Katoomba Views Care Community

Performance Report

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KATOOMBA NSW 2776  
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**Commission ID:** 2279

**Provider name:** DPG Services Pty Ltd

**Site Audit date:** 13 December 2021 to 16 December 2021

**Date of Performance Report:** 4 February 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 13 January 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

The Non-compliance is in relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(d). Reasons for the findings are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement (3)(e) not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirement below.

Consumers and their representatives were not all satisfied the service identifies or supports each consumer’s cultural needs, individual identities and preferences, choices or activities where risks are involved. Consumers were satisfied staff and the service respect consumer’s privacy and personal information is kept confidential.

The organisation has policies and procedures to support consumer dignity and choice including promoting a culture of inclusion and respect. The service has a system to assess, identify and support each consumer as an individual, including to take risks, and plan care that is culturally safe and meets the diverse needs of each consumer. However, the service has not consistently or effectively implemented the organisation’s procedures and consumer assessments and plans are not always completed with consumers or their decision makers to ensure each consumer’s culture, diverse needs or wishes to take risks are identified and supported.

Observation showed staff do not always treat each consumer with dignity and respect. While some consumers were supported to take risks and make choices and decisions about their care, other consumers were not supported, and staff were not aware of consumers current decision maker.

## 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 the service did not demonstrate each consumer is treated with dignity and respect, or that each consumers’ identity, culture and diversity is valued. Evidence relevant to the finding includes:

* Two consumers interviewed were not satisfied staff were aware of or supported their individual identity, culture or diversity, including in relation to their life histories, cultural preferences and grooming preferences.
* The Assessment Team observed consumers not being treated with dignity and respect. Examples included:
  + One consumer walking down the corridor, screaming and undressed.
  + Care staff shouting at a consumer inappropriately in communal areas in relation to their continence.
  + Care staff shouting and swearing at a consumer during the delivery of personal care.
* Documentation confirmed consumers care plans did not reflect their life histories or cultural preferences.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and have implemented actions to address the deficits including consultation with consumers and their representatives, updating consumers assessments and plans to include life histories, cultural preferences and personal preferences and staff training is planned.

The Approved Provider’s response provided clarifying evidence and information in relation to other evidence in the Assessment Team’s report they identified as inaccurate. I acknowledge the supporting evidence and information provided and have therefore not considered those examples provided by the Assessment Team when coming to my finding.

I acknowledge the service has taken appropriate actions to address the deficits identified by the Assessment Team in relation to consumers’ identity, culture and diversity not being supported and staff not treating each consumer with dignity and respect. However, at the time of the site audit the service did not ensure consultation, assessment and planning processes with consumers or their representatives were effective at identifying and communicating the individual and unique cultural and personal preferences of each consumer to ensure care and services were delivered in line with each consumer’s unique identity. Staff practices observed were not supportive of consumers dignity and staff interactions did not demonstrate respect for each individual consumer. Consumer and their representative feedback confirmed staff providing care and services do not understand or value each consumer’s individual, cultural and diverse needs. The service’s own monitoring and governance systems had not identified the consumer feedback or the deficits in staff practice, staff knowledge and assessments and planning not being completed.

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

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

*Care and services are culturally safe.*

The Assessment Team found the service did not demonstrate care and services are culturally safe for each consumer. Evidence relevant to the finding includes:

* One consumer with an Indian background and culture did not have their cultural needs identified, recognised or supported. The service had not considered the cultural needs of the consumer when planning and delivering care and services including; religious services, social supports and activities and food and meal choices.
* Three other consumers or their representatives did not think staff were aware or supported their culturally diverse backgrounds.
* Most staff interviewed could not describe what culturally safe practice was and could not provide examples of how they support consumers with culturally diverse needs and preferences.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and have implemented actions to address the deficits including reviewing and updating identified consumers’ files and planned training for staff in relation to cultural safety. The service has reviewed consumers needs and identified consumers with languages and cultures other than English and plans to implement supports for these consumers after consultation with them and provision of education to staff.

I acknowledge the service has taken appropriate actions to address the deficits identified. However, at the time of the site audit the service did not have an effective system to ensure consumers with culturally diverse backgrounds and needs were recognised and provided care and services in a culturally safe way. The service has policies and procedures to guide staff in culturally safe care and has assessment and planning processes to identify and communicate the culturally diverse needs of consumers to the staff delivering care and services. However, these systems and processes were not being effectively implemented by staff and monitoring and governance systems had not identified the deficit in staff practice. Consumer and staff feedback confirmed consumers are not all receiving care and services that are culturally safe and staff do not have the knowledge and information to provide care and services in a culturally safe manner.

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

### Requirement 1(3)(c) Non-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.*

The Assessment Team found the service did not demonstrate each consumer is supported to exercise choice and independence, specifically in relation to others involved in their decision making and maintaining relationships. Evidence relevant to the finding includes:

* Three consumers did not have up to date information on their decision-making capacity, who else was involved in their decision making, including consumers with guardianship arrangements in place not having current contact details.
* Four consumers or their representatives interviewed provided examples of the service not supporting consumers to exercise decisions or maintain relationships including in relation to care and activity choices and maintaining contact with loved ones during restricted visiting.
* The service initiated a program for staff to support consumers during restrictive visiting and additional phone and video conferencing facilities.
* Staff confirmed approximately 38 consumers spend majority of their time alone in their rooms. Staff interviewed confirmed they do not have sufficient time to spend with consumers.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and have implemented actions to address the deficits including; consultation with consumers and their representatives on decision making, choices and supporting relationships, updating care plans to reflect consumer decision making and how to support relationships, updating contact details for consumers with guardianship orders in place and providing training for staff on supporting communication and relationships between consumers and people important to them.

The Approved Provider’s response also provided evidence the service had actively contacted and communicated with consumers and their representatives in relation to communication and support to remain connected during restricted visiting periods. Evidence provided showed additional telephone calls and video calls were supported during restricted visiting to assist consumers in maintaining relationships and connections.

I acknowledge the service has taken actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have an effective system to ensure consumers were supported to exercise choice including in making decisions and maintaining connections and relationships. The service did not have current details for each consumer in relation to their decision-making capability or those involved making their decisions, documented and communicated to staff delivering their care. The service’s documentation did not reflect consumers current choices and decisions about care to ensure staff delivering care supported consumers choice. While the service had implemented processes to support consumers in making connections and maintaining relationships these processes were not effective at ensuring each consumer was supported to remain connected and maintain relationships important to them. The service’s monitoring systems were not effective at identifying the deficits as identified by the Assessment Team.

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

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

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

The Assessment Team found the service did not demonstrate each consumer is supported to take risks to enable them to live their best life as consumers wanting to leave the service were not supported and consumers wishing to smoke did not have documentation completed. Relevant evidence included:

* Two consumers who expressed wanting to leave the service to participate in the community were not being supported to do so.
* Three consumers who choose to smoke did not have documentation including ‘dignity in risk’ assessments completed or reviewed in line with the risk policy and procedures.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and provided clarifying evidence and actions taken including updating consumer documentation. The service states one of the consumers wishing to leave the service was assessed as not being suitable to leave due to their cognitive impairment and associated risks. The other consumer has been reviewed and avenues to support them participating in the community are being explored.

I acknowledge the service has reviewed the deficits identified by the Assessment Team and taken actions to update and review the documentation and assessments. However, at the time of the site audit the service did not have an effective system to ensure consumers were supported to take risks to enable them to live their best life. Consumers wanting to participate in the community were not being supported to do so. The risks associated with leaving the service were not discussed in consultation with the consumers and no strategies, supports or risk mitigating processes were considered or implemented to support the consumers to live the life they choose. Consumers who were being supported to take risks associated with smoking did not have their risk assessments completed appropriately including no evidence of discussion of the associated risks, no signatures consenting to the risks and reviews had not occurred in line with the procedure. The service’s monitoring systems were ineffective and had not identified the deficits as identified by the Assessment Team.

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

### 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.*

The Assessment Team found the service does not ensure information provided to consumers or their representatives is communicated in a way that is accurate, clear or easy to understand to ensure consumers or their representatives can exercise choice. Evidence relevant to the finding included:

* One consumer’s representative stated they had trouble understanding some staff and staff had not discussed with them how they communicate with the consumer.
* Consumers had not seen their care plans.
* Representatives were not communicated all details in relation to incidents or wounds.
* Some staff interviewed confirmed a language barrier between consumers and staff.
* Written information is provided in English only.

The Approved Provider’s response provided additional evidence and information clarifying the evidence including some inaccuracies in the Assessment Team’s report. Evidence in the response included strategies staff use to communicate and support information sharing with consumers with communication barriers.

The service has processes to provide information to consumers including through verbal and non-verbal communication to support consumers in making choices including in relation to care, food and activities. Evidence in relation to consumers not accessing their care plans and lack of communication with representatives of details of incidents and wounds I have addressed where I find more relevant in other Requirements which I have found Non-compliant including; Standard 2 Requirement (3)(d) and Standard 3 Requirement (3)(b). The evidence provided by the Assessment Team in this Requirement does not sufficiently support a finding of Non-compliance.

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

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

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

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Non-compliance is in relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(e). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement (3)(d) not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirements below.

The service does not effectively complete assessments and plans in line with the organisation’s assessment and planning procedures. Documented assessments and plans are not consistently completed, accurate or reflective of consumers current needs, goals and preferences to inform those delivering care and services. Assessments are not always completed to identify risks or in response to a change or incident. Consultation with consumers and their representatives about consumers preferences does not always result in those preferences being documented. Care plan reviews occur, however are not effective at identifying deficits in assessment and planning and do not result in updates or new strategies being implemented.

Consumers confirmed staff discuss their care needs with them and some consumers are aware and have access to their care plans. However, not all consumers and their representatives were satisfied assessments and planning were effective as consumers did not always receive the care in line with their preferences.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found assessment and planning, including consideration of risks is not always completed to ensure assessments and plans inform the safe delivery of care and services. Evidence relevant to the finding included:

* Three consumers did not have assessments for restrictive practices in use, including environmental and chemical restraint, accurately completed including consent in relation to the risks associated with restraint.
* One consumer with current use of doll therapy did not have assessments and plans completed to inform the safe and effective delivery of care in relation to the doll therapy.
* One consumer did not have a completed care plan on entry to the service in the first 24 hours.
* One consumer did not have appropriate assessments and plans completed following behaviour incidents to identify and inform the management of the associated risks.
* Two consumers did not have appropriate assessments and care plans completed to inform the safe and effective management of risks associated with wounds.
* One consumer did not have assessments completed following a change in mental health to identify and inform the management of the risk.

The Approved Provider’s response acknowledged the deficits identified in the Assessment Team’s report and provided evidence of actions taken or planned to address the deficits. Actions include a review of the restrictive practice processes and assessments and review and update of consumers assessments identified in the Assessment Team’s report. The response included evidence paper-based assessments and plans were available for the one consumer in the 24 hours after entry and further review of ensuring the electronic assessment processes are available and completed on admission are underway.

The response clarified inaccurate evidence in the Assessment Team’s report in relation to one consumers assessment and room placement. Therefore, I have not considered this information in my finding.

I acknowledge the service has implemented actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have an effective system to ensure assessment and planning, including consideration of risks was used to inform the delivery of safe and effective care. The service has an assessment and planning system including risk assessments, however staff were not completing the assessments accurately or consistently to ensure care risks were identified and care plans were updated to inform staff on how to provide care and manage risks. Assessments in relation to restrictive practices and associated risks were not all accurately completed and did not have evidence of consent and consultation with the consumer or their representative. Assessments and care plans were not completed or updated, including consideration of risks, to reflect known risks following incidents or after the development of wounds and did not ensure staff providing care were informed of current strategies to manage the consumers care. The service’s monitoring systems were not effective at identifying the deficits in assessment and planning.

