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Performance Report

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**Commission ID:** 7242

**Provider name:** Uniting Church Homes

**Review Audit date:** 9 March 2020 to 11 March 2020

**Date of Performance Report:** 20 April 2020

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Non-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) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | 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** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | 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 Review Audit; the Review 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 Review Audit report received 6 April 2020
* the Assessment Team’s report for Assessment Contact conducted on 5 March 2020.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

The Assessment Team found Requirements 1(3)(a), 1(3)(b) and 1(3)(f) in relation to Standard 1 Consumer dignity and choice not met. Based on the Assessment Team’s report and the Approved Provider’s response my finding differs from the Assessment Team and I have found the service Non-compliant with Requirement 1(3)(a) and 1(3)(f) and Compliant with Requirement 1(3)(b). I have provided reasons for my decision below.

The Assessment Team found the majority of consumers and their representatives interviewed confirmed consumers are treated with dignity and respect. Consumers confirmed the service involves them and others they wish to be involved in making decisions about their care, including where risks are involved, and staff respect their choices. Consumers confirmed their privacy is supported and respected and they are provided information relevant to their care which is current, accurate and easy to understand.

The Assessment Team found the service has comprehensive policies and procedures to support consumer choice, cultural safety and the management of risk. However, staff practice was not in line with the organisation’s expectations or the Quality Standards, including not demonstrating treating each consumer with dignity, respect or each consumer’s unique identity and needs were valued and understood by staff in line with consumers’ documented needs and preferences. Observation of staff practice showed consumer information was not always kept in a secure and confidential manner.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team found not all consumers were treated with dignity and respect and consumers’ individual identities, culture and diversity were not valued. Evidence relevant to my decision included:

* Observation during Assessment Contact conducted on 5 March 2020 showed a vulnerable consumer in a comfort chair was left in a public area with their legs, lower torso and continence aids exposed.
* Written posters observed during Assessment Contact conducted on 5 March 2020, in the dementia support area of the service use disrespectful terminology and refer to consumers as “Dementia Residents”. Management acknowledged the posters as not appropriate and removed them following feedback from the Assessment Team.
* Staff did not demonstrate respectful or dignified language or understanding of individual consumer’s needs in relation to consumers living with dementia, during the Assessment Contact conducted on 5 March 2020 and during the Review Audit. Examples included:
	+ Staff referred to a consumer who appeared to be uncomfortable, including grimacing facial expressions and agitated body movements, as just having behaviours.
	+ Staff isolate one consumer from other consumers due to their behaviours disrupting others and to attend to their “feed”.
	+ Staff confirmed only one staff in the dementia support area for a period of time during the afternoon and this did not impact toileting or continence of consumers as they are all incontinent anyway.
	+ Care staff were aware of individual consumer’s backgrounds and cultures. However, they were unable to demonstrate how they delivered care in line with each consumer’s individual needs.
* One consumer’s documentation identified the consumer as having a specific cultural background and identified specific cultural days of significance. However, the documented care plan did not provide strategies or directives to guide staff on how to support the consumer’s cultural diversity and identity. Staff interviewed were unable to demonstrate how they support or deliver services in line with the consumer’s cultural needs.
* Four consumers were observed to be in bed with lights off in their rooms in the afternoon. Staff interviewed, and handover sheets confirmed the consumers are to remain in bed a number of days a week. However, this directive was not in the documented care plan.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following relevant evidence:

* The service has an organisational comprehensive “Supporting Cultural Safety” policy and procedure and all staff have completed cultural safety training. Following the Review Audit all staff were reminded of their obligations in meeting the organisation’s expectations in relation to the policy and procedure.
* One consumer who was observed to be in a public area in an undignified manner with lower body exposed has been identified in the care plan as preferring “quiet spaces on my own” and is known to be physically agitated including causing disarray to their clothing.
* Four consumers who were observed to be in bed, had current sleep assessments indicating a sleep period in the afternoon would be beneficial. The service had discussed the consumers’ individual needs with staff and the consumers’ representatives and the directives to encourage and support sleep due to declining condition was communicated through handover processes. However, the service did not provide evidence the directions were updated in the consumers’ care plans and a memorandum to staff reminding staff to ensure the results of the sleep assessments were documented and reflected in the care plans.
* One consumer observed to be in discomfort, grimacing and agitated did have appropriate and current pain assessments and care plans in place.
* Following the Review Audit toolbox training was provided to staff relation to “Consumer Dignity and Choice” and the organisation’s expectations of staff.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has a comprehensive system supported by organisational policy and procedures and staff training program to guide staff in delivering care and services to consumers in a manner that is respectful and dignified. The service has processes to identify and direct staff in identifying and valuing each consumer’s individual identities, and to value the diversity of each consumer.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service was unable to demonstrate staff practice consistently supported the dignity of consumers or care and services were always delivered in a respectful manner. Two consumers were observed to be in undignified states and staff response was not reflective of consideration of the consumers’ dignity. Staff language and documented signs observed did not demonstrate staff treated consumers living with dementia in a respectful manner or as individuals with unique needs and identities. Documented care plans did not inform staff on strategies to support the dignity and care of consumers who had been assessed as requiring additional periods of sleep and rest in their rooms. Staff interviewed were unable to demonstrate examples or strategies of how they support and provide care which is unique and reflective of each consumer’s identity and cultural needs in line with the service’s expectations or the consumers’ documented needs.

