Keith & District Hospital Inc

Performance Report

35 Hill Avenue   
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**Commission ID:** 6197

**Provider name:** Keith & District Hospital Inc

**Site Audit date:** 23 March 2021 to 25 March 2021

**Date of Performance Report:** 18 June 2021

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 30 April 2021.
* Information provided by the Intake and Complaints Resolution Group.
* Information provided by the compulsory reporting team

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Overall, sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. Consumers interviewed confirmed their personal privacy is respected, they are treated with respect and staff support and encourage them to do things for themselves.

Lifestyle, care and clinical staff interviewed provided individual examples of how they support consumer choice so that they live the life they want. They said they support consumers in relation to dignity and respect, their identity culture, and what is important to them, their diversity and maintaining their independence and relationships of choice.

Staff said information is provided to consumers and their representatives, to help them to make informed decisions about the care and services consumers receive.

Consumers are treated with dignity and respect. The service’s recruitment, orientation and training program assist and support staff to promote consumers diversity, culture and dignity of consumers. Clinical and lifestyle staff undertake a range of assessments to identify consumers' culture and diversity care needs. Staff provide care that is centred around the consumer and their personal preferences. Consumers are supported to live the life they want in consultation with staff, their authorised representative and the service.

The service demonstrated how care and services are culturally safe. Each consumer has a care and lifestyle care plan developed in consultation with them or their authorised representative. Each care plan documents what culturally safe means to the consumer, this is based on their cultural, religious and personal preferences

Consumer are supported to make decision about the care and services they receive. Consumers are encouraged to exercise choice and independence, including to make decisions about their own care and the way care and services are delivered; and make decisions about when family, friends, carers or others should be involved in their care; and communicate their decisions; and make connections with others and maintain relationships of choice, including intimate relationships.

The service demonstrated information is provided to each consumer and or their representative that is current, accurate and timely, and communicated in an easy-to-understand way, that enables them to exercise choice.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

The Assessment Team provided information that the service was not able to demonstrate each consumer is supported to take risks to enable them to live the best life they can. One named consumer, who has dementia and severe cognitive deficit did not have his risks associated with smoking effectively identified and managed despite having a Dignity of Risk Support Tool completed. The designated smoking area did not have fire safety equipment. The smoking area does not allow effective supervision of consumers who chose to smoke and require monitoring for safety. The named consumer does not have an effective means to notify staff in the event of an incident. Feedback from the consumer and representative indicates the named consumer is unable to communicate effectively and is not aware of any potential risks posed by smoking unsupervised. Three nursing staff and one care staff said they do not supervise the named consumer when they are smoking.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a diagnosis list, correspondence with representatives, clinical assessments, photographs of the service environment and policies. The Approved Provider does not agree with the Assessment Team’s findings.

In relation to the named consumer, the Approved Provider provided a diagnosis list that corrected errors in the reporting of the diagnosis by the Assessment Team. The Approved Provider acknowledged that there was not a smoking risk assessment conducted to identify potential risks and mitigation strategies. However, they contend that additional evidence provided, including extracts from clinical assessment and progress notes indicated that the named consumer demonstrated a capacity to smoke safely. In relation to the smoking area not being safe, the Approved Provider noted that a fire hose reel was located adjacent to the smoking area.

Following the audit, the Approved Provider has undertaken a range of improvement activities, including a review of the named consumer’s clothing for potential fire risks, a new cognitive assessment has been sourced and implement for the named consumer, the new assessment tool provides for consumers who are nonverbal to be assessed for cognitive decline. This assessment indicated no cognitive decline since the previous assessment was completed. A smoking risk assessment has been introduced at the service and the corresponding policy has been updated. A dignity of risk assessment has been redone to include aspects of smoking in the assessment, and the named consumer’s care plan has been updated. The Approved Provider has relocated the smoking area to the front of the service and consumers who choose to smoke are now able to be supervised by staff within the service. The Approved Provider has communicated with the representative of the named consumer and correspondence indicates that the risks of smoking had been previously discussed where the representative has acknowledged the risk and wishes for the consumer to continue smoking.