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

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

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

The Assessment Team found assessments and plans did not identify and address the consumers current needs, goals and preferences including in relation to end of life care. Relevant evidence included:

* One consumer’s skin assessment was not accurately completed to reflect the current skin condition.
* One consumer’s care plan did not reflect the consumer’s wishes in relation to end of life care being provided at the service.
* One consumer’s care plan was not updated to reflect their current diabetic management.
* One consumer’s care plan did not reflect their current use of psychotropic medication and had not been updated following a change.
* One consumer’s care plan stated a consumer had an air mattress. However, it was observed no air mattress was in use.
* One consumer’s falls risk assessment was not reflective of their current falls risk.
* One consumer stated they were not involved in advanced care planning.
* Staff interviewed were not able to describe consumers’ current needs and preferences.
* Management confirmed there are processes to ensure assessments and plans are current including regular reviews and updates following changes and providing consumers and their representatives with advanced care plans to complete.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and provided evidence the identified consumers’ assessments and care plans were reviewed and updated to reflect current needs. Restrictive practice assessments and plans are being reviewed and advanced care directives will be reviewed in line with case conferences planned.

I acknowledge the service has taken action to update the consumers’ assessments and care plans as identified by the Assessment Team and have plans in place to review processes for restrictive practice assessments and the completion of advanced care directives. However, at the time of the site audit the service did not have an effective assessment and planning system to ensure consumers’ current needs, goals and preferences including advanced care planning were identified, assessed, documented and communicated to staff delivering care and services. The service had a process of review and updating care plans, however this monitoring process was not effective at ensuring changes to consumers’ needs were assessed and care plans viewed did not reflect current consumers’ needs. Staff were unable to demonstrate consumers current needs demonstrating the assessment and care plan process was not effective at communicating the consumers’ current needs to those delivering the care.

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

### Requirement 2(3)(c) Non-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 demonstrate assessment and planning is based on ongoing partnership with consumers and others as documentation demonstrating consultation was not completed and two consumers representatives were not satisfied with consultation. Evidence included:

* Dignity of risk forms were not consistently completed, consumers had not signed the form and there was no documentation to show discussion occurred.
* Restrictive practice consent forms were not signed by consumers and or their representatives and there was no documentation to show discussion occurred.
* One consumer’s representative provided information to the service in relation to care. However, has not heard anything back from the service.
* One consumer’s representative interviewed was not made aware by the service of the extent of the consumer’s condition.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have reviewed the dignity in risk forms in consultation with consumers and updated them including with consumer signatures. The response provides evidence of review and updates of all restrictive practice processes including review of the consent and authorisation forms in consultation with consumers and or their representatives.

I have also considered evidence throughout the Assessment Team’s report relevant to this Requirement when coming to a finding. Evidence throughout the report shows consumers and representatives are not consistently consulted or involved in assessment and planning following incidents or changes in consumers care needs and other individuals are not always involved or consulted appropriately.

I acknowledge the service has taken action to consult with the consumers identified by the Assessment Team in relation to their assessments and plans associated with dignity in risk and restrictive practices. The service has a process to consult with consumers and or their representatives and involve them and others in the assessment and planning of care. However, at the time of the site audit the service’s consultation processes with consumers, their representatives and others, was not effective. Consultation was not occurring in line with procedures and assessments and care plans were not updated to reflect consultations when they did occur. There was no documented evidence of consultation, discussion and consent from the consumer or their representatives when assessing and planning for the use or restrictive practices or where consumers were choosing to take risks.

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

### 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.*

The Assessment Team found the service did not ensure outcomes of assessment and planning are effectively communicated to the consumer or in a format that is always readily available. Evidence included:

* The service has an electronic assessment and planning system and care plans are reviewed three monthly and the outcomes discussed with the consumer or their representative.
* A staff was observed to share consumer information through a paper-based form during the audit as the electronic system was not working.
* Two consumers stated they had seen their documented care plan.
* One consumer’s representative stated the outcome of strategies they suggested had not been communicated to them.
* One consumer’s representative stated they had not been adequately communicated the extent of the consumer’s condition.

The Approved Provider’s response states the service’s electronic and care planning system was working at the time of the site audit. The response states lists are printed from the care plan system and used by care staff where care is provided. The service has a regular care plan review process where assessments and plans are communicated with consumers. The response shows the service is reviewing the care plan review and communication process and has undertaken communication and reviews with consumers identified throughout the report.

I acknowledge the service has an assessment and care planning system which enables staff to have access to the care and services plan where care is delivered. Management confirm systems are in place for regular discussions with consumers or their representatives in relation to care being delivered. Two consumers confirm having access to a care plan. There is insufficient consumer feedback evidence in the Assessment Team’s report to support the finding that outcomes of care plans are not communicated to consumers or that consumers do not have access to care plans. I find evidence in relation to consumers’ representatives not being satisfied with communication about consumers condition and strategies has been appropriately addressed and used in more relevant Requirements where Non-compliance has been found.

Based on the summarised evidence above, I find the service Compliant with 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 found the service did not review care and services for effectiveness when circumstances changed or when incidents impacted on the needs of consumers. Consumers care plans were not reviewed, updated or changed appropriately following changes in consumers’ needs including in skin integrity, wounds, weight changes, following falls and behaviours. Evidence relevant to the finding included:

* One consumer’s nutritional care plan had not been reviewed for over five years.
* One consumers leisure and lifestyle care plan had not been reviewed in over two years.
* One consumer with significant dietary, nutritional and behavioural needs has not had the care plan reviewed and updated for effectiveness.
* Multiple consumers’ wounds and skin integrity assessments and plans are not updated accurately to reflect current needs.
* Multiple consumers’ mobility and pain assessments and plans are not consistently updated following falls.
* Multiple consumers’ assessments and plans are not updated following weight changes or significant weight loss.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have implemented actions to address the deficits including; review of consumers assessments and plans, comprehensive staff training plan including on assessment of pain, wounds and post fall assessments.

I acknowledge the service is taking appropriate action to address the deficits in assessments not being reviewed and updated following incidents and has implemented training for staff to ensure assessments are completed accurately and appropriately in the future. However, at the time of the site audit the service was not ensuring consumers’ assessments and plans were reviewed regularly for effectiveness including following incidents or changes in consumers needs. Staff were not completing and updating consumers’ assessments and plans consistently, accurately, appropriately or in line with procedures following incidents or changes in consumers needs. The effectiveness of strategies to manage consumers needs including increased risks following incidents, changes or deterioration were not being assessed and new strategies to effectively manage changes were not being identified through assessments or implemented in care plans. The service’s own monitoring systems did not identify the deficits in assessment and planning including regular scheduled care plan reviews which were not completed effectively.

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Non-compliance is in relation to Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g). Reasons for the finding are detailed in the relevant Requirements below.

Consumers and their representatives were not all satisfied consumers were provided safe and effective clinical care and personal care. Consumers or their representatives confirmed consumer’s pain is not effectively managed and skin breakdown including wounds aren’t managed well. Some consumers were not satisfied other consumer’s with behaviours were managed effectively resulting in ongoing behaviours impacting consumers.

Consumer’s clinical files, assessments, progress notes and plans showed consumer’s clinical care is not managed in line with best practice or in line with consumer needs. High impact and high prevalence risks including pressure area care, pressure injuries, pain, weight loss, falls and behaviours are not effectively assessed, monitored and managed to support the health and wellbeing of consumers. Consumer’s were not always appropriately referred when changes occur.

Staff practice is not in line with best practice or infection control guidelines. Staff confirmed they do not always have time to provide the care consumers require. Observation shows staff were not always providing clinical and personal care to support consumer outcomes including in relation to pain and behaviours.

### 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 each consumer was not receiving personal care and clinical care in line with best practice, tailored to their needs or which optimised the consumers’ health and wellbeing. Deficits identified were in relation to consumers’ wound management and skin care not being delivered in line with best practice resulting in deteriorating wounds, consumers’ pain not being managed effectively and use of restrictive practices not being managed in line with best practice. Relevant evidence to the findings included:

* One consumer was observed to be in severe pain during the provision of care due to existing wounds and skin condition on the legs. Documentation confirmed wounds and skin condition were not assessed and managed in line with best practice and pain was not assessed or managed in line with best practice.
* One consumer was not satisfied their skin and pain were managed appropriately resulting in unmanaged pain. Documentation confirmed pain was not managed in line with best practice and psychotropic medication was administered for pain management without any consideration or assessment of its use a chemical restraint or alternatives to its use documented or trialled.
* One consumer and their representative were not satisfied the consumer’s pain associated with a lower leg condition was managed appropriately resulting in ongoing severe pain. Documentation confirmed a deterioration in the lower leg had resulted in severe pain and pain charting to monitor and manage the pain had not been completed in line with best practice.
* Documentation where restrictive practices is used is not completed in line with best practice. Including; three consumers with environmental restraint did not have documentation signed by the consumer or their representative to show consent, one of the consumer’s did not have chemical restraint documentation signed or updated when the medication was ceased, one consumer did not have any documentation in relation to the use of mechanical restraint.
* One consumer did not have skin risk assessment completed in line with best practice.
* Staff did not demonstrate knowledge and application of best practice in relation to restrictive practices, wound and skin management and pain management.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team as outlined above. The response provided clarifying information which showed inaccuracies in other evidence in the Assessment Team’s report, therefore I have not considered that evidence when coming to my finding for this Requirement. The response provided details of the actions taken and planned to address the deficits identified including; review of restrictive practices procedures, documentation and staff training, review of skin and wound assessment, management and staff training, and review of pain assessment, management, procedures and staff training.

I acknowledge the service has implemented appropriate actions to address the deficits identified in restrictive practices, wound and skin management and pain management. However, at the time of the site audit the service did not have effective systems to ensure each consumer received clinical care in line with best practice, in line with their needs or that optimised each consumer’s wellbeing. Three consumers were experiencing pain which was not identified, assessed or managed effectively by staff. Two consumers had deteriorating wounds or skin integrity and documentation confirmed skin and wound management was not in line with best practice. Restrictive practices were not being assessed, documented or applied in line with best practice to ensure the wellbeing of consumers was optimised. The service’s monitoring systems and clinical oversight were not effective and did not identify the deficits in staff practice resulting in the ongoing deficits in the delivery of clinical care impacting the health and wellbeing of consumers.

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

### 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 the service did not effectively manage high impact and high prevalence risks associated with the care of each consumer. Risks of pressure injuries were not managed effectively resulting in consumers developing pressure injuries. Risks associated with pain, weight loss, nutrition, behaviours and falls were not managed effectively impacting on the health and wellbeing of consumers. Evidence relevant to the finding included:

Pressure injuries, skin and wounds

* One consumer with known high risk of pressure injury developed an unstageable right heel pressure injury at the service which was not identified until it was dark in colour and significant in size. Pressure injury prevention strategies were not implemented and monitoring of skin was not effective. The pressure injury was not managed appropriately after it was identified, and an air mattress was not applied to prevent further pressure or breakdown of the injury. Wound management, monitoring and documentation was not completed in line with best practice and the wound deteriorated. Pain associated with the wound was not managed effectively and signs of pain were not monitored or assessed. The consumers significant weight loss of over 10 per cent of weight in one month and risk of malnutrition was not managed effectively and monitoring of food and fluid intake did not occur. The consumer’s representative was not satisfied the extent of the wound was communicated to them and confirmed the consumer was experiencing pain which was not managed effectively.
* One consumer developed a left heel pressure injury at the service following a change in condition, pressure injury prevention was not effective, and the pressure injury was not managed or monitored effectively with wound assessment describing it as unstageable and necrotic. Skin assessments and management plans were appropriately completed or updated to reflect the pressure injury and required prevention strategies.
* One consumer with known risks associated with their bariatric condition has a deteriorated skin condition and wounds which have not been managed appropriately. The consumers dietary needs and weight management have not been effectively monitored or managed and directives by specialists have not been clearly communicated to those delivering care. The consumers risks of skin breakdown and pressure injuries have not been managed appropriately and prevention strategies such as appropriate mattress and monitoring have not been implemented resulting in ongoing deterioration of skin integrity. Assessments and strategies relating to behaviours were not reflective of current needs.