I acknowledge the service has implemented appropriate actions to address the deficits in staff practice identified including further staff education and reminders to staff in relation to the organisation’s expectations of treating each consumer with dignity and respect. However, at the time of the Review Audit and Assessment Contact the service did not demonstrate staff treated each consumer with dignity, respect or each consumer’s unique identity and needs were valued and understood by staff.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

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

*Care and services are culturally safe.*

The Assessment Team found the service identifies and documents information in relation to consumers’ cultural heritage, preferences and needs. However, the service could not demonstrate how the information is incorporated and used to deliver consumers’ care in line with their individual or cultural backgrounds. Examples provided by the Assessment Team relevant to the decision included:

* One consumer’s documentation identified the consumer as having a specific cultural background and identified specific cultural days of significance. However, the documented care plan did not provide strategies or directives to guide staff on how to support the consumer’s cultural diversity and identity. Staff interviewed were unable to demonstrate how they support or deliver services in line with the consumer’s cultural needs in relation to cultural days and events.
* Staff interviewed could not provide an example of a current consumer who requested a preference for male or female staff to attend to their needs or of a current consumer which required support in maintaining personal relationships. Staff confirmed consumers’ sexuality or preferences for intimate relationships are not identified or recorded.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following relevant evidence to demonstrate the service has a system to provide care and services to consumers which is culturally safe:

* The service has an organisational policy and procedure “Supporting Cultural Safety” which is comprehensive and provides guidance to staff in delivering care and services which supports the cultural safety of individual consumers. All staff have attended annual cultural safety training in relation to implementing the policy and procedure.
* The policy and procedure provide directions and guidance in relation to identifying and supporting consumers’ individual cultural needs including preferences in relation to the provision of care, supporting personal relationships and consumers’ sexuality.
* The service has a detailed assessment and plan in place for one consumer which includes their cultural, spiritual and family history, background and current preferences. The plan identifies the consumers’ culture and provides directives to staff on how to support the consumer including consideration of current preferences and barriers. The consumer is provided weekly spiritual support in line with their current preference as per consultation with the consumer and their family. The service identified barriers to attending and celebrating cultural and celebration events due to a preference of remaining in their room. The plan provides alternatives to support the cultural history of the consumer through music, television and reading materials in line with their culture.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has demonstrated a comprehensive system supported by organisational cultural safety policy and procedures including staff training. The procedure directs the identification of each individual’s historic and current preferences in relation to cultural, spiritual, relationship and sexuality needs. Documentation provided shows the service has identified and documented a plan to support individual consumer’s cultural needs.

The one consumer identified by the Assessment Team as not having their cultural preferences supported by the service does have an appropriate assessment and care plan completed including strategies for staff to support their preference in relation to their cultural background including where current barriers impact on the attendance and celebration of cultural events. The consumer’s care plan reflects the consumer’s current preference of what is important culturally and spiritually to them which includes regular religious and spiritual support and ongoing support and visits from family.

Staff interviewed during the Review Audit were unable to demonstrate specific examples of strategies used to support individual consumer’s needs and preferences that support their unique identities and culture. The staff were unable to demonstrate strategies used to support the consumer’s preference in celebrating the specific cultural events used as an example by the Assessment Team. I have addressed the deficit identified by the Assessment Team in staff knowledge of individual consumer’s identities and strategies to support individuals in Standard 1 Requirement 1(3)(a). While the staff did not demonstrate specific strategies to support cultural needs of consumers, they did show an understanding of consumers’ cultural and individual backgrounds.

Based on the summarised evidence above, I find the service Compliant in this Requirement.

### 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) Non-compliant

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

The Assessment Team found the service did not demonstrate each consumer’s personal information is kept confidential. Relevant examples to my decision include:

* The Assessment Team observed confidential consumer information in relation to medications left visible and accessible in public areas of the service on three occasions during the Review Audit.
* The Assessment Team observed doors to the staff office with consumers’ confidential information displayed on boards and in documents accessible and visible.
* Management acknowledged the observations and would follow up with staff.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following relevant evidence to demonstrate consumer information is kept confidential:

* The service has an organisational “Documentation and Information Policy” which stipulates the service’s commitment to protecting consumer information.
* The service is in the process of producing further information security policies to ensure information confidentiality.
* The service in response to the observations made by the Assessment Team completed a memorandum to staff requesting all staff to be more diligent in the management of consumers’ confidential information.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has a comprehensive policy and procedure to ensure consumer information is kept confidential. However, at the time of the Review Audit observations show staff practice was not in line with the service’s policy and consumer information was not stored in a secure and confidential manner.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Assessment Team found Requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e) in relation to Standard 2 Ongoing assessment and planning with consumers not met. Based on the Assessment Team’s report and the Approved Provider’s response my finding differs from the Assessment Team and I have found the service Non-compliant with Requirements 2(3)(d) and 2(3)(e) and Compliant with Requirements 2(3)(a) and 2(3)(c). I have provided reasons for my decision below.

The Assessment Team found the majority of consumers and representatives confirmed they are partnered and involved in the ongoing assessment and planning of consumers’ care and services. Consumer representatives confirmed they are informed and consulted when incidents or changes occur and are invited to participate in regular reviews of consumers’ care. However, majority of consumers and representatives confirmed they have not seen the consumer’s care plan and did not know they could request to see the care plan.

The Assessment Team found the service has a comprehensive system to ensure consumers’ care needs are assessed and documented in care plans. Assessments and care plans are based on best practice including risk assessments to identify risks to consumers’ clinical health. Documentation shows the service involves other health professionals in the assessment and planning of consumers’ care. Staff interviewed demonstrated knowledge and application of the service’s assessment and planning process including how they communicate and inform consumers and/or their representatives in relation to consumers’ care and incidents. The service has an incident reporting system to identify changes and effectiveness in relation to consumers’ care. However, the service does not consistently reassess consumers’ behaviours following incidents of aggressive behaviours towards other consumers and care plans were not always updated following assessments which identified changes in consumers’ sleep needs.

## 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 assessment and planning was consistently completed including consideration of risks to consumers’ health and wellbeing. Relevant evidence included:

* Consideration of risks associated with loneliness or isolation due to three consumers remaining in their rooms and in bed were not assessed and no documented strategies to manage the risks were recorded in the care plan.
* One clinical staff interviewed was not aware of assessments in relation to isolation being completed for these consumers.