I have considered the Assessment Team’s report and the Approved Provider’s response. I note the issues raised by the Assessment Team in relation to the identification of risk for consumers who smoke, however, I also note information provided by the Approved provider in relation to the risk, discussions of risk with the consumer and representative, and acknowledgement of the risks by the representative. I also note the improvement activities undertaken by the Approved Provider since the Site Audit.

Whilst I acknowledge that the Approved Provider did not have a specific smoking risk assessment in place at the time of the audit and that the dignity of risk form did not specifically address all smoking risks, I am satisfied that the Approved Provider was aware of the risks posed to the named consumer, the Approved Provider had established communication and management processes for smoking and that the consumer’s representative was informed of the risks associated with smoking and their wish was for the consumer to continue to smoke. This existing knowledge of the consumer as well as the improvement activities undertaken have addressed the matter of risk in relation to smoking.

I find this requirement is compliant.

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

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

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

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

Consumers and representatives interviewed stated they have had been involved in the assessment and care planning process and can access medical and allied health staff as needed.

Care planning documents showed regular meetings with representatives and consumers and care plans being updated accordingly. Consumer representatives were satisfied with the assessment and planning process.

Staff were able to describe completing assessments in partnership with others which included others, such as Allied health staff, medical staff and other clinical and non-clinical personnel. Staff were able to describe notifying consumers and representatives of outcomes of assessments. Care plans were observed to be accessible in hard copy.

Staff said they review care and services according to a set schedule and when incidents occur. Documentation viewed showed care and service are regularly reviewed.

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

## Assessment of Standard 2 Requirements

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

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Overall, sampled consumers considered that they receive personal care and clinical care that is safe and right for them. Consumers and representatives confirmed they are aware of the care plan and can access this document. Consumers and representatives confirmed they are in regular contact with clinical staff and are informed of the outcomes of assessment and planning.

The service was not able to demonstrate consistent effective management of high impact or high prevalence risks associated with the care of each consumer

The service was not able to demonstrate effective standard and transmission-based precautions to prevent and control infection in relation to COVID-19.

The service was able to demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

The service was able to demonstrate deterioration or changes of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. The service is collocated with an acute hospital and consumers who required acute care are transferred and managed in the acute care setting.

The service was able to demonstrate 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. All consumers at the service have a care plan which is accessible to all staff. Staff were able to describe how they are informed of consumer’s needs and preferences.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services. The service has access to a range of service providers and refers consumers where appropriate.

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

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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 provided information that the service was not able to demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to their needs and optimises their health and well-being. The service does not have a best practice process to identify consumers who are at risk of malnourishment or are malnourished to inform care planning. The service was not able to demonstrate wounds are effectively managed as wound assessment documentation is not consistently recorded to facilitate best practice and effective monitoring of wounds.

The Approved Provider provided a response to the Assessment Team’s report that included clarifying information as well as progress notes, medical correspondence, clinical assessments, policies and procedures, best practice information and improvement activities. The Approved Provider did not agree with the Assessment Team’s findings.

In relation to a named consumer with weight loss, the Approved Provider has demonstrated that the consumer is currently being medically treated to reduce body fluid volume, is on a fluid restriction, is being monitored by staff for food and fluid intake and is being managed by the medical officer. In the context of the current medical condition and treatment, I accept that weight loss would be occurring and that associated progress notes and clinical assessments indicate the management plan is being monitored for effectiveness.

In relation to a named consumer with weight loss (deceased) the Approved Provider has provided context to the weight loss, and I accept that weight loss is likely to occur as a consumers’ condition deteriorates and they enter the palliative phase of care. Additional dietary supplements were provided, and the medical officer was reviewing this consumer, including monitoring their diet/intake. Whilst I do not accept that a referral to a dietitian or speech pathologist was not required due to the condition of the consumer, I do accept that the consumer was being monitored and managed by the medical officer.