Behaviours

* One consumer was observed partially dressed, screaming and distressed in the corridor. The consumer’s known ongoing risks of behaviours associated with dementia including faecal smearing, verbal and physical aggression and disturbance have not been managed effectively. Behaviour assessments and plans have not been completed accurately and strategies to manage the behaviours are not effective.
* One consumer living with dementia and actively using doll therapy to manage associated behaviours does not have appropriate assessments and strategies in place in relation to managing the doll therapy.
* One consumer with known behaviours associated with an intellectual disability and acquired brain injury including wandering, intrusive to others space and unwanted sexual and physical behaviours impacting others was not managed effectively and behaviours were ongoing. Staff interviewed confirmed the ongoing behaviours including sexual behaviours. Behaviour monitoring is not appropriately completed and incidents for behaviours of intrusion and spitting and attempting to touch other consumers have not been documented on incident forms. Two consumers confirmed the consumers behaviour impacted on them including disruption and feeling unsafe.
* One consumer with known behaviour risks associated with diagnosis of dementia has not had the behaviours managed effectively. Specialists reviewed the consumer following incidents of aggression impacting other consumers. However, the assessments and management plans were not updated and reviewed to reflect recommendations, activities to prevent behaviours were not implemented and behaviours and signs of pain were not appropriately monitored or managed. The consumer’s representative was not satisfied with the activities and support to manage the behaviours.

Falls

* One consumer had an unwitnessed fall with injury and clinical observations and monitoring were not appropriately implemented to monitor the risks of pain and injury following a fall. Pain charting was not completed when there were signs of significant pain and neurological observations were not completed to monitor for head or other injuries. Three days after the fall a medical officer reviewed the consumer and the consumer was sent to hospital for investigation of pain and suspected fracture.
* One consumer had an unwitnessed fall with injury and clinical observations and monitoring were not appropriately implemented to monitor the risks of pain and injury following a fall. Pain charting and neurological observations were not completed by the service.

The Approved Provider’s response has acknowledged the above deficits identified by the Assessment Team. The response included evidence of actions taken and planned to address the deficits, including; comprehensive review of consumers wounds and wound management by specialists with new strategies and management updated in care plans, comprehensive review of consumers with behaviours impacting others by a specialist with new strategies implemented to manage and comprehensive training on wounds, skin integrity, pain management, falls management and behaviour management to be delivered to staff.

The response confirmed one consumer that developed a pressure injury and had weight loss and pain has died since the site audit. The other consumer with significant pressure injury shows improvement and healing of the wound.

Deficits raised by the Assessment Team in this Requirement in relation to medication storage and documentation I have addressed in Standard 7 Requirement (3)(c) where I find the information to be more relevant.

Deficits raised by the Assessment Team in this Requirement in relation to incidents not being reported I have addressed in Standard 8 Requirement (3)(d) where I find the information to be more relevant.

I acknowledge the service has implemented actions to address the deficits identified by the Assessment Team. However, at the time of the site audit the service was not effectively managing the high impact and high prevalence risks associated with the care of consumers. Three consumers with known risks of skin integrity breakdown or pressure injuries did not have the risks managed effectively. Two consumers developed pressure injuries when appropriate pressure injury prevention strategies and skin integrity monitoring strategies were not implemented and not effective. The pressure injuries were not identified until they were significant and wound management was not consistently managed and monitored and documentation not accurately completed. A third consumer developed worsening skin breakdown and injury as strategies were not implemented, reviewed or managed in line with their known risks. Other risks associated with wounds and skin integrity were not managed including weight loss, malnutrition and pain. Consumers with known risks associated with behaviours impacting on themselves and others did not have the behaviours managed effectively and ongoing behaviours impacting the consumer and other consumers were observed or evidenced through staff interviews and documentation. Risks of injuries and pain following falls were not managed effectively and two consumers were not appropriately monitored for pain and injury following falls where signs of injury and pain were present. The service had not identified or effectively monitored risks and consumers with known risks to ensure the risks were being managed effectively.

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

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

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

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

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

The Assessment Team found the service did not recognise and respond to deterioration or change in consumers’ mental health or physical function in an appropriate or timely manner. The service did not recognise deterioration in skin condition resulting in pressure injuries and did not respond appropriately to consumers with deteriorated mental health. Relevant evidence to the finding included:

* Two consumers did not have deterioration in their skin condition recognised and responded to in a timely manner. Both consumers developed pressure injuries which were not identified until the wounds were of a significant size and dark in colour. Appropriate strategies including air mattresses and monitoring of pressure area care were not implemented in a timely manner to ensure appropriate management of the deteriorated condition. Increased pain secondary to the deteriorated condition was not recognised, monitored or managed. Weight loss for one of the consumers was not followed up in a timely or appropriate manner.
* Two consumers had deterioration in mental health which was not recognised or responded to in a timely manner. One consumer had an incident of attempted suicide which did not result in appropriate or timely response and no actions were taken to assess and manage the consumer’s deterioration in mental health. The representative for the consumer confirmed the deterioration was not managed. One consumer reported a deterioration of mental health to staff over a period of time which was not recognised, reported or responded to appropriately. No follow up assessments or supports were implemented. The consumer confirmed they were not satisfied their deteriorated condition was managed appropriately.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and evidence provided shows appropriate actions have been implemented or planned to address the deficits. Actions include; review of skin and wound care procedures, specialist reviews of current wounds, training on skin and wound assessment and management for staff, training for lifestyle staff and review of lifestyle supports and assessments for consumers.

The response also provided evidence the two consumers with deteriorated mental health had been referred to specialists, one had seen a specialist three times and the other had refused to see the specialist. The service is following up with staff about their response to one consumer’s reports of needing support for their mental health and has identified the care staff reported the concern to nursing staff. The service also provided activity attendance records demonstrating the consumers had participated in activities. Additional assessments and supports have since been completed and are being implemented to support the mental health needs of the consumers.

I acknowledge the service has taken action to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have effective systems to ensure deterioration in consumers mental or physical condition was recognised and responded to appropriately or in a timely manner. Two consumers skin deteriorated significantly developing pressure injuries which were not identified in a timely manner and the deterioration did not lead to an appropriate response to manage the deterioration and change in skin care needs. One consumer had an incident showing significant deterioration in mental health which did not result in appropriate response. While the consumer was referred to and seen by a mental health specialist, the service did not take appropriate actions to implement emotional and social supports for the consumer to manage the deterioration in condition. One consumer reported deterioration in mental health and provided examples of staff not responding or supporting them appropriately. While the staff may have reported the concern to nursing staff there is no evidence to show the nursing staff took appropriate action to assess, monitor and manage the reported deterioration in mental health as reported by the consumer. All consumers identified have required further assessment and strategies to be implemented to manage the deterioration since the deficits were identified by the Assessment Team. The service’s own monitoring systems did not identify the deficits in the staff not recognising and responding to deterioration.

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

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

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

The Assessment Team found the service does not have an effective system to ensure information about the consumer’s condition, needs and preferences is documented and communicated within the organisation and to staff responsible for delivering care. Evidence relevant to the finding included:

* One consumer who resided at the service for only 24 hours prior to their death did not have assessments, information and plans inputted into the electronic care plan system on entry to the service. An email and progress note were completed, however only contained minimal information about the consumers needs. Not all staff responsible for providing care were communicated the information about the consumer.
* Documented information about consumer needs and condition is not consistently accurate or updated in the assessment and care plans to ensure information communicated to staff providing care is correct.

The Approved Provider’s response acknowledges the deficits identified above by the Assessment Team and have implemented actions to address the deficits including; training for staff and review of consumers assessment and planning procedures including on entry in the first 24 hours. The response also clarified and raised concerns with evidence in the Assessment Team’s report which was not raised or verified with management during the site audit. Therefore, I have not considered this evidence in coming to the finding for this Requirement.

I acknowledge the service has taken appropriate actions to address the deficits identified. However, at the time of the site audit the service did not have effective systems to ensure information about the consumers’ needs, condition and preferences were accurately documented or communicated within the organisation or to the staff providing care. Vital information about a consumer’s condition on entry to the service was not communicated effectively to all staff responsible for their care. Evidence and outcomes throughout this report show consumers assessments, plans and information documented on the electronic system is not accurate, not updated and not reflective of consumers’ current needs. Staff and others responsible for care are reliant on this information as it is a key communication tool for sharing information about consumers.

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

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

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

The Assessment Team found the service does not complete timely and appropriate referrals to individuals, other organisations and providers of care and services for consumers when needed. Evidence included:

* Two consumers requiring mental health support were not referred to appropriate specialists. Staff confirmed one of the consumer’s needs specialist support.
* Two consumers with behavioural issues were not referred to specialists appropriately.

The Approved Provider’s response disagrees with the Assessment Team’s findings and provided evidence the four consumers used as examples were referred to and had specialist support within the last 12 months in response to consumers needs. Evidence included; one consumer was reviewed three times by mental health specialist, one consumer was reviewed once and then refused any other mental health specialist support and four consumers have been referred to and reviewed by behaviour specialists.

The response also provides evidence and information the two consumers requiring mental health support have since been referred and reviewed by the organisation’s internal specialists and reports and recommendations have led to new strategies and actions being implemented. Consumers identified in the report with behaviours not managed have also been referred and reviewed by the organisation’s internal specialist and updated strategies and plans have been implemented.

I acknowledge the service has a referral system and referrals to specialists have been made for consumers identified in the report. However, evidence in this Requirement and throughout the report indicates that while the service refers consumers to specialists when an incident or change occurs, the referral is not always timely or reviewed for their appropriateness or outcomes. While one consumer was reviewed on the three occasions by a mental health specialist, the recommendations made of requiring additional social support did not result in further referral to individuals or providers of that social support within or outside the organisation. One consumer who refused when further mental health referrals were offered, did not have any alternative referrals for social and emotional support offered or made to ensure the needs of the consumer were met. Consumers were referred to behavioural specialists, however the referrals did not result in appropriate implementation of the recommendations to ensure the needs of the consumer were met. All consumers identified have had further referral resulting in appropriate review and actions to support the consumers. One consumer identified in Standard 3 did not have a referral to a dietitian following identified weight loss in line with the procedure. Consumers with wounds identified in Standard 3 while most were reviewed by a specialist, the reviews were not always timely.

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

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found the service did not demonstrate practices to minimise infection related risks through standard and transmission based precautions were implemented when a consumer had a suspected skin based infection. Evidence relevant to the finding included:

* One consumer with a current suspected skin based infection receiving treatment and requiring standard and additional infection control precautions did not have the precautions effectively implemented to minimise the risk of infection. Staff were not all aware of the infection or what precautions should be implemented. No signs or personal protective equipment were implemented to prompt staff to use additional precautions. Equipment and staff communication did not occur in a timely manner until after the deficit was raised by the Assessment Team.
* One consumer with a previous skin based infection requiring treatment did not have documentation completed appropriately in relation to monitoring the treatment, progress and outcome of the infection.