The Approved Provider’s response acknowledges the service requires improvement in relation to the process of assessment and planning documentation. The service acknowledges deficits occurred in completing assessments and updating documented care plans following changes or incidents in relation to consumers’ aggressive behaviours, which were identified in Standard 2 Requirement 2(3)(e) of the Assessment Team’s report for Assessment Contact conducted on 5 March 2020. The service acknowledges the care plans for consumers remaining in bed in their rooms were not updated following assessment which identified the consumers’ required increased rest and sleep periods due to declining health. This deficit in process has been addressed in Standard 2 Requirement 2(3)(e) where I find the evidence to be relevant. The response does provide evidence relevant sleep assessments were completed for the consumers prior to the Review Audit and the changed need was communicated to staff through handover processes.

The service plans to implement the following actions: review process of assessment to ensure assessments are person centred, recent implementation of ‘document at the point of care’ process and regular discussion and review of care plans with consumers and/or their representative when changes occur. The service has reviewed and updated assessments and/or care plans for consumers where relevant as identified in the Assessment Team’s report.

I have considered information in relation to staff practice and comments of putting consumers to bed in their rooms on a routine basis not in line with the documented care plan in Standard 1 Requirement 1(3)(a) and Standard 7 Requirement 7(3)(a). Based on the additional evidence provided by the Approved Provider I consider the issue and comments of staff in relation to putting consumers to bed in their rooms is more relevant to adequate numbers of staff and related to Standard 7 Requirement 7(3)(a) and not a significant deficit in the service’s process of assessing the consumers’ needs in relation to sleep or communicating the assessed need to inform staff on the delivery of care. I have addressed the deficit identified of not updating the care plan following the assessed change in Standard 2 Requirement 2(3)(e) where I feel the deficit is more relevant.

The deficit identified in relation to the service not reviewing, reassessing and updating strategies in response to incidents of consumer aggression has been considered and found non-compliant in relation to Standard 2 Requirement 2(3)(e) where I find the evidence to be appropriately relevant.

The Assessment Team’s report and the Approved Provider’s response confirm other evidence which indicates the service is effectively assessing and identifying consumers’ needs, including consideration of risks. The service uses validated risk assessments to assess and plan for risks in relation to consumers’ nutrition, swallowing, weight loss, falls, pain, skin, pressure injury, continence and sensory loss. Documentation confirmed the assessments had been completed and used to develop care plans including strategies to direct staff in managing the risks.

Based on the summarised evidence 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.*

The Assessment Team found the service did not meet this Requirement in relation to one consumer’s representatives not being consulted in all decisions of day-to-day care identified at the Assessment Contact conducted on 5 March 2020. Evidence included:

* One consumer’s representative confirmed they were involved in initial assessment and planning of the consumer’s care. However, confirmed the service had not consulted with them in relation to the following:
	+ The consumer having meals in a separate area to other consumers.
	+ Suitable clothing in relation to continence needs.
	+ Administration of ‘as required’ medication for agitation on three occasions.

The Assessment Team identified at the Review Audit the service’s planning documents do not reflect who the consumer wishes to have involved in decisions in relation to care. However, all staff interviewed confirmed they were aware of consumers’ contact person and who and when to call them in relation to consultation about consumers’ care. All representatives and consumers interviewed confirmed the service involves and consults with the nominated person in relation to assessment and planning. Representatives stated they are informed of any incidents or changes in consumers’ care and are involved in regular reviews of care.

The Approved Provider’s response refutes the Assessment Team’s recommendation of not met in this Requirement and provided the following evidence:

* The service has a comprehensive system to ensure consumers and/or their nominated representatives are involved in assessment and planning.
* There are documented processes in place to identify who is to be involved in the assessment and planning of consumers’ care.
* Electronic incident and care review forms all have mandatory questions in relation to informing and consulting with consumer and family to ensure staff complete and document this step prior to completion of documentation.
* Consumers and representatives confirmed this process and their involvement in assessment and planning during the Review Audit.
* Evidence provided in response to Standard 3 Requirement 3(3)(a) shows the consumer’s representative was involved in regular reviews of care and had been consulted and consented to the use of ‘as required’ medication when it was initially commenced.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has a comprehensive system to ensure consumers and/or their representatives are involved and partnered in the assessment and planning of consumers’ care and services. The service has inbuilt directives and prompts to ensure staff contact and consult with consumers and/or their representatives when care reviews, changes or incidents occur. Consumers and representatives confirmed they are involved and consulted in relation to assessment and planning and are satisfied with the level of consultation. While one consumer’s representative was not consulted in relation to three aspects of day-to-day care for the consumer, documentation shows ongoing and regular consultation occurs with the representative.

Based on the summarised evidence above, I find the service Compliant in this Requirement.

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

The Assessment Team found the service did not demonstrate current care plans are readily available and communicated effectively to consumers and/or their representatives. Relevant evidence included:

* Nine of 12 consumers and/or representatives interviewed stated they had not seen the consumer’s care plan.
* Three representatives interviewed were not aware they could ask to see a care plan.
* Four care plans viewed were not an accurate reflection of some aspects of consumers’ current care needs including requiring extended rest periods in bed.
* Consumers and representatives confirmed the outcomes of assessment, planning and changes to consumers’ needs are communicated to them and discussed with them regularly.
* Observations show, and staff confirm care plans are available electronically and staff use electronic care plans at the point of care delivery.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and have implemented actions to address the deficits including:

* Consultation with consumers and representatives in relation to communicating outcomes of assessment and planning.
* Training and support strategies for staff to ensure changes are accurately reflected in plans of care and communicated effectively.

The service at the time of the Review Audit did not ensure consumers and/or representatives had access to documented care plans and majority of consumers and representatives confirmed they had not seen the consumer’s care plan.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

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

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

The Assessment Team during Assessment Contact conducted on 5 March 2020, found the service did not demonstrate two consumers’ behaviour assessments and care plans were reviewed for effectiveness following incidents of physical aggression towards other consumers. Relevant evidence included:

* One consumer had six incidents of physical aggression towards other consumers, the service used discretion not to report the incidents due to cognitive impairment. However, the service failed to appropriately review, reassess and update strategies in the care plan to manage the ongoing aggressive behaviours following each incident.
* One consumer had two incidents of physical aggression towards other consumers, the service used discretion not to report the incidents due to cognitive impairment. However, the service failed to appropriately review, reassess and update strategies in the care plan to manage the aggressive behaviours following the incidents.

