurred at the service. Management said they had identified they were behind with the performance appraisal of staff and the new residential manager was developing a schedule for, this with the staff in the high care areas being prioritised first.

The residential manager presented the ‘Annual Development Meeting Record’ used to document the appraisal of staff at the service. It included four sections including the year in review, a capability framework, a personal and professional development plan and goal setting, sign off and record summary.

The personal and professional development plan is designed to capture the development a staff member may need or wish to undertake over the next twelve months. The staff member is asked to identify one effective strength capability they would like to further strengthen and one development capability they would like to develop. Education goals are also set as part of this process.

All staff said they had not received feedback about their performance ever or for years and would like this very much. They felt very strongly about this and felt they had not received formal recognition. The workplace trainer said the probationary period includes monitoring for a new staff member and the identification of other areas requiring support.

Management said staff were performance managed as needed and provided examples. For example, during the performance assessment a volunteer spoke abruptly to the residential manager north when asked to not enter the room and the manager responded immediately to ensure the volunteer was followed up by management.

Training needs are normally identified at performance appraisal and arranged for the staff member. Staff said this had not occurred as they could not remember when or if they had ever had a performance appraisal. The service has an organisational staff performance framework. Performance coaching and performance improvement plans are utilised where indicated.

While the service was able to demonstrate it has a staff performance framework, staff appraisals were not up to date and staff confirmed that this had not occurred at all for some, and not for years, for others. Staff said they felt a lack of formal recognition from the service

In response to the Assessment Team’s findings the approved provider clarified that annual performance appraisals are only one of the ways in which they asses, monitor and review staff performance. A full-time work-place trainer works on the floor with staff at the service, staff are subject to competency assessments, annual education, and review if incidents occur. The approved provider also advised of observation audits they undertake, and the role of registered nurses and team leaders in monitoring the performance of staff.

Although the approved provider’s response indicates a range of activities that are undertaken to monitor staff performance, and how action is taken if development needs are identified, they confirmed that annual development meetings were not up to date at the time of the visit. Action has been taken to complete these which appears reasonable. While the approved provider’s response and the Assessment Team’s observations shows there are various monitoring systems in place, it remains that annual performance appraisals had not occurred, and that staff expressed concern with a lack of performance feedback.

I find this requirement non-compliant.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Most representatives interviewed felt the service was well run and they said they were satisfied with the care and services that staff provided to their loved ones. They said staff were very kind, caring, capable and always calm while juggling complex priorities. Representatives felt comfortable to make a complaint, raise a problem and provide feedback with staff and/or management.

Representatives said they were well informed about the care their loved one received, and they were very grateful of the volunteers who gave of their time to support consumers at the service.

While the organisation has systems in place to ensure effective governance the Assessment Team found the service has not demonstrated they are implementing the organisation’s systems and practices to ensure high impact high prevalence risks are managed.

The Quality Standard is assessed as non-compliant as one 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) 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) 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.*

The Assessment Team found that the service did not demonstrate the implementation of the organisation’s systems and practices to ensure high impact or high prevalence risks are managed. While the service has a ‘Clinical Care Management Plan’ that provides a structure and system for the delivery and oversight of clinical care. The document guides assessment, planning implementation, monitoring and evaluation of clinical care. Despite this some consumers did not have assessments or interim care plans in place at the time of the visit.

The Assessment Team also considered the service had not demonstrated are comprehensive awareness of what a relevant diagnosis is for specific classes of psychotropics. The psychotropic register did not list relevant diagnoses for certain classes of prescribed psychotropics.

There is a policy and process in place to guide all staff in responding to the abuse of older people. All incidents of alleged or suspected abuse are entered into the electronic system. Service managers do not report discretionary incidents if they meet the requirements. There is evidence of comprehensive discretionary reporting with an approach to investigation that matches the way incidents that are reportable are managed. Staff were very familiar with this process. An example of this was staff explained that all incidents reported by a consumer that were caused by the behavioural psychological symptoms of dementia that the consumer experienced were reported in incident forms each time and the registered nurse was notified.

There are several policies that ensure consumers are supported to live the best life they can. Staff were able to explain how confidentiality, privacy and maintaining the dignity of the consumers through respectful interactions were normal business for them.

A residential care summary of high impact and high prevalence incidents is presented to the Quality Safety and Risk subcommittee of the board quarterly, and weekly clinical meetings discuss and monitor clinical incidents and risk at the service.

In response to the Assessment Team’s finding the approved provider submitted additional information about the risk management systems and practices in place at the service. The approved provider also referenced the information it submitted in response to other requirements and specific gaps identified by the Assessment Team and how these are or have been addressed. Although significant and immediate work has been undertaken by the approved provider, it is acknowledged particularly in relation to Standard 3 Requirements (3)a and (3)b that issues were found at the time of the visit.

I find this requirement non-compliant.

### 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.

**Standard 2 Requirement (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*

**Standard 3 Requirement (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.*

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

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

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

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

**Standard 8 Requirement (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.*

In relation to the above areas for improvement, the approved provider must implement a plan for continuous improvement to ensure the service is able to demonstrate compliance with each requirement under the Quality Standards.