In relation to best practice assessments not in use to identify malnutrition, I accept that the approved Provider did not have a specific assessment tool for malnutrition, however, I note in their response that they are aware of the factors that may lead to malnutrition and that these factors are currently assessed via a range of clinical assessments.

In relation to wound management the Approved Provider identified that the wounds referred to in the Assessment Team’s report were skin tears and provided information of the best practice management of skin tears. The Approved Provider contends that they are following best practice for the management of skin tears. In relation to a named consumer with wounds, the Approved Provider has identified that these wounds are skin tears and the potential cause of the skin tears has been noted and is likely due to the condition of the consumer’s skin, as opposed to injuries caused by equipment. Whilst I acknowledge there is room for improvement in the recording of wound information, including measurements and or photographs of the wounds, there is no information to indicate that wounds are not being appropriately treated or that wounds are not healing.

I note the Approved Provider has implemented improvement actions, including the introduction of a specific malnutrition screening tool and assessment of all consumers with the tool. Additional sources for dietitian referrals are being explored due to long wait times with the current provider. Wound documentation has been reviewed and amended to include documentation of the size of wounds and education for staff is being provided.

I have read and considered the Assessment Team’s report and the Approved Provider response. I am satisfied that the Approved Provider was aware of the weight loss of named consumers, I accept that malnutrition was being assessed via a range of current assessment tools and that the medical officer was involved in the management of both named consumers in relation to weight loss and diets. Whilst I note that there was room for improvement in the documentation of wounds, I note that there was no indication that wounds were not healing, and the Approved Provider has since updated wound assessments and educated staff. I also note the improvement activities undertaken by the Approved Provider.

I find the requirement compliant.

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

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

The Assessment Team provided information that the service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer in relation to minimising the use of restraint, medication management and the management of supra pubic catheters.

The Approved Provider provided a response to the Assessment Team’s report that included clarifying information, as well as clinical assessments, a quality activity action plan, various flowcharts, the risk management policy, procedures, a skin incident supplement report form and a training schedule. The Approved Provider does not agree with the Assessment Team’s findings.

In relation to the two named consumers the Assessment Team identified as being restrained, the Approved Provider has provided context to the two consumers and has identified through clinical assessments completed prior to the Site Audit that both consumers are immobile and make no voluntary movements. As such, I do not find that these consumers have been restrained. The Approved Provider provided an updated procedure on responsive behaviours and restraint in aged care, the definition for physical restraint is not the definition as outlined in the *Quality of Care Principles 2014* and no definition for chemical restraint is record in the updated procedure. Whilst I accept the consumers were not restrained, the Approved Provider has not demonstrated that the risks associated with the use of support pillows and bed rails was explained to the consumers’ representatives.

In relation to medication management, the Approved Provider acknowledge that incident forms were not completed for two occasions when a medication patch was unintendedly removed from the named consumer. The Approved Provider contends that as the patches were witnessed to be unintentionally removed, that this did not warrant an incident form being completed, and that following the third episode of the patch being unintentionally removed corrective actions were implemented and there have been no further incidents. I am not persuaded by the explanation from the Approved Provider that the episodes of the unintentional removal of the patch being witnessed meant no incident form was needed to be completed. All episodes of medication patches being unintentionally removed should be recorded as a medication incident.

In relation to the named consumer and management of the supra pubic catheter, The Approved Provided through clinical records review demonstrated that potential blockage was a know matter and the care plan contained actions to address this matter should it arise. Drainage of the catheter is monitored and when decreased or no drainage is identified, then corrective actions as outlined on the care plan are undertaken and drainage recommences. I accept the explanation from the Approved Provider that the management of the catheter is noted on the care plan and that staff followed the process to resume drainage when decreased or no drainage was identified. I also note the consumer is satisfied with the management of the catheter. I also note the Approved Provider is aware of pain or discomfort that may be experienced by the consumer and has a pain management plan to manage this.