I find evidence in relation to consumers being left in their bedrooms without documented strategies in the care plan more relevant to Standard 1 Requirement 1(3)(a) and Standard 2 Requirement 2(3)(a). The service has provided evidence the consumers were reassessed as requiring increased rest and sleep periods in the afternoons and had deteriorating health states which had been reviewed by medical officers including being in palliating condition. However, care plans were not updated following changes in the consumers’ health status, sleep and rest needs which had been identified through both assessment processes and through review and consultation with medical officers. The service failed to review the effectiveness of current care plans and failed to update the care plans to reflect the consumers’ changed needs.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following relevant evidence:

* The service provided evidence of ongoing behaviour charting and progress notes of behaviours in relation to one consumer demonstrating behaviour management is reviewed for effectiveness.
* The organisation has comprehensive processes in relation to identifying and reporting of incidents of consumer assaults and compulsory reporting including where discretion not to report is used and all staff have relevant and current training.
* Staff have attended recent training in relation to “Responsive Behaviours”.

Based on the Assessment Team’s report and the Approved Provider’s response I find the organisation has a comprehensive system of review and reassessment including when incidents occur or when changes occur in each consumer’s needs. However, at the time of the Review Audit and the Assessment Contact the service failed to demonstrate it consistently reviewed each consumer’s care and services for effectiveness in response to incidents of aggression or when a consumer’s condition deteriorated requiring a change in sleep needs. Documentation shows care plans were not updated or reviewed for effectiveness and management and clinical staff were unable to demonstrate appropriate reviews or updates to care plans occurred.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team found Requirements 3(3)(a) and 3(3)(d) in relation to Standard 3 Personal care and clinical care not met. Based on the Assessment Team’s report and the Approved Provider’s response my finding differs from the Assessment Team and I have found the service Compliant with Requirements 3(3)(a) and 3(3)(d). I have provided reasons for my decision below.

The Assessment Team found consumers and representatives confirmed consumers receive appropriate personal and clinical care in line with their needs. Consumers confirmed they have access to medical officers and other health professionals when they need them. Consumers and representatives confirmed clinical staff provide appropriate clinical care that is safe and optimises consumers’ wellbeing, including pain management, diabetes management and falls management.

The Assessment Team found the service has comprehensive systems to identify, document and direct staff in the delivery of safe and effective personal and clinical care for consumers. Documentation and interviews with staff and representatives confirmed the service recognises and addresses consumers nearing the end of life and ensure consumers’ comfort and dignity are maintained. Staff interviewed described processes to manage risks associated with consumers’ care including the reporting of incidents and provision of strategies to minimise the impact of risks. However, staff did not consistently document changes or strategies used to manage consumers’ care appropriately in progress notes or care plans.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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 during Assessment Contact conducted on 5 March 2020 the service did not demonstrate one consumer was administered ‘as required’ medication for agitation in line with best practice on three occasions. Evidence included:

* One consumer was administered ‘as required’ medication prior to showering or hygiene on three occasions in the week prior to the visit.
* Documentation did not show evidence the consumer was assessed as having agitation or anxiety prior to the administration of the medication on each occasion.
* Documentation did not show evidence of alternatives tried prior to the administration of medication.
* On one occasion following administration of the medication the consumer’s representative observed the consumer to be drowsy. Staff informed the representative administration had been administered for agitation prior to hygiene care which may have contributed to the drowsy state.

The Approved Provider’s response refutes the Assessment Team’s recommendation of not met in this Requirement. However, the service acknowledges one clinical staff’s practice in documentation following administration of ‘as required’ medication was not in line with the service’s expectations. The service provided the following evidence to demonstrate this Requirement is met:

* The consumer has a comprehensive assessment and care plan which has identified behaviours including agitation and anxiety during the delivery of care, showering and hygiene. Responses to other Requirements in relation to this consumer show the service had consulted with the consumer’s representative in relation to the use of the ‘as required’ medication for agitation when the medication was initially prescribed and reviewed by the medical officer.
* The consumer has been regularly reviewed by the medical officer in relation to behaviours, including agitation and anxiety. The medical officer has prescribed ‘as required’ medication and directed staff to use the medication for signs of agitation and anxiety.
* Medication administration records confirm the ‘as required’ medication is rarely used as the alternative strategies in the care plan are effective.
* It was identified by staff and reported and communicated through the handover process and documentation in the week prior to the visit, increasing agitation and anxiety during showering and hygiene care in the mornings.
* The clinical staff involved in the handover discussions in relation to this behaviour administered the ‘as required’ medications in response to this issue being identified.
	+ The clinical staff confirmed with management they failed to document the reasons and discussions and alternatives tried in the progress notes and did not update the care plan to reflect the new strategy of administering ‘as required’ medication if the consumer was agitated prior to hygiene and showering.
	+ Management have followed up with this staff member in response to this issue.
* The service has an imbedded monitoring process in place including regular medication chart audits and monitoring of the use of psychotropic medications. Administration and effectiveness of psychotropic medications are discussed monthly at the Clinical Quality and Safety Committee.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has a system including assessments and care planning processes which are based on best practice and are used to guide staff in delivering personal and clinical care. The service has demonstrated a comprehensive system supported by clinical governance frameworks to assess, review and monitor the use of psychotropic medications including review by medical officers and specialists. The service acknowledges one clinical staff did not complete appropriate documentation in the progress notes and care plan in relation to one consumer being administered ‘as required’ medication for agitation. However, there is evidence to show the consumer’s agitation during showering in the morning had increased in recent weeks and staff had appropriately identified and reported the increased behaviour to clinical staff. The increased agitation had been appropriately assessed by the clinical staff who administered ‘as required’ medication for agitation in line with medical officer’s prescribed directives. It is acknowledged the new strategy of administering ‘as required’ medication prior to showers to reduce the consumer’s agitation was not documented in the care plan. However, I find it reasonable the administration of the medication on the three occasions was administered in line with the prescribed purpose and was administered for the benefit of the consumer to decrease agitation and to ensure the consumer’s hygiene was attended without causing distress to the consumer and supporting the consumer’s wellbeing.