The Approved Provider’s response states there was no infection outbreak at the service in relation to this consumer’s skin condition. However, the response includes evidence the service has implemented additional training and information for staff on managing infections.

I acknowledge the service has taken appropriate action following the Assessment Team identifying and raising concerns with the management and implementation of precautions for a suspected infectious consumer. However, at the time of the site audit the suspected infection did not result in appropriate or timely implementation of infection control precautions and staff were not all aware, informed or consistent with how the suspected infection should be treated including what precautions and equipment were required. While there may not have been an infectious outbreak, the service did not demonstrate effective processes were in place including staff knowledge, staff response and provision of timely information and equipment to ensure an outbreak would be managed effectively if one occurred.

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

The Non-compliance is in relation to Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(g). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement (3)(e) not met. However, my finding differs from the recommendation and I find this Requirement Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Consumers are not all satisfied they receive the support and services required to meet their social, emotional and lifestyle needs and preferences or to optimise consumer’s health, wellbeing and quality of life. Consumers were not satisfied they were provided supports to engage in activities of interest to them or that there were sufficient staff to assist them to engage and attend social activities both within and outside the service. Consumers and their representatives were not always satisfied consumers received appropriate emotional supports when consumers required it, including when requested or following consumer incidents of suicidal ideation.

The service has a system to assess, identify and plan each individual consumer’s requirements, needs and preferences for daily living. Activities are planned, and attendance records are completed to assist in monitoring and evaluating the effectiveness of the social engagement. However, lifestyle staff do not always accurately complete assessments and plans, and attendance records are not accurately recorded to reflect the services and supports actually provided.

Observations show consumers, including those living with dementia, were not provided appropriate social engagement and supports to do things of interest to them. Consumers were observed to spend majority of time alone in rooms and when outside their rooms were not supported to engage in activities or social relationships.

Staff confirmed they do not have time to provide the one to one emotional and social supports as required or in line with the consumers assessed needs.

Consumers are satisfied the food and meals provided are of good quality and meet their dietary needs. The service has a system to communicate consumer’s dietary needs to those preparing and delivering meals.

Observations show mobility aids provided to consumers are not cleaned and staff confirm there is no effective process in place to ensure mobility aids such as walking frames and wheelchairs are cleaned regularly.

## 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 does not ensure each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs and preference or optimises their independence, health and wellbeing. Consumers are not satisfied they receive adequate supports and services to meet their needs and staff confirm they do not have the time or resources to provide the services and supports the consumers require. Observations confirm consumers are not supported in their daily living to ensure consumers needs are met or their independence, health, wellbeing and quality of life optimised. Evidence relevant to the finding included:

* Seven consumers and or their representatives stated consumers are not supported to engage in activities of interest to the consumer or to support the consumers quality of life. Examples included:
  + Activities are not suitable or accessible for consumers in wheelchairs.
  + Activities are not suitable or adequate to consumers needs, preferences and abilities.
  + Consumers living with dementia are not engaged or supported in appropriate activities.
  + Staff do not support, engage or encourage consumers to attend and participate in lifestyle activities.
* Staff interviewed confirmed consumers are not always supported to engage in activities in line with consumers needs and preferences. Examples included; staff are too busy to support consumers with activities or one to one engagement and consumers in the dementia support unit are difficult to engage in activities.
* Consumers, particularly in the dementia support unit and level two of the service were observed not engaged in activities and not engaged with lifestyle or other staff throughout the site audit. Consumers were observed alone in their rooms and those out of their rooms were sitting or standing alone and not supported to engage in any activity. Lifestyle staff were observed pre-filling activity attendance and engagement documentation when no activity attendance had occurred. This practice was confirmed when two deceased consumers attendance records showed attendance at activities after they had died.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and provided evidence of actions taken to address the deficits. The response provided evidence and information the organisation has a comprehensive lifestyle and activity support program based on the wellbeing framework which includes training for staff and assessment and planning procedures. Actions undertaken in response to the deficits include; lifestyle survey distributed to all consumers and representatives, reassessment and consultation in relation to consumers’ lifestyle needs, goals and preferences and review of program with staff. The response provides evidence the consumers identified in the Assessment Team report, had participation records of attending activities and did provide some clarification in relation to representative feedback on support for consumers living with dementia. However, the response shows activity and engagement for consumers identified, has been reviewed and reassessed resulting in new strategies and plans being implemented to support consumers wellbeing and quality of life.

I acknowledge the service has an organisation wide comprehensive wellbeing and lifestyle framework with processes to guide staff in identifying and supporting consumers wellbeing and quality of life, including engagement in meaningful activities. However, at the time of the site audit the service was not effectively implementing the framework and consumers were not being adequately or effectively supported to engage in daily living activities of interest to the consumer, in line with their needs or preferences to optimise the consumers’ wellbeing or quality of life. Consumers were observed not to be engaged or supported to undertake activities. Consumers and staff interviewed, and observations confirmed one to one support and engagement with activities was not occurring in line with consumers needs or the expectations of the organisation. Staff confirmed they were not always able to provide the support to consumers in line with consumers’ lifestyle and activity needs as they did not have sufficient time. The service’s monitoring systems including review and attendance records were not effective or accurate at identifying consumers were not receiving services and supports in line with their needs to ensure consumer wellbeing and quality of life.

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

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

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

The Assessment Team found the service was not providing services and supports for daily living which promoted each consumer’s emotional, spiritual and psychological wellbeing. Consumers interviewed, and documentation confirmed some consumers were not provided services and supports resulting in consumers feeling isolated, depressed and at times exhibiting suicidal ideation. The service did not demonstrate services and supports were provided to promote each consumer’s spiritual wellbeing. Evidence relevant to the finding includes:

* One consumer entered the service in July 2021 and had known risks of depression with loneliness being an assessed trigger and a psychiatric specialist involved in care identifying the consumer required social support and visitors to manage. The consumer was unable to leave their room independently and required supports to attend social activities. The service did not demonstrate appropriate or adequate social supports were provided to the consumer, including during periods of visitor restrictions due to Covid-19. The consumer confirmed they did not have anyone to speak to at the service and that staff were too busy to spend time with them. The consumer’s representative confirmed the consumer’s depression and psychological state had worsened after entering the service. The consumer had an incident of suicidal attempt approximately four months after entering the service. No additional supports, psychological reassessment or referrals occurred following the suicide attempt.
* One consumer with known risks associated with a history of mental health and anxiety was observed to be visibly distressed during the site audit. The consumer confirmed they were feeling suicidal and had expressed this earlier and on previous occasions to staff. The consumer felt staff did not care and did not provide adequate time or support to manage their needs. While staff interviewed were aware of the consumers psychological condition, there was no indication in the assessments or plans on the recent feelings of suicidal ideation or how to manage them. No reassessment of depression or consultation with the consumer about their psychological needs had occurred following this change. The service did commence increased monitoring and a referral to the medical officer after the Assessment Team reported the consumers concerns and suicidal ideation.
* One consumer with non-Christian spiritual and religious beliefs confirmed the service had not discussed their spiritual needs with them and no supports or services were provided to support their spiritual needs.
* One consumer with psychological and emotional needs related to the loss of a child did not have appropriate assessments and strategies in place to guide staff in providing appropriate emotional supports.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and have implemented appropriate actions to address the deficits. Actions include referral and review by specialists with updated assessments and strategies in the care plan to direct staff in providing appropriate social, emotional and psychological supports and services. The response provided clarifying information that the two consumers with suicidal ideation had previous interaction and referral with mental health specialists. The consumer with emotional needs relating to the loss of a child had doll therapy in place and staff were aware of the consumer’s psychological needs. The response acknowledges spiritual services have been impacted and reduced due to Covid-19 restrictions and following the site audit spiritual services have commenced on Sundays and are available to all consumers on electronic streaming services if they are unable to attend.

I acknowledge the service has a system to identify, assess and provide supports for consumers’ psychological, emotional and spiritual needs including assessments, referral to specialists and provision of social and spiritual activities. However, at the time of the site audit each consumer was not receiving adequate and appropriate services and supports for daily living to promote the consumer’s emotional, spiritual and psychological wellbeing. Two consumers with known history and risk of mental health conditions including depression and anxiety were not provided adequate supports, impacting on their psychological wellbeing including resulting in suicidal ideation. While the consumers had both had reviews by specialists, the service had not implemented and ensured additional emotional and social supports were implemented or that the psychological condition of the consumers was monitored and managed effectively. Consumers with other spiritual and emotional needs were not adequately assessed and did not have strategies documented to support their needs, with one expressing loneliness and feelings of isolation. While the service has systems to provide spiritual supports and services, there is no evidence alternatives were implemented when restrictions impacted on the delivery of the spiritual supports for consumers.

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

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

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

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

The Assessment Team found consumers were not provided services and supports for daily living to assist each consumer to participate in the community, within and outside the service, have social relationships or do things of interest to them. Consumers interviewed confirmed the service does not support them to participate in social activities or to do things of interest to them and observations confirmed the consumers feedback. Evidence relevant to the finding included:

* Eight consumers or their representatives interviewed gave examples of not being supported to participate in the community within or outside the service, maintain relationships or do things of interest to them. Examples included:
  + Two consumers were not provided adequate support to maintain contact with loved ones during times of visitor restriction.
  + One consumer wanted access to bus trips and more social or group activities with other consumers.
  + One consumer had not been supported to attend a club in the community with his friends.
  + One consumer is not able to attend social areas of the service as is not independently mobile.
  + One consumer wanted to get out of the service but was not supported.
  + One consumer stated staff don’t encourage or support social engagement with other consumers.
* Observations showed minimal interaction between consumers and staff or other consumers during the site audit. A large number of consumers were observed to remain in their rooms on their own throughout the site audit, including for meals. A minimal number of visitors were observed throughout the audit.
* Results from the last representatives survey show family members who telephoned consumers to speak with them were frequently told to call back at a later time.
* Management and staff confirmed a ‘meaningful mates’ program for staff to spend one to one time with consumers was implemented to encourage relationships and engagement. However, staff interviewed confirmed they did not have time to spend the one to one time with consumers in line with the program.
* Some consumers care planning documents had identified consumers activities of interest to them and relationships important to them and one consumer and staff provided an example of one consumer regularly being supported to access a community activity of interest to them. However, other observations and feedback show the care plans were not reflective of what services and supports were provided.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team above and provided evidence of actions taken to address the deficits. The response disputes the validity of some of the consumer feedback as consumers or their representatives have provided them with positive feedback. The response provided evidence of the organisation’s comprehensive framework to identify, support and provide services to engage consumers in relationships, the community and activities of interest to them. Actions undertaken include completion of a consumer and family survey, review of the lifestyle and activity program, review of spiritual services and review of individual consumers lifestyle assessments, needs and preferences. Additional training is planned for all staff in relation to providing social supports. The service had implemented additional communication supports and one to one support programs during times of visitor restriction.

I acknowledge the service is committed to supporting consumers and has implemented comprehensive actions to address the deficits identified. However, at the time of the site audit the service did not demonstrate each consumer was being supported to participate in the community within or outside the service and relationships with loved ones, staff and other consumers were not supported or fostered. Consumers were not being supported to engage in activities of interest to them and were observed to be left alone in their room majority of the time. The service had implemented programs to support consumers engagement with staff and their loved ones, however the service did not effectively implement or monitor these programs to ensure staff were delivering the additional services. While I acknowledge the provider has received positive feedback from some consumers about support provided to consumers, majority of consumer feedback provided to the Assessment Team demonstrated each consumer is not satisfied they are supported, engaged or participating in their communities or with each other.