I have considered the assessment teams report as well as the Approved Provider’s response. I find that consumers were not being restrained as they no longer have the capacity for voluntary movement, however, I note the procedure for the management of restraint is not reflective of current legislation. I also note that the risks associated with the use of support pillows and bed rails was not explained to consumers’ representatives. I find that whilst incidents forms were not completed for two potential medication incidents, staff were monitoring the consumer and the use of a medication patch, and that corrective action was implemented and has been successful in the prevention of further incidents of unintendedly patch removal. I accept that the management of a supra pubic catheter is in accordance with established care planning.

The Approved Provider identified improvement activities in relation to this requirement, including implementing a high impact high prevalence risk management policy with associated staff training in the policy. Incident reporting is a priority action on the implementation plan for new policy. The policy on restraint has been updated, however, I note it is not reflective of current legislation.

Whilst I find the Approved Provider was able to demonstrate effective management of some high impact or high prevalence risks associated with the care of each consumer, I also find that incident reporting was not effective in recording all medication incidents, the new procedure for the use of restraint is not reflective of the current legislation and the risks associated with the care of consumers is not consistently explained to consumer representatives.

I find this requirement is non-complaint.

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

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

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

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

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

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

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

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

### Requirement 3(3)(g) 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 provided information that the service was not able to demonstrate effective standard and transmission-based precautions to prevent and control infection in relation to COVID-19. The Assessment Team found staff had not been adequately trained and lacked knowledge on infection control practice in relation to donning and doffing of personal protective equipment. Additionally, the service’s outbreak management plan did not include sufficient information to guide staff in the in the event of an outbreak and other key information required in the event of an outbreak was stored electronically with no reference in the plan. Whilst management provided documents relating to COVID-19 outbreak management, this information was not complete and management were unable to locate additional information.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report, as well as assessment templates, information on infection control, a medication advisory committee agenda, supplier contacts and an updated outbreak management plan.

The Approved Provider explained that staff work at both the aged care facility and the co located acute care facility and that there are variations between the sequence for donning and doffing between the two facilities and this could explain why staff provided inconsistent sequencing information to the Assessment Team.

The Approved Provider acknowledge the outbreak management plan could not be located during the Site Audit. The outbreak management plan has been updated to included information that was not available at the time of the Site Audit. The Approved Provider has entered into a contract with an external provider to provide clinical governance for medication management, including the establishment of a medication advisory committee. I note that antimicrobial stewardship forms part of the agenda for the committee.

The Approved Provider has planned to retrain all staff in donning and doffing of personal protective equipment.

I have considered the Assessment Team’s report and the Approved Providers response and I find that at the time of the Site Audit the Approved Provider was not able to demonstrate they had a completed outbreak management plan and that staff did not demonstrate consistent understanding of the use of personal protective equipment.

I find this requirement is non-compliant.

# STANDARD 4 COMPLIANT Services and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Overall, most sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers said they receive safe and effective services and supports for daily living that helps their health, well-being and quality of life. Consumers interviewed confirmed they are supported by the service to do the things they like to do and confirmed that they are supported to keep in touch with people who are important to them.

Consumers interviewed advised they like the food, they get enough to eat and they have choice with their meals. Consumers and representatives said the equipment provided is clean and well maintained.

The service was able to demonstrate 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 service has a range of policies and assessments to support staff in identifying consumers’ needs, goals and preferences which includes lifestyle therapy assessments. Care plans viewed demonstrated consumers get safe and effective services for daily living.

The service was able to demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. The service supports consumers from diverse religious backgrounds which is documented in a care plan based on an assessment. Staff described how they support consumers’ emotional, spiritual and psychological well-being.

The service was able to demonstrate how they support consumers to participate in the community, have personal and social relationships and do things that are of interest to them. Staff were able to describe the range of assessments completed to identify activity preferences and social and personal relationships. Records and observations confirmed consumers participate in the community, have relationships and have things of interest to do.

Staff were able to describe how they maintain privacy and how information is communicated within the service and other organisations. Staff were able to describe how they refer consumers to other organisations and providers of other care and services.

The service was able to demonstrate where meals are provided, they are varied and of