The Assessment Team identified at the Review Audit and Assessment Contact conducted on 5 March 2020, examples of staff feedback demonstrating there were not adequate numbers of staff resulting in staff practice which was not tailored to consumers’ needs. Examples included high use of agency staff who are not aware of consumers’ needs and do not have knowledge in relation to use of slide sheets, not enough staff in the dementia support area of the service to attend to consumers’ toileting or assist with meals and not enough staff to transfer all consumers each day into comfort chairs so consumers now remain in bed.

Based on the Assessment Team’s report and the Approved Provider’s response I find this evidence to be relevant to Standard 7 Requirement 7(3)(a) and it has been considered in the associated finding of Non-compliance. Staff feedback shows inadequate staff numbers results in poor staff practice in relation to the delivery of care in the dementia support area. However, examples provided did not demonstrate negative impact on the delivery of individual consumer’s personal or clinical care needs in relation to not being safe or effective for each consumer.

Based on the summarised evidence above, I find the service 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.*

### 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.*

The Assessment Team found the service did not demonstrate the deterioration in one consumer’s health condition was recognised or responded to in a timely manner. Relevant evidence included:

* The consumer was observed to have thick mucous on their clothes and to be coughing up further mucous.
* The consumer’s representative confirmed he was concerned about the mucous and had asked for a nurse to come and check the consumer. The representative stated the consumer appeared to have deteriorated in the preceding two days including not smiling as much and refusing food and medications.
* Clinical staff stated it was not a new issue for the consumer to cough up mucous.
* A medical officer reviewed the consumer following the Team’s feedback and recommended the service consider a palliative pathway for the consumer.
* Documentation shows staff recorded refusal of medication on two occasions in three days prior to the visit.
* Staff interviewed were aware of the consumer’s swallowing difficulties and cognitive deficits.
* Staff interviewed demonstrated knowledge and understanding of how to report and respond to signs of deterioration in a consumer’s condition in line with the service’s documented procedures.

The Approved Provider’s response refutes the findings of the Assessment Team and provided evidence to demonstrate the consumer’s condition had been monitored appropriately and the service had identified and consulted with the family in relation to the consumer’s deterioration over a period of time, including being in a palliative state prior to the visit. Relevant evidence included:

* Progress notes a month prior to visit show a medical officer had reviewed the consumer including their ongoing deterioration, pain, variable oral intake, resuscitation and end of life plans and providing palliative care at the service when further deterioration occurs. The review had occurred in consultation with four representatives from the consumer’s family.
* Further progress notes weeks prior to visit show another review from the medical officer of ongoing dribbling which indicated the consumer was not in distress due to this.
* Previous medical officer notes show ongoing twice monthly reviews in relation to the consumer’s health and ongoing consultation with the consumer’s family in relation to deterioration. Issues reviewed and discussed include mucous and saliva in throat and cough, trouble swallowing, cough when feeding, deterioration in communication and cognition, outcomes of speech pathology reviews and acknowledgement of possibility of aspiration and discussion of requiring palliation in the future.
* The consumer was first identified as deteriorating and entering the palliative phase in September 2019 and documentation shows this was reviewed by medical officer and discussed with the consumer’s representatives.
* A referral to palliative care specialists was made following the Review Audit.
* The refusal of medication was documented on missed medication charts to ensure the issues were reported, reviewed and monitored by senior clinical staff.
* The clinical nurse manager completes a review of all changes and deteriorations in consumers’ conditions each day at 11.00am to provide staff with directions and ensure appropriate response occurs.
* Clinical staff were aware of the consumer’s condition and were actively monitoring and communicating with medical staff and clinical manager.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has systems in place to identify and respond to deterioration in consumers’ cognitive and physical condition. The service actively reviews incident reports, including missed medications, has comprehensive handover processes, has daily monitoring and reporting to senior clinical staff and management and monthly clinical governance meetings to review and discuss deteriorating consumers, instigates medical officer reviews in a timely manner and referrals to specialists where required. In relation to the one consumer identified by the Assessment Team I find the additional evidence in the Approved Provider’s response demonstrates ongoing monitoring, medical review and consultation with the family in relation to the consumer’s deteriorating physical and cognitive condition over time. The issues of excessive mucous, coughing during meals and difficulties swallowing were not new issues or signs of deterioration, the issues had previously been identified by staff, reviewed by specialists and medical officers, and communicated and discussed with the consumer’s family. The consumer had been reviewed and assessed by medical officer as being in a palliative phase six months prior to the Review Audit. Regular reviews and discussion in relation to deterioration and palliative care decisions had occurred between the medical officer and the family in the six-month period. The service had identified the consumer’s deterioration, had responded through referral to medical officer and discussion with family, and appropriate ongoing monitoring of the deterioration was occurring.

Based on the summarised evidence above, I find the service Compliant in this Requirement.

### 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 NON-COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

The Assessment Team found Requirements 4(3)(a) and 4(3)(c) in relation to Standard 4 Services and support for daily living not met. Based on the Assessment Team’s report and the Approved Provider’s response my finding differs from the Assessment Team and I have found the service Non-compliant with Requirement 4(3)(a) and Compliant with Requirement 4(3)(c). I have provided reasons for my decision below.

The Assessment Team found consumers and their representatives confirmed consumers receive the services and supports for daily living that are important to consumers’ health and wellbeing and enable them to do the things they want. Consumers provided examples of engaging in activities and being supported to maintain relationships. However, some consumers and representatives stated they didn’t attend activities on the program and don’t have an opportunity to provide feedback about activities. All consumers and representatives confirmed consumers enjoy the food and are able to provide feedback about foods they like and don’t like, and their choices and preferences of food are supported by the staff and the service.