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

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

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

The Assessment Team found information about the consumer’s condition, needs and preferences in relation to their supports for daily living are not communicated effectively within the organisation or with others where responsibility for care is shared. Evidence relevant to the finding included:

* Lifestyle attendance records are not accurately recording information or communicating information about attendance and engagement at activities as two deceased consumers activity records show attendance at activities after they died. Staff were observed pre-filling attendance and engagement records prior to activities occurring.
* Consumers leisure and lifestyle care plans are not completed or updated. One consumer’s leisure and lifestyle care plan had not been reviewed or updated since 2019. One consumer did not have a plan completed.
* One consumer was marked as attending multiple activities during the site audit when observations show the consumer was in their room during the activity.
* Staff are not communicated important information about consumers current needs and preferences. Staff were not aware of one consumer who had a mental health incident. Staff were not aware of a consumer’s who preference for grooming.

The Approved Provider’s response acknowledged the deficits identified above by the Assessment Team and improvements have been implemented to address the deficits. Improvements include training for lifestyle staff, completion of a consumer lifestyle survey, update and review of all consumers lifestyle and leisure assessments and plans.

I acknowledge the service has implemented appropriate actions to address the deficits and is committed to improving the accuracy and communication of consumer information to support consumer lifestyle and wellbeing outcomes. However, at the time of the site audit information about consumers lifestyle activities and attendance were not accurately recorded or communicated, all care plans and assessments were not completed or updated, and staff were not aware of specific information about consumers current needs.

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

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

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

The Assessment Team found the service has not referred consumers to individuals and other organisations or providers of care in relation to consumers lifestyle, social and spiritual supports. Evidence included:

* One consumer had not attended a music therapist since Covid-19 restrictions had been implemented.
* One consumer wanted to have emotional support on a daily basis.
* Consumers confirmed no volunteers had been involved in the lifestyle program like they used to be.
* Staff and documentation did not demonstrate the involvement of other organisation’s or services and confirmed volunteers could not enter the service without full vaccination due to Covid-19 restrictions.
* Representatives from organisations in the community no longer attended the service as previously arranged.

The Approved Provider’s response acknowledged that Covid-19 restrictions had impacted the volunteers attending the service. However, the response provided additional clarifying information demonstrating one consumer was attending music therapy virtually on a regular basis and one consumer was supported to engage in emotional support regularly with their family and other consumers. The response indicated services previously provided by volunteers such as engagement in group activities were now provided as online and virtual activities for the consumers identified as interested in them. Consumers are regularly referred and reviewed by physiotherapist to ensure independence, exercise and physical activity needs are met and monitored.

I acknowledge the service has been impacted and limited with accessing other organisations and services to support consumers lifestyle and social needs. However, evidence shows the consumers in the examples raised by the Assessment Team have been referred to and given access to additional supports in relation to their needs. There is insufficient evidence from consumer feedback or consumer documentation to show appropriate referrals have not been made to support the Assessment Team’s recommendation.

The deficit in relation to referrals to mental health specialists for two consumers has been appropriately addressed in Standard 3 Requirement (3)(f) which was found Non-compliant where I find the information more relevant as the referrals relate to existing clinical diagnosis.

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

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

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

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

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

The Assessment Team found equipment provided to consumers to support mobility including mobility aides, walking frames and wheelchairs was not clean. Evidence included; observations of mobility aids showed equipment to be visibly dirty, consumers interviewed confirmed they do not have their mobility aids cleaned, staff confirmed they do not know the process for or who is responsible for cleaning mobility aids.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team, however states the organisation has a clear documented procedure for cleaning mobility aids. This procedure has been provided to staff and training and education on cleaning mobility equipment has occurred to address the deficits identified.

Other evidence raised by the Assessment Team in relation to equipment has addressed in Standard 5 Requirement (3)(b) where it is more relevant.

I acknowledge the service has an organisational procedure to guide staff on cleaning mobility equipment. However, at the time of the site audit the service was not ensuring equipment provided to consumers to support their mobility was clean. Observations confirmed the equipment used by consumers was not clean and staff confirmed the service had not implemented and did not have an effective process to ensure the equipment was clean and suitable for consumers to use.

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

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Non-compliance is in relation to Requirement (3)(b). Reasons for the finding are detailed in the relevant Requirement below.

Consumers confirmed they enjoyed the service environment, felt it was clean and well maintained and felt they belonged as the service was homely and they could personalise their rooms. Some consumers felt the environment at times was noisy at night due to other consumers making noise. Consumers were satisfied with the equipment, furniture and fittings at the service. Not all consumers were satisfied they could easily access the outdoors or leave the service.

The service has a system for scheduled and reactive cleaning and maintenance of the environment and equipment, including the engagement of contractors to monitor and manage equipment and safety systems. Staff confirm the reporting of maintenance and documentation confirmed maintenance was completed. Staff confirmed they knew how to report environmental safety issues.

Observation of the service environment showed some outdoor areas were not clean or well maintained and some indoor areas had dirty floors and were cluttered with a malodour. However, observations of the furniture and décor showed warm furnishings with art and decorations throughout the service and consumers rooms which were personalised.

## 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 environment was not observed to be clean, safe and well maintained and consumers were not enabled to move freely both indoors and outdoors. Evidence relevant to the finding included:

* Observations made during the site audit show the service environment was not clean or well maintained. Including;
  + The courtyard tables, chairs, railing and barbeque were dirty, covered in dust and cobwebs and unusable.
  + The service environment was cluttered, and resources and equipment were not stored appropriately or tidily, including used glasses stored on rails outside rooms.
  + The service had an odour of urine and faeces and urine was observed on the floor.
  + Boxes were stored blocking access to handrails.
  + Dementia support unit was unclean including; floors were sticky after cleaning, curtains were dirty and had been pulled off the railing, pain on windows was chipped and a build up of dirt on floors and window frames.
* Fifty nine consumers, living outside the dementia support unit do not have free access to outdoor living spaces as the outdoor access was locked and key coded.
* Consumers and their representatives confirmed they do not have free access to outdoor spaces, cannot freely leave the service and cannot move freely indoors when mobility is impaired due to lack of staff support. One consumer described the service as ‘like a prison’ and another consumer stated they felt unsafe in the environment due to wandering and aggressive consumers.
* Staff confirmed they do not have time to support consumers to access the outdoor areas and consumers who want to go outdoors are not supported to do so. Staff confirmed the outdoor areas are locked and consumers need staff assistance to access them.
* Staff confirmed it is not clear whose responsibility it is to clean the outdoor areas.

The Approved Provider’s response acknowledged the deficits identified in the cleanliness and maintenance of the service environment and implemented immediate actions to address the deficits. Actions included; cleaning of the outdoor environment, removal of broken and unusable outdoor barbeque and equipment, review and update of cleaning schedules and education for cleaning contractors and maintenance staff, toolbox training for staff on hazards and clearing of clutter and immediate review and removal of clutter and hazards.

The response shows the service is reviewing environmental restrictive practices for all consumers and confirmed consumers who are able and want access, have the key code to access outdoors.

I acknowledge the service is committed and has taken appropriate action to address the deficits identified by the Assessment Team. However, at the time of the site audit the service environment was not clean, safe or well maintained. Observations show indoor and outdoor areas were dirty and cluttered and odour was impacting the environment. Floors, furniture and equipment were not well maintained and there were hazards covering hand rails used by consumers. While seven consumers in the dementia support unit had free access to indoor and outdoor spaces, the other 59 consumers could not freely access the outdoors without staff support. Consumers interviewed confirmed they could not freely access the outdoors without staff assistance.

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

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

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

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

The Non-compliance is in relation to Requirement (3)(d). Reasons for the finding are detailed in the relevant Requirement below.

The Assessment Team also recommended Requirements (3)(a), (3)(b) and (3)(c) not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

Consumers and their representatives felt comfortable and encouraged to raise complaints and provide feedback. Consumers and their representatives are aware of complaints processes. However, some consumers and their representatives had provided suggestions or feedback in relation to consumers needs which hadn’t resulted in change.

The service has a comprehensive feedback and complaints system supported by the wider organisation and includes multiple mechanisms to encourage and support consumers in providing feedback. Mechanisms include meetings, feedback forms, online surveys, visitor feedback, verbal feedback and online feedback tools. The organisation ensures complaints information and mechanisms, advocacy services and language services information are available and accessible to all consumers and their representatives including in multiple languages. Surveys are undertaken with consumers with supports and tools to accommodate and gather feedback from consumers with cognitive deficits. Complaints and feedback are supported to be made anonymously where a consumer chooses.

Staff are aware of feedback procedures and mechanisms and support and encourage consumers to make complaints. Staff are directed in the use of open disclosure through organisational policies and procedures including contacting representatives when incidents occur, and things go wrong.

The service has a continuous improvement system supported by the organisation. However, the service is not effectively capturing all consumer feedback to ensure it is used to identify and lead to improvements in the delivery of care and services.

## 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.*

The Assessment Team found while the service demonstrated it encourages consumers and their representatives to provide feedback and make complaints it does not support them in doing so. Evidence included:

* One consumer had raised with staff wanting facial hair removed, which had not been done.
* One consumer stated they raised with staff wanting to leave the service, and this had not been supported.
* One representative stated they raised concerns about the activities not being suitable and nothing changed.
* Consumers and representatives were unsure if feedback they provided staff was passed on or of the outcome of the feedback.
* The feedback and complaints log did not contain the feedback provided by consumers or their representatives to the Assessment Team.
* Consumer meeting minutes noted feedback and suggestions made by consumers.
* Recent survey had been completed identifying consumer feedback which had then been discussed with consumers.
* Staff provided examples of how they support a consumer who has feedback.

The Approved Provider’s response disagrees with the recommendation of the Assessment Team and provided evidence to support the service has a robust and comprehensive system to encourage and support consumers in providing feedback and make complaints in a variety of ways, including those from non-English speaking backgrounds and consumers with cognitive impairment. Evidence included:

* Management have an open-door policy and encourage and support consumers to verbally discuss any feedback and concerns and action those accordingly.
* Consumer feedback forms are available throughout the facility and available in multiple languages.
* The organisation and service have implemented multiple feedback mechanisms in 2021, with outcomes and evidence showing positive feedback received and action taken where concerns raised. Surveys are available in 13 languages and the platform allows for easy to answer questions and pictorial responses for cognitive impaired consumers.
  + Covid-19 response satisfaction survey completed with positive results
  + Consumer satisfaction survey completed with positive results
  + Online reviews completed with positive results
  + Visitor comments automated with visitor log completed with positive results
* Management acknowledges not all feedback has been recorded on the complaints and feedback log. Management are committed to improving the practice of documenting all complaints on the log. However, where complaints are raised by a consumer or their representative progress notes are completed outlining the issue and actions taken. Examples of recent entries where complaints were raised and resolved were provided.

I acknowledge the service has a complaints and feedback system that is supported by the organisation’s broader complaints and feedback framework. The evidence and examples provided in the response show the service has actively sort feedback and complaints from consumers and their representatives in multiple ways and through multiple platforms throughout 2021, including additional feedback mechanisms specifically in response to Covid-19 restrictions. The service supports consumers with cognitive deficits and language barriers to participate in surveys through providing mechanisms in different languages and through pictorial and easy to use methods.

Evidence in the Assessment Team’s report confirms that consumers and their representatives feel comfortable making complaints and providing feedback and have multiple methods to do so including verbally to staff and through meetings. Evidence shows while consumers are encouraged and supported to raise complaints and feedback their verbal feedback made to staff may not always result in a known outcome. However, I find the three examples used by the Assessment Team have been addressed under Standard 2 where the examples are more relevant to deficits in the assessment and planning of consumer care not reflecting consumers current needs or preferences. The service has a feedback and complaints system that encourages and supports consumers to provide feedback and raise complaints.