The Assessment Team found the service has a system to identify consumers’ needs and preferences in relation to supports for daily living including social, relationship, spiritual, emotional and food preferences. The service involves others in supporting consumers’ independence and social engagement needs including pastoral care program, volunteers and access to community groups. However, the service does not always effectively engage all consumers in feedback and development of the scheduled activity program to ensure it is meeting all consumers’ preferences. The service did not update or consider changes to the social supports for consumers with changed or deteriorating health needs who spend increased time in their rooms.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-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 did not demonstrate each consumer gets effective supports to meet the consumers’ needs or optimise their wellbeing and quality of life. Relevant evidence included:

* During the Assessment Contact conducted on 5 March 2020, the Assessment Team observed, and staff confirmed four consumers are routinely left in bed all day or for the majority of the day.
* The four consumers’ care plans do not reflect the current practice of the consumers remaining in bed.
* There are no documented needs, goals or preferences in relation to how to support the consumers’ needs, wellbeing and quality of life in relation to remaining in their rooms. There are no social support or activities documented in relation to preventing isolation for the four consumers.
* Consumers and representatives interviewed confirmed there were group activities available to the consumers. However, majority chose not to attend the scheduled activities and did not attend the meetings where activities were discussed and planned.
* Staff responsible for planning and provision of social activities confirmed not all consumers attend activities.
* Staff responsible for provision of one-to-one support activities confirmed the documented activity was usually a quick question and did not reflect quality time spent with consumers, including those at risk of isolation.

The Approved Provider’s response acknowledges the deficits identified in the Review Audit report and have implemented the following actions to address the deficits:

* The care needs of consumers identified in the Assessment Team’s report have been reviewed and updated to reflect and support staff to provide activity and lifestyle interventions in accordance with the consumers’ needs and preferences.
* A new survey has been developed to provide consumers and representatives the opportunity to provide feedback and input into the lifestyle and activity program.
* A review of avenues for consumers to have increased input into the development of the lifestyle and activity program.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service at the time of the Review Audit did not have effective systems to ensure each consumer’s needs, goals and preferences in relation to social and recreational activities were identified and provided to meet consumers’ needs or to optimise their wellbeing and quality of life. Consumers who remain in their rooms and do not participate in scheduled activities were not provided appropriate or effective social supports or interactions. The service did not have effective processes to gather feedback and input from consumers and or their representatives to ensure the planned activity program was developed in consultation with consumers and based on consumer needs and preferences.

Based on the summarised evidence above, I find the service Non-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.*

The Assessment Team found the service did not demonstrate four consumers were supported to participate in their community within and outside the service environment. Evidence included:

* Four consumers were observed to spend majority of time in bed with minimal interaction.
* Care planning documentation for the consumers does not reflect the consumers are provided opportunity to engage in the community or attend activities of interest to them.
* Other consumers provided examples of participating in activities within and outside the service including bus outings, children’s groups attending the service, engaging in social activities with others and going out with family and friends.
* Staff interviewed provided examples of supporting consumers to engage with family and friends and maintain relationships with others.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following evidence to demonstrate the service meets this Requirement:

* The four consumers observed spending time in their beds had recent sleep assessments which identified the consumers as requiring additional rest periods during the afternoon due to deteriorating physical health including palliation.
* The service acknowledges while the assessments had been completed the care plans had not been updated to reflect the change in consumers’ needs.
* At other times during the day the four consumers are engaged in diversional therapy in line with their needs.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has effective processes in place to identify consumers’ social needs and provides supports to assist consumers in participating in social activities. Staff interviewed provided examples of how they support consumers to remain engaged with family and friends and consumers provided examples of engaging in social activities. I find the evidence in relation to the four consumers observed to remain in their rooms without social stimulation has been relevantly addressed in Standard 1 Requirement 1(3)(a) in relation to consumers’ individual identities, Standard 2 Requirement 2(3)(e) in relation to care plans not being updated to reflect an assessed change in sleep needs and Standard 4 Requirement 4(3)(a) in relation to the service not reviewing and updating care plans in relation to social activities following a change.

Based on the summarised evidence above, I find the service Compliant with this Requirement.

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team found the service did not meet Requirement 5(3)(b) in relation to Standard 5 Organisation’s service environment, I agree with the Assessment Team’s recommendation and have found the service Non-compliant in this Requirement. I have provided reasons for my decision below.

The Assessment Team found consumers and representatives confirmed they felt the service environment is safe and comfortable. Consumers and their representatives confirmed the service is well maintained and clean and they have the ability to personalise their rooms. Consumers and representatives confirmed the environment is welcoming and visitors are encouraged.

The Assessment Team confirmed through observation the service environment to be clean, equipment appropriately stored and corridors and outdoor areas neat and uncluttered. Observations show the service provides consumers with single bedrooms with ensuites, and a variety of indoor and outdoor communal living spaces for group and private social activities. However, observation and staff interviews confirmed consumers living in the dementia support unit do not always have free access to outdoor living spaces. Documentation shows appropriately qualified staff are involved in the assessment and provision of appropriate equipment, furniture and fittings to meet the consumers’ needs.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

The Assessment Team found the service does not ensure consumers located in the service’s dementia support unit have free access to outdoor areas. Evidence relevant to my decision includes:

* Observation by the Assessment Team showed doors to the outdoor areas in the dementia support unit were locked.
* Staff interviewed confirmed the doors to the outdoor area were kept locked and consumers could only go out if escorted by staff or visitors.
* Management confirmed the doors to the outdoor area in the dementia support unit should be unlocked to ensure free access to consumers and stated they would follow up the issue.

The Approved Provider’s response refutes the finding of not met in this Requirement and provided the following evidence:

* Staff make an assessment throughout the day in relation to consumers’ access to the outdoor space, and staff have an understanding of the need for both indoor and outdoor activities for consumers.
* Doors to the outdoor area are not routinely locked.
* Staffing levels do not prevent the use of outdoor spaces.
* Management have completed a reminder to staff to ensure the availability of access to the outdoor areas.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service has appropriate outdoor areas for consumers in the dementia support unit to access and use. However, at the time of the Review Audit doors to ensure free access to the outdoor areas for consumers in the dementia support unit were observed to be locked and staff confirmed the doors were locked. The service did not demonstrate the consumers in the dementia support unit could freely move and access the outdoor areas.