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

### 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.*

The Assessment Team found consumers were not able to recall being offered advocacy services or information on how to make complaints externally. Staff were unable to provide examples of how they support a consumer with communication deficits to make a complaint and one representative was unsure how staff communicated with a consumer. However, advocacy services, language services and external complaints mechanisms information was displayed and available at the service and in consumer information packs.

The Approved Provider’s response disagreed with the recommendation of the Assessment Team and provided evidence to support the service does ensure consumers and their representatives are aware and have access to advocacy, language services and external complaints mechanisms. Evidence included; advocacy, language services and complaints processes are available at the service, online and in consumer information packs and in multiple languages to ensure access to all consumers and staff all complete complaints and other services training online.

I acknowledge consumers interviewed at the time of the site audit may not have recalled details on how to access advocacy services or external complaints mechanisms. However, the response has provided sufficient evidence to show consumers and their representatives are made aware of and have access to multiple sources of information on how to access advocacy and language services and details on complaints mechanisms. No specific examples or concerns were raised where a consumer has been unable to access advocacy services when required or that consumers with English as a second language have not had family or other supports to provide feedback or communicate their needs.

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

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

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

The Assessment Team found the service did not demonstrate appropriate action is always taken in response to consumer feedback and open disclosure is not consistently used when things go wrong. Evidence included:

Feedback

* One consumer raised issues in relation to accessing outdoors and behaviour management with no evidence of actions taken.
* One consumer’s representative raised an issue about the lifestyle program and was not satisfied action had been taken.
* Two consumers said they feel they can make complaints but don’t see the point as feel like nothing will change.
* One consumer’s representative provided feedback about supports needed for the consumer and did not hear back about the actions taken.
* Staff are aware of complaints processes and provided example of management actioning feedback.

Open disclosure

* A consumer was administered the wrong medication in August 2021. Progress notes indicate a phone call to disclose the incident to the consumer’s representative was made. However, when interviewed the representative stated the consumer told them of the incident and they were not informed by email or telephone from the service of the incident.
* A consumer’s pressure injury was identified as unstageable in November 2021. However, the consumer’s representative was not aware of the extent of the wound and was not clear of the cause of the wound. When the service contacted the representative in December to gain consent for a specialist review of the wound the representative said no and she did not understand the extent of the wound on the right heel.

The Approved Provider’s response disagrees with the recommendations of the Assessment Team as the service was not provided opportunity at the site audit to respond to specific concerns about complaints management. The response provided clarifying evidence to demonstrate how the service actions complaints and uses open disclosure when things go wrong. Evidence included:

Feedback

* The service has a comprehensive system to manage complex and serious complaints when they arise which is supported and monitored through organisational procedures.
* The service completes progress notes when minor feedback and concerns are raised, actioned and resolved.

Open disclosure

* The service has updated policies, procedures and incident forms which direct staff in the use of open disclosure when incidents occur.
* An incident form and progress note dated in August 2021 in relation to the medication incident show the service contacted the representative and informed them of the incident.
* No injury occurred for one consumer as a result of a fall incident. The consumer’s representative was aware of the pressure injury. The service has attempted to contact and further clarify with the consumer’s representative.

I acknowledge the service has a comprehensive complaints management procedure and open disclosure process supported by the wider organisation. The evidence in the Assessment Team’s report in relation to consumers and representatives who raised concerns with the Assessment Team have been addressed in Standard 2 which has been found Non-compliant as consumers preferences and current needs were not being reflected in assessments and plans. I find the issues raised more relevant to the assessment and planning not being effective as the concerns raised were not raised as complaints or feedback with the service but rather as information about the consumers current preferences and needs which should have led to updated and reviewed assessments and plans. The response demonstrates the service does have an open disclosure procedure and incident reports direct staff to contact and inform the consumer’s representative when incidents occur. There is documented evidence showing the service did contact the representative and use open disclosure when a medication incident occurred in August 2021. In relation to the consumer’s representative not being aware of the extent of the wound for another consumer, there is no evidence to support that the representative had not been informed of the wound in line with open disclosure. The wound not being managed appropriately has been addressed in Standard 2 and Standard 3 which have been found non-compliant including in relation to assessment, monitoring, management and communication of wounds not being effective. Based on the weight of the evidence I find the consumer’s representative feedback on the wound more relevant in Standard 2 and Standard 3 and not sufficient to demonstrate the service does not use an open disclosure process when things go wrong.

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

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

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

The Assessment Team found the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Evidence included:

* The service does not always recognise feedback and complaints including feedback and complaints raised by consumers and representatives with the Assessment Team. Examples provided throughout this Standard and throughout the report include: consumers wanting more access to outdoors, consumers not being satisfied with the lifestyle activities, consumer’s representatives wanting more supports for consumers, consumers wanting more cultural supports, consumers wanting assistance with their grooming and consumers providing feedback they have been impacted by other consumers behaviours.
* The service’s feedback and complaints log does not reflect all feedback or complaints made by consumers and their representatives.
* The service couldn’t demonstrate an improvement activity that was a result of consumer feedback.

The Approved Provider’s response disagrees with the Assessment Team’s recommendation and provided evidence of the organisation’s comprehensive feedback processes which lead to the continuous improvement system. The system includes multiple feedback mechanisms, generating data and information reports which are reviewed, monitored and distributed through the service, organisation and board and used to identify areas for improvement. The service has not had any major complaints or external complaints lodged in recent times.

I acknowledge the service has a continuous improvement system supported by the broader organisation’s governance and quality management systems. However, I have considered information and evidence throughout the Assessment Team’s report including consumer feedback identifying issues, staff feedback identifying issues and the Assessment Team’s observations and review of consumer’s files identifying issues. The service acknowledges the issues raised in the report and concerns raised verbally by consumers and representatives are not always documented on the service’s feedback and complaints log. Concerns are actioned when raised and some but not all are documented in consumer’s progress notes. It is noted that similar feedback to the concerns raised by consumers with the Assessment Team have been noted in consumer meeting minutes in September 2021 of wanting more lifestyle activities and in the October 2021 survey of wanting to spend more time in the garden. Staff stated in Standard 7 they have raised concerns with management about staffing levels and improving the quality of care. The service has not accurately documented and captured all consumer, representative and staff feedback to ensure the reports, analysis and data distributed and used by the organisation and service to identify areas for improvement is effective. The service could not demonstrate improvements being implemented based on feedback and complaints by consumers.

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

# 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 five of the five specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e). Reasons for the finding are detailed in the relevant Requirements below.

Consumers representatives were not always satisfied staff had the skills to competently perform their roles. Some consumers were satisfied there were sufficient staff, however other consumers and representatives provided examples of staff being busy, staff not attending to their needs in a timely manner and there not being enough staff there to assist them when needed. While majority of consumers were satisfied staff interactions with consumers were kind and respectful, observations of staff interactions showed staff interactions with some vulnerable consumers were not kind, caring or respectful and staff did interactions did not support each consumer’s identity and diversity.

The organisation has a comprehensive system to recruit, train and monitor staff and implement a roster to ensure appropriate numbers of qualified staff are deployed to deliver care and services. However, the systems were not always effective at the service, and staff competency and performance were not effectively or consistently monitored to identify deficits in staff practice or the effectiveness of training. Staff confirmed there was not always sufficient time or staff to provide consumers with the care and services they required.

## 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 number of members of the workforce deployed does not enable the delivery of safe and quality care and services. Consumers, their representatives and staff provided examples of staff not having time to provide care and services. Relevant evidence included:

Consumer and representatives

* One consumer who is immobile, is not provided the assistance to go downstairs and attend social activities as there is not enough staff to assist him.
* One consumer said there is not enough staff, and staff leave.
* One consumer said there are not enough staff to assist him outside the service.
* One consumer said he throws things down the corridor to get staff attention as there are not enough staff and staff don’t respond to the call bell in a timely manner.
* One consumer said there is a bit of a wait for call bells as staff are busy with other consumers.

Staff

* Staff interviewed stated there is not enough staff to provide effective care to consumers.
* Management confirmed a high turnover of staff recently.
* Care staff stated they don’t have time to provide support to consumers in relation to daily living, lifestyle, one to one support and emotional support.

Documentation

* Rosters show five of the last 14 days prior tov the site audit had shifts hot filled.
* Call bell reports show majority of bells are answered in under 10 minutes. However, a small percentage were in excess of 10 minutes and one of the consumers whose bell was in excess does not allow the staff to turn the bell off until they have provided the care.

I have also taken into consideration evidence and information throughout the Assessment Team’s report when coming to a finding in this Requirement. Relevant evidence includes; observations by the Assessment Team of consumers left unattended, with no activities and with no support or engagement for long periods of time, consumers left in their rooms, only one lifestyle staff for over 60 consumers, clinical and lifestyle documents not being completed appropriately or accurately and no evidence of consumers receiving appropriate and regular pressure area care and consumers with behaviours not managed.

The Approved Provider’s response acknowledges the deficits identified in the Assessment Team’s report, however state the staff turnover is below industry average and a system is in place to review rosters and retain staff. The service has completed a review of staffing at the service and are now recruiting for additional and replacement positions across all areas including lifestyle, clinical, maintenance and care staff. The response shows the service will continue to implement the organisation’s procedures to recruit, train and support staff to ensure rosters are filled appropriately.

I acknowledge the service has taken appropriate actions to address the deficits in staffing and to ensure sufficient staff will be recruited and are deployed to provide care and services to consumers in line with these Standards. However, at the time of the site audit the service did not demonstrate sufficient staff numbers and mix were deployed to ensure the delivery of safe and quality care and services. Consumers report staff not being available to assist them. Consumers were observed to be left alone without staff support available for lifestyle and social engagement. Consumers with behaviours were observed undignified without staff around to assist and consumers reported other consumers behaviours impacting them. Staff interviewed confirmed they are busy and unable to assist and provided examples of not being able to assist with one to one support and social engagement. Staff interviewed raised concerns the lack of staff is impacting on the quality of care and they have raised this with management. Outcomes of Non-compliance as found in Standards 1, 2, 3, 4 and 5 demonstrate the impact of lack of staffing on the care and service delivery for consumers.

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

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

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

The Assessment Team found observations of staff interactions with consumers were not always kind, caring and respectful of each consumer’s identity, culture and diversity. Relevant evidence includes:

* The Assessment Team observed a consumer screaming for help due to pain in their leg, a care staff was observed to tell the consumer to ‘shut up’.
* The Assessment Team observed a staff member shout at a consumer in front of other consumers ‘I want to see in our pants, you’re smelling’.
* Staff advised they do not want to provide care for a consumer who raised concerns about staff and has mental health conditions and therefore the consumer does not receive the care she needs.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and clarify all staff have received training and further training is being implemented for staff on supporting the dignity of consumers and recognising each consumer’s culture and diversity. The service has implemented additional monitoring of staff practice and the interactions with consumers to ensure it aligns with training and expectations.

I acknowledge the service has implemented appropriate actions to address the deficits identified by the Assessment Team. Majority of consumers interviewed were satisfied staff treat them with dignity and respect. However, the observations made by the Assessment Team of staff interactions with consumers show staff do not treat consumers with dignity and respect. A vulnerable consumer was shouted at and sworn at by staff and another staff spoke disrespectfully about a consumer’s continence needs in front of others. Staff practice observed demonstrates the service does not ensure all staff interactions with consumers are kind, caring and respectful of each consumer.

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

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

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

The Assessment Team found the service does not ensure the workforce is competent and have the knowledge to effectively perform their roles, evidence identified throughout the site audit report demonstrates staff are not performing their roles as required. Evidence relevant to the finding includes:

* Consumers’ representative feedback shows not all representatives are satisfied staff are competent or have the knowledge to perform their roles, examples included:
  + One representative stated recently the consumers leg was very swollen and the consumer has been in a lot of pain, nursing staff have not managed the issues.
  + One representative was not satisfied staff have provided the emotional support to the consumer following a suicide attempt.
  + One representative was not satisfied staff were managing the consumer’s pain and deterioration.
* Evidence identified in other Standards indicates staff are not managing consumer’s clinical needs competently, examples included:
  + Staff had pre-emptively signed the S8 medication register.
  + Medication was not stored appropriately or in line with requirements.
  + Skin risk and pressure injury risk assessments were not completed accurately in line with procedures.
  + Pain assessments were not completed when required or not completed accurately.
  + Behaviour assessments and plans were not completed or not completed accurately.
  + Wound charts and assessments were not completed accurately or in line with best practice.
  + Repositioning and pressure area care was not performed or documented appropriately.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and have implemented additional training and clinical education resources to support and build staff’s clinical knowledge and competency. Actions taken and planned include; review and implementation of clinical training, additional clinical educator hours and support, additional care manager to support monitoring and education of clinical staff and specific refresher and additional training on wound and pain management.

I acknowledge the service has a system to onboard qualified staff and provide them with training to perform their roles. However, at the time of the site audit evidence shows staff were not effectively performing their roles, specifically in relation to consumers clinical care. Clinical staff were not competently completing assessments in relation to wounds, skin, pain and behaviours and were not identifying changed consumers needs. The delivery of pain management and pressure injury care were not competently performed by staff resulting in consumers experiencing pain and developing pressure injuries. Consumers’ representatives were not all satisfied staff were performing their roles effectively, impacting on the consumers’ wellbeing. The service has systems in place to train and monitor staff performance and competency. However, these systems were not effective, and the service did not identify deficits in staff competency.

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

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

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

The Assessment Team found the service has processes to recruit and train staff, however they are not effective, and staff are not equipped and supported to deliver the outcomes required by these Standards. Evidence relevant to the finding included:

* Where incidents occurred such as pressure injuries or medication incidents, these did not lead to additional staff training to ensure further incidents or deficits did not occur.
* Staff were provided training on restrictive practices. However, the training was not effective in ensuring restrictive practice documentation and procedures were effectively followed by staff.
* Training has not been effective, and staff are not equipped or supported to deliver outcomes in relation to pain management and behaviour management as identified through outcomes in Standard 3 Requirement (3)(b).

The Approved Provider’s response demonstrates the service has a recruitment, training and monitoring system supported by the wider organisations recruitment and training framework. The response acknowledges deficits in the effectiveness of the training and support for clinical staff and has implemented additional clinical education hours and support and provided a training plan for staff to ensure appropriate training is provided where indicated.

I acknowledge the organisation has a comprehensive recruitment and training framework to ensure qualified staff are recruited and staff are provided training to perform their roles. However, at the time of the site audit deficits in staff skills were not identified and additional training not provided to ensure staff were supported to perform their roles. The training provided was not monitored for effectiveness and staff were not provided the support to deliver the outcomes required by these Standards.

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

### 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 staff performance is not effectively monitored or undertaken on a regular basis to identify deficits in staff practice. Evidence relevant to the finding included:

* Lifestyle staff’s performance is not always monitored and as a result staff were not delivering lifestyle and therapy services in line with consumers need.
* Clinical and care staff performance is not always monitored and as a result staff were not delivering effective pressure area care, wound management or pain management.
* The service has undertaken annual performance reviews with staff and there is some evidence where staff performance issues are identified action is taken.

The Approved Provider’s response acknowledges deficits in the monitoring of staff performance and has implemented actions to address including recruitment of full-time lifestyle officer, increased care manager roles to ensure supervision and monitoring of staff performance and retraining for staff where deficits in performance are identified.

I acknowledge the service has undertaken appropriate actions to address the deficits. The service does have a system supported by organisation procedures to review staff performance on a regular annual basis and when incidents or performance issues occur. However, at the time of the site audit the service was not effectively monitoring the performance of staff and deficits in staff practice were not being identified to ensure staff performance review and management occurred.

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Non-compliance is in relation to Requirements (3)(c), (3)(d) and (3)(e). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirements (3)(a) and (3)(b) not met. However, my finding differs from the recommendation and I find these Requirements Compliant. Reasons for the finding are detailed in the relevant Requirements below.

The service is supported and governed by the wider organisation and has a governing body, the Board, which is accountable for the delivery of care and services and promotes a culture of inclusivity. The organisation has multiple mechanisms to engage consumers in the development, delivery and evaluation of care and service delivery. The service has an effective financial governance system to ensure resources are provided and the service is well maintained.

The service has organisational systems which have not been implemented effectively at the service including in relation to information management, workforce governance, continuous improvement and regulatory compliance. Consumer information is not accurately documented or communicated to ensure safe and effective care delivery. Information in relation to feedback and incidents is not always recorded to identify areas for improvement and incidents are not always management in line with legislative requirements.

The service has a risk management framework including policies, procedures and training. However, staff practice is not consistent with procedures resulting in consumer’s high impact and high prevalence risks not being managed effectively and consumer incidents and neglect not always being identified and actioned.

Clinical governance framework is implemented at the service supported by the wider organisation. However, the service has not implemented clinical governance procedures in relation to the minimisation of the use of restraint in line with organisational expectations and processes.

## 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.*

The Assessment Team found not all consumers are engaged in the development, delivery and evaluation of care and services. The Assessment Team provided three examples of consumers who had communicated to staff their needs, but this had not resulted in the consumers getting the care they required.

The Approved Provider’s response acknowledged the deficits in the three consumers assessment and planning processes and have implemented reviews and case conferences in consultation with all consumers in relation to their assessments and plans. The response does demonstrate consumers had been involved in annual case conferences to discuss their needs. The response also provided additional evidence on the service’s multiple processes for engaging consumers in the development, delivery and evaluation of care and services. Processes included; monthly consumer meetings, monthly lifestyle surveys, surveys and feedback processes.

I acknowledge the service has implemented actions to address the deficits in consumers expressed needs not resulting in changes to their assessments, plans or delivery of care. However, this deficit has been addressed in Standard 2 where I find it is more relevant to the assessment and planning in consultation with consumers. The service does have imbedded systems to engage consumers which were being actively undertaken at the service at the time of the site audit. Meetings were being regularly undertaken and minutes show consumers were engaged and supported to provided feedback and be involved in care and service delivery. Surveys had been undertaken regularly and recently and reports show consumer feedback was recorded and reported. Case conferences and consultation with consumers was occurring, however these were not always effective at resulting in changes and updates to assessments, plans and care.

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

### 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.*

The Assessment Team found the service has an organisation wide governing body comprised of a Board, Chief executive officer and various committees who report to the Board. Systems are in place to communicate to the Board care and service delivery outcomes to ensure the governing body has oversight and information to make decisions. However, the Assessment Team found the service could not demonstrate changes made or driven by the governing body in relation to consumer feedback and deficits identified by the Assessment Team at the site audit. Examples included; consumers with cultural needs not being identified and supported, staff not competently delivering clinical care and behavioural incidents not being managed effectively.

The Approved Provider’s response details evidence of the comprehensive organisational systems in place to ensure the governing body has oversight of each service and is active and responsive at ensuring inclusive, safe and quality care is delivered. The organisation’s governing body is supported by multiple expert committees who use information from the services, the sector and more broadly to inform the governing body. The governing body disseminates information through the various committees and communications to staff, consumers and their representatives. The governing body was informed and has implemented timely and appropriate actions in response to the deficits identified through the site audit including a commitment to provide staff training and additional resources and extensive improvements.

I acknowledge the governing body does promote a culture of safe, inclusive and quality care and services and is accountable for their delivery. The governing body and the organisation have comprehensive systems in place to ensure oversight and action is taken when issues arise. The examples provided by the Assessment Team demonstrate the service was not identifying deficits in assessment, staff practice and delivery of care. These examples of deficits have been addressed in all other Standards and Requirements found Non-compliant throughout this report where they are more relevant to the purpose and intent of the Requirement. The service failed to identify these deficits and therefore information, reports and analysis being communicated to the governing body were not accurate or reflective of actual outcomes at the service to ensure the governing body was informed to enable them to take appropriate action. Where the governing body has been informed of issues, action has been taken and the governing body has taken timely and appropriate action in response to the deficits identified at the site audit. The organisational system and the governing bodies actions demonstrate the governing body is accountable and takes actions where appropriate.

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

### 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 organisation wide governance systems in relation to human resources, information management, continuous improvement and regulatory compliance in relation to incident management. Relevant evidence from throughout the report supporting this finding included:

Workforce governance

* The organisation has a workforce governance and human resource management system including recruitment, training, monitoring and rostering of staff. However, the organisational system was not effective at the service. The service did not effectively monitor staff practice and performance to identify deficits in training or competency. The service did not monitor feedback to ensure sufficient staff were available to provide care to consumers. Non-compliant outcomes in Standard 7 demonstrate workforce governance systems are not effective.

Information management

* The organisation has an information management system including an electronic assessment and care planning system, various communication systems including meetings and handovers and feedback, complaints, incident data and improvement systems to record and monitor data. However, these systems were not effectively implemented at the service. Consumers assessments and plans were not updated, completed or reviewed to ensure consumer information was accurate, complete or communicated. Feedback, complaints and incident information was not consistently documented to ensure accurate information and data was available. Non-compliant outcomes across all the Quality Standards demonstrate information systems are not effective.

Continuous improvement

* The organisation has a continuous improvement system. However, it was not effective at the service to ensure areas for improvement were identified. Consumer, representative and staff feedback and complaints was not always recorded and documented on the feedback register to ensure areas for improvement could be identified. Incidents were not always accurately reported to ensure incident data and reports identified trends and areas for improvement. Monitoring of staff practice was not effective to identify areas for improvement. Monitoring systems including audits did not identify deficits to ensure areas for improvement were identified. Non-compliant outcome in Standard 6 Requirement (3)(d) demonstrate continuous improvement systems are not effective.

Regulatory compliance

* Incidents management systems, including in relation to ‘Serious Incidents’ were not consistently effective. Staff were not always identifying and reporting incidents, including in relation to wounds, neglect and behaviours, specifically a behaviour of attempted inappropriate sexual contact. As not all incidents were reported follow up actions, investigation and consideration in relation to requirements for reporting of ‘Serious Incidents’ was not undertaken in line with new incident management legislation.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided clarifying information in relation to incidents, including confirming the service has now reported the incidents of pressure injuries as incidents of neglect through the serious incident response scheme and follow up did occur for an attempted incident of inappropriate sexual contact. The response provided evidence of actions taken and planned to address the deficits. Actions included; various staff training, training in relation to incident management and serious incident reporting requirements, recruitment of additional staff, increased monitoring and supervision of staff and review and updating of consumers documented information.

I acknowledge the service is supported by wider organisational governance systems in relation to information management, human resources, continuous improvement and regulatory compliance. The service has governance systems in place and staff and management are aware of the systems, policies and procedures and have received training in relation to the systems. However, the service does not consistently follow the organisation’s procedures and has not ensured staff practice aligns with expectations. The service did not demonstrate information management, human resources, continuous improvement or regulatory compliance systems were effective at the time of the site audit based on the evidence and outcomes above.