The Assessment Team identified the memory support units of the service are a secure environment and key code access is required to freely exit the area and access the other internal areas or exit the service. The Assessment Team discussed this with the service in relation to environmental restraint and not providing consumers in the memory support units free access and movement within the service.

The Approved Provider’s response shows all consumers residing in the memory support units of the service had the secure nature including consumers’ restricted access to other areas of the service communicated and agreed upon by the legal representatives of the consumers as part of acceptance of the room and signing the room agreement. All current consumers in the area entered the service prior to October 2019 when legislative changes occurred in relation to environmental restraint. The service is implementing a new procedure of consent for environmental restraint for new consumers entering the service and the consent process is planned to be implemented for existing consumers in the future. The service’s response to the issue of consumers in the dementia support area freely accessing the internal areas and exit door of the service is reasonable.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement as consumers did not have free access to outdoor areas.

### 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

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

The Assessment Team found most consumers and their representatives confirmed they are encouraged and supported to provide feedback and make complaints. Consumers and representatives confirmed where they have raised concerns the service has responded and followed up on the issues until the issue is resolved. Consumers and their representatives confirmed they are aware of and have access to external complaints mechanisms if they require them.

The Assessment Team found the service has an effective complaint and feedback system and feedback and complaints are identified through a variety of sources and mechanisms. Documentation confirmed complaints are identified, recorded and monitored through a complaints log and complaints have appropriate actions taken to resolve. The service has a documented complaints policy and procedure including the use of open disclosure. Staff and management interviewed confirmed knowledge and application of the service’s complaints processes and provided examples of how they support consumers in raising complaints and feedback and how they forward the feedback to the appropriate person for resolution.

## 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

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

The Assessment Team found the service did not meet Requirement 7(3)(a) in relation to Standard 7 Human resources, I agree with the Assessment Team’s recommendation and have found the service Non-compliant in this Requirement. I have provided reasons for my decision below.

The Assessment Team found consumers and representatives interviewed confirmed the service’s own staff are kind and caring, treat consumers with respect and provide safe and quality care. However, consumers and representatives were not always satisfied there were adequate numbers of staff to attend to consumers’ needs in a timely manner and agency staff were not always knowledgeable in relation to individual consumer’s needs.

The Assessment Team found the service has established systems which are effective in recruiting, training and monitoring staff to ensure staff have the skills and knowledge to perform their roles. However, staff interviewed provided examples where inadequate staff numbers resulted in poor staff practices in relation to the delivery of care in the dementia support unit. Documentation shows the workforce has the required skills and qualifications to perform their roles competently and the range and skill mix of staff is planned and based on consumers’ needs. However, the service does not effectively monitor the timeliness of staff response to consumers’ call bells to ensure it meets the service’s expectations or the consumers’ needs.

## Assessment of Standard 7 Requirements

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

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

The Assessment Team found the service did not demonstrate the number of staff enables the delivery and management of quality care and services. Consumers and their representatives are not satisfied there are adequate numbers of staff to attend to consumers’ need. Staff interviewed provided examples of inadequate staff numbers in relation to attending to consumers’ needs. Relevant evidence included:

Consumer and representative feedback:

* One representative was not satisfied staff had sufficient time to appropriately assist the consumer with meals and there is a high use of agency staff who do not know the consumer or notice changes in consumer’s condition. The representative provided the example of requesting a clinical staff to review the consumer on the day of the Review Audit and having to wait a long time for the clinical staff to attend to them. This was confirmed through Assessment Team’s observation.
* One representative was not satisfied there are sufficient staff to assist the consumer at meal times so the family come in and assist the consumer with meals. The representative also provided examples of there not being sufficient staff in the evenings including the family assisting the consumer with going to the toilet and brushing their teeth prior to settling. The representative stated the consumer often goes to the toilet on their own as staff don’t respond to the call bell in a timely manner. The representative stated they have reported their concerns to management.
* Consumers and representatives said there are not enough staff particularly in the evenings and weekends.

Staff feedback:

* The Assessment Team observed evening meal on 10 March 2020 which showed adequate numbers of staff in each area assisting consumers with meals. Staff interviewed stated this was not normal practice as staff were asked to stay back and assist or come from other areas to assist in the certain areas of the service. Staff allocation sheets showed additional staff were present in one area of the service at meals times during the observation.
* Staff interviewed stated consumers are not routinely toileted if wearing an incontinence aid as it takes one staff to change an aid and two staff to transfer a consumer onto the toilet and staff do not have time to do this in the afternoons. A review of consumers requiring two-assist for transfers confirms 31 consumers require two staff assist.
* Two care staff interviewed stated they reported to clinical staff several months ago they did not have time or enough staff to get everyone who required a mechanical lifter to transfer them from bed up each day. The care staff stated they were directed to leave some consumers in bed on certain days in response to their feedback.
* Care staff said at times there was only one staff in the dementia support units to assist consumers with meals and continence due to staff breaks.
* Care staff reported a high usage of agency staff and the staff feel like they have to do “two people’s job” when they work with agency staff.

Call bell response times:

* Call bell reports confirm staff response to call bells is not in line with the service’s expectation of staff to respond within 10 minutes. Call bell report for the consumer who was not satisfied with call bell response confirms a wait time of 22 minutes for the example provided. Call bell reports confirmed on the day prior to the Review Audit, 22 call bells were not answered within the 10-minute response time and consumers had to wait up to 27 minutes.
	+ Management confirmed they do not routinely monitor call bell reports except in response to complaints. Management stated the call bell system is soon to be replaced.

Agency usage and vacant positions:

* Management confirmed an agency registered nurse has been filling the vacant position of clinical nurse manager since 23 December 2019.
* Management confirmed a registered and enrolled nurse had resigned the preceding week and they are currently recruiting to fill the positions.
* Documentation confirmed 15 nursing shifts and 28 care staff shifts had been filled by agency staff in the month preceding the Review Audit.