Consumer information is not accurately gathered, assessed, documented or communicated. The service has not accurately completed feedback and complaints logs or incident logs and date to ensure areas for improvement are identified and other monitoring processes have not identified areas for improvement as identified through the site audit. The service did not identify or consider the identification and development of pressure injuries or attempted sexual contact behaviour as incidents to be recorded, reported or actioned in line with incident management system legislation. The pressure injuries were only reported as neglect and serious incidents after the Assessment Team identified the deficits in the pressure area care and wound management and not within the reporting timeframe requirements. While the occurrence of an attempted sexual contact behaviour was documented in progress notes and followed up by a registered nurse, the staff failed to complete an incident form and did not consider whether it required reporting as a serious incident, therefore the incident was not managed in line with incident management to ensure impacted parties or their representatives were informed or consulted, care plans reviewed for effectiveness.

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

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

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

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

The Assessment Team found the organisation has risk management systems to direct and guide staff. However, the risk management systems have not been consistently implemented or effective and staff are not always following organisational risk management procedures to ensure high impact and high prevalence risks are managed, abuse is identified and responded to, consumers are supported to live their best life or incidents are managed or prevented in line with the incident management system. Evidence relevant to the finding included:

* Consumers high impact and high prevalence risks were not managed effectively. Staff practice was not in line with clinical procedures in relation to the high impact risks of pain, wounds, pressure injuries, falls and behaviours. Assessments were not consistently or accurately completed, clinical care to manage the risks was not delivered in line with consumers needs resulting in consumers having unmanaged risks impacting on their health and wellbeing. Three consumers with known risks weren’t managed appropriately and developed pressure injuries or had deterioration in skin. Consumers at risk of pain due to falls or wounds were not monitored or managed effectively resulting in consumers having unmanaged pain. Consumers with risks associated with behaviours in relation to cognitive deficits were not managed effectively to prevent or reduce behaviours. Consumers with falls were not monitored effectively to identify injuries.
* The service did not identify or respond to neglect of consumers including; neglect in the care of consumers leading to pressure injuries was not identified as neglect.
* Behaviour incidents impacting on consumers are not all reported and recorded, progress notes, charts, observation and feedback indicates multiple consumers have had behaviours including intrusive behaviour, attempted sexual contact, attempted spitting, screaming and wandering in corridor disrobed which are not recorded on incident reports and not followed up in line with incident management systems. Incidents are not reported, actioned or monitored to ensure similar incidents are prevented in line with incident management systems.
* Consumer feedback and observations of consumers show not all consumers are supported to undertake risks, to do the things of interest to them and to live the best life they choose. Consumer feedback included consumers not being able to leave the service or access outdoors or the community and consumers not being provided support to attend activities.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provides actions taken and planned to address the deficits. Actions include; staff and management training on incident management and training on skin, falls, wound, pain and behaviour management.

I acknowledge the service is taking appropriate action to address the deficits identified by the Assessment Team. However, at the time of the site audit the service did not have an effective risk management system. Staff practice was not in line with risk management procedures in relation to incidents, management of high risks, recognising and responding to neglect and supporting consumers to live the best life they can. The services own monitoring systems including audits and incident report analysis did not identify the deficits.

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

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

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

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

The Assessment Team found the organisation has a clinical governance framework. However, the framework including procedures were not consistently or effectively implemented at the service and staff could not demonstrate knowledge or practice in line with procedures and the framework for minimising the use of restraint or antimicrobial stewardship. Evidence included:

* The service has an effective clinical governance framework to guide and support antimicrobial stewardship, however the service didn’t demonstrate infection control procedures were followed for one consumer with a suspected skin infection.
* The service does not consistently use open disclosure, specifically for two consumer representatives in relation to an incident and a wound.
* The service does not ensure the organisation’s restrictive practice framework and procedures are consistently implemented or that staff have knowledge and practice in line with the procedures. Consumers with restrictive practices of chemical, environmental and mechanical restraint did not have assessments, consents and authorisations accurately or appropriately completed. Not all restrictive practices were identified to ensure assessments, consents and authorisations occurred including for environmental and mechanical restraints.

The Approved Provider’s response acknowledges the deficits in restrictive practice procedures not being implemented effectively and have taken action to address the deficit including review of all restrictive practice assessments and authorisations and refresher training for staff. The response states 55 per cent of staff attended restrictive practice training in 2021. However, the response disagrees with the recommendation in relation to open disclosure and antimicrobial stewardship. The response states the service has provided staff training and staff practice is in line with procedures in relation to open disclosure and antimicrobial stewardship and provided detailed evidence in relation to the examples used by the Assessment Team.

I acknowledge the organisation has a comprehensive clinical governance framework and the service had effectively implemented and imbedded procedures and practices in relation to antimicrobial stewardship and examples of antibiotic use and prescribing in line with the procedures were evident in the Assessment Team’s report and the response. The deficit in the management of one consumer’s suspected skin infection and staff practice and knowledge not being in line with procedures and infection control measures not being implemented appropriately or in a timely manner has been addressed in Standard 3 Requirement (3)(g), which was found Non-compliant, where it is more relevant to infection control.

I acknowledge the organisation has an open disclosure policy and procedures which are imbedded into practices at the service. The service has provided staff training on open disclosure and processes for informing consumers or their representatives are inbuilt into incident reports. The two examples provided by the Assessment Team have been addressed in Standard 6 Requirement (3)(c) which was found Compliant for the reasons provided.

I acknowledge the organisation has a minimising the use of restraint policy and procedure. However, the service has not consistently implemented the procedures and staff practice is not in line with procedures in relation to completing assessments, consents and identifying what a restrictive practice is. Restrictive practice legislation was amended in 2021, however only 55 per cent of staff at the service have had training on restrictive practices in 2021. Consumers files viewed who had restrictive practices in place did not have accurate or completed restraint assessments and consent to show the restrictive practice and its risks had been discussed, understood and consented to by the consumer or their representative. The service had not identified the practice of low beds as a restrictive practice for all consumers where it was used, and environmental restraint had not been considered or assessed for all consumers. The service had not followed procedures, did not demonstrate an understanding or application of the minimising of restraint principles or procedures. The clinical governance framework was not implemented as it was intended at the service and therefore not effective.

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

# Areas for improvement

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

Standard 1 Consumer dignity and choice

* Requirement (3)(a) Ensure each consumer is treated with dignity and respect and their identity, culture and diversity is valued. Ensure the service identifies consumers preferences in relation to their unique individual needs and cultures and that staff interactions and treatment of consumers is in line with consumer preferences.
* Requirement (3)(b) Ensure consumers cultural needs are identified in consultation with consumers and staff delivering care and services are informed of the cultural needs and preferences of consumers.
* Requirement (3)(c) Ensure consumers care plans reflect and record current details of the consumers decision making capability, consumers choices and preferences and the details and contact information of other people involved in making decisions for the consumer.
* Requirement (3)(d) Ensure consumers are consulted and those who express to undertake activities involving risk are supported to live the life they choose and to understand the risks involved.

Standard 2 Ongoing assessment and planning with consumers

* Requirement (3)(a) Ensure assessments and plans are completed and accurate in line with the organisation’s procedures including risk assessments when changes occur. Ensure monitoring of assessments and plans is effective at identifying and rectifying deficits in assessments and plans, including consideration and completion of assessments of risk.
* Requirement (3)(b) Ensure assessments and plans are updated and reflective of consumer’s current needs, goals and preferences including advanced care planning where the consumer wishes. Ensure monitoring is effective at identifying deficits and ensuring consumer’s assessment and plans are current.
* Requirement (3)(c) Ensure assessment and planning is done in partnership with the consumer and outcomes of consultation with the consumer and or their representative are recorded in the assessments and plans to inform care.
* Requirement (3)(e) Ensure assessments and care plans are reviewed regularly for effectiveness including when incidents or changes occur and that appropriate updates are made to the plans to ensure consumers changed needs are met.

Standard 3 Personal care and clinical care

* Requirement (3)(a) Ensure each consumer gets safe and effective personal care and clinical care which is in line with best practice and the consumers needs. Ensure staff practice in relation to restrictive practices, wound care, skin care and pain are in line with best practice and the service’s procedures to optimise the wellbeing of the consumer.
* Requirement (3)(b) Ensure high impact and high prevalence risks associated with the care of the consumer are managed effectively. Ensure risks associated with pressure injuries, falls, behaviours and pain are identified, and appropriate assessments and strategies are implemented to manage and minimise the risks. Ensure monitoring of staff practice is effective at ensuring consumers risks are being managed effectively.
* Requirement (3)(d) Ensure deterioration or change in consumer’s physical or mental condition is recognised and responded to appropriately and in a timely manner, including when pressure injuries occur or when incidents or expressions of self-harm or suicidal ideation occur.
* Requirement (3)(e) Ensure information about the consumer’s condition is documented, recorded and communicated effectively to the staff providing care to the consumer.
* Requirement (3)(f) Ensure referrals are completed appropriately to specialists when changes occur and in line with consumers needs.
* Requirement (3)(g) Ensure staff practice and actions to manage consumer infections is in line with infection control management procedures and guidelines.

Standard 4 Services and supports for daily living

* Requirement (3)(a) Ensure each consumer receives effective services and supports for daily living that meets the needs, goals and preferences of the consumer and which optimises the consumer’s health, wellbeing and quality of life.
* Requirement (3)(b) Ensure each consumer receives services and supports that promote and support the consumer’s emotional, spiritual and psychological wellbeing. Ensure consumer’s specific emotional, spiritual and psychological needs are identified through consultation with consumers, incidents, feedback and changes and strategies are implemented effectively including one to one social and emotional support when required.
* Requirement (3)(c) Ensure each consumer is provided the assistance and support to attend and engage in activities of interest to them, activities within and outside the service and social and personal relationships are supported and valued.
* Requirement (3)(d) Ensure information about the consumer’s condition, needs and preferences is accurately and effectively completed and communicated to those involved in supporting the consumer, specifically in relation to consumers activity and social engagement, attendance, assessments and records.
* Requirement (3)(g) Ensure mobility equipment provided to consumers and used by consumers is clean and suitable for use.

Standard 5 Organisation’s service environment

* Requirement (3)(b) Ensure all consumers can freely access both indoor and outdoor environments and that all spaces used by consumers are kept clean and suitable for use.

Standard 6 Feedback and complaints

* Requirement (3)(d) Ensure all feedback is recorded through the feedback system in line with procedures to ensure areas for improvement are identified, monitored and actioned.

Standard 7 Human resources

* Requirement (3)(a) Ensure sufficient staff are deployed to support care and service delivery in line with consumers needs and to meet these Quality Standards.
* Requirement (3)(b) Ensure all staff interactions with consumers are kind, caring and respectful, and support each consumer’s identity, culture and diversity. Ensure monitoring of staff interactions with consumers is effective at identifying deficits in staff practice.
* Requirement (3)(c) Ensure staff are competent in performing their roles including through implementation of effective monitoring, training and review of staff practice.
* Requirement (3)(d) Ensure staff are provided sufficient training where deficits in staff knowledge and practice has been identified. Ensure the effectiveness of staff training is monitored and reviewed.
* Requirement (3)(e) Ensure ongoing monitoring and review of staff practice and performance occurs to identify deficits, areas for improvement and opportunities for further training and support.

Standard 8 Organisational governance

* Requirement (3)(c) Ensure the organisational governance systems of information management, continuous improvement, workforce governance and regulatory compliance are effectively implemented and monitored at the service.
* Requirement (3)(d) Ensure staff practice aligns with the organisation’s risk management framework and procedures including in relation to recognising, reporting and managing incidents, effectively managing consumer’s high impact and high prevalence risks and supporting consumers to live the best life they can.
* Requirement (3)(e) Ensure the clinical governance framework in relation to minimising the use of restraint is effectively implemented and monitored at the service, including providing staff training and ensuring all restrictive practices are identified, assessed and that consultation and consent occurs with consumers or their representatives.