The Approved Provider’s response refutes the Assessment Team’s finding of not met in this Requirement and provided the following relevant evidence in response:

* The service’s average agency staff use has been 1.96 per cent of total staff hours. However, the service acknowledges agency staff use has significantly increased since January 2020 to 9.3 per cent of total staff hours.
* The key reasons for increase in agency staff use are due to increase in direct care staff hours and addition of new roles including the clinical nurse manager which has been filled by an agency registered nurse.
* The service has increased staffing hours in response to consumer care needs including in the service’s dementia support unit. Adjusted staff hours include increased care staff hours during meal times and in the afternoon and evening.
* The service has recently recruited staff including eight casual care staff to reduce agency staff use and a further six casual care staff are being recruited. Enrolled nurses, kitchen hands and cleaning staff have also been recruited.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service does have a system to review requirements for staffing hours based on consumers’ needs and appropriate skilled staff are recruited through organisational recruitment processes. The organisation ensures vacant shifts are filled including through the use of agency staff. However, the service’s response has not addressed the feedback from consumer representatives and staff in relation to not having adequate staff numbers to attend to consumers’ needs in a timely manner. The service has not demonstrated effective monitoring of staff practice in relation to staff responding to consumer call bells in a timely manner or in line with the service’s expectations. I acknowledge the service has recently increased staff hours including significant increases in staff hours in the dementia support units. I acknowledge the service has undertaken significant recruitment to reduce the increased use and reliance on agency staff. However, in coming to my decision, I placed weight on the staff feedback indicating staff are taking measures to manage work tasks and consumer care which is not in line with consumers’ needs or reflective of delivery of safe and quality care and services.

Based on the summarised evidence above, I find the service Non-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 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team found the service did not meet Requirement 8(3)(c) in relation to Standard 8 Organisational governance, I agree with the Assessment Team’s recommendation and have found the service Non-compliant in this Requirement. I have provided reasons for my decision below.

The Assessment Team found consumers and their representatives confirmed the service is well run and management are approachable and address issues when they are raised. Consumers and their representatives feel the service engages them in the development of care and services through encouraging their feedback and through regular meetings where information is shared and discussed.

The Assessment Team found the service is supported by the wider organisation’s governing body and board, which actively supports and promotes a culture of safe, inclusive and quality care and services. Management interviewed and documentation viewed confirmed governance systems are in place, supported and monitored through information systems which ensure effective communication from a service level to the governing body. The service has an effective clinical governance framework which includes risk management systems and appropriate guidance to ensure best practice care. However, the service does not effectively monitor the workforce to ensure adequate staff numbers to meet consumers’ needs.

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team found the service did not demonstrate effective organisational governance systems in relation to workforce governance and review of consumers’ behaviours following incidents of aggression where the service used discretion not to report in line with regulatory compliance. Relevant evidence included:

* The service’s governance systems have not been effective in identifying and appropriately actioning feedback from staff and consumer representatives in relation to inadequate staff numbers. The service has an expectation on staff response to consumers’ call bells. However, does not effectively monitor call bell response times to ensure staff practice is in line with expectations or there are appropriate numbers of staff to respond to consumers’ needs in a timely manner.
* The service has an effective system to ensure incidents of physical aggression between consumers are identified and reported in line with legislative requirements of mandatory reporting. However, the service does not consistently review consumers’ behaviour care plans for effectiveness within 24 hours following incidents where discretion not to report an incident has been used.

The Approved Provider’s response refutes the findings of the Assessment Team and provided the following evidence:

* Staff resources are allocated to the service and monitored at a corporate level and ensure there are sufficient staff. Staffing numbers at the service are favourable to the industry average. The organisation regularly reviews incident data, agency use data and complaints data for changes and staff numbers are considered when trends are identified.
* The organisation has a comprehensive governance framework to manage reportable and non-reportable incidents. The service has implemented a computerised tracking system in March 2020 to monitor and manage incidents and to ensure timely actions are taken where required including review of behaviour incidents.

Based on the Assessment Team’s report and the Approved Provider’s response I find the organisation has comprehensive governance systems including policies, procedures and guidelines, which are supported and monitoring through corporate processes. Systems are in place to regularly review the number of staff and identify trends or areas for improvement. However, the systems were not effective in responding to feedback from consumer representatives and staff in relation to inadequate staff numbers or identifying deficiencies in the monitoring of staff practice in relation to response to call bells. The organisation has a structured and effective process to identify and report incidents which require reporting in line with legislative requirements. However, for incidents where discretion not to report was used, the service did not demonstrate evidence of review of the consumers’ behaviour care plans within 24 hours.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

### 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.*

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

* Ensure staff practice supports consumer dignity and is respectful of consumers’ unique individual identities and needs.

Standard 1 Requirement 1(3)(f)

* Ensure consumers’ confidential information is stored appropriately.

Standard 2 Requirement 2(3)(d)

* Ensure consumers and/or their nominated representative have access to accurate and current care plans.

Standard 2 Requirement 2(3)(e)

* Ensure consumers’ care plans are reviewed for effectiveness and appropriately updated following incidents of aggressive behaviours or when assessments identifying a changed need occurs.

Standard 4 Requirement 4(3)(a)

* Ensure consumers and/or their representatives are engaged in providing feedback and consulted in the development of the activity program and planning of group and individual activities.
* Ensure consumers with changed health needs have supports for social engagement reviewed.

Standard 5 Requirement 5(3)(b)

* Ensure consumers in the dementia support unit have free access to outdoor areas.

Standard 7 Requirement 7(3)(a)

* Ensure feedback from consumer representatives and staff is captured and monitored and used to review the service’s provision of adequate numbers of staff.
* Ensure staff practice including response to call bells is monitored and used to review and plan staff numbers to ensure adequate numbers of staff to meet consumers’ needs.

Standard 8 Requirement 8(3)(c)

* Ensure monitoring of workforce governance is effective in ensuring adequate numbers of staff.
* Ensure monitoring of service’s review of consumers’ behaviour management plans following incidents of physical aggression where discretion not to report is used occurs in a timely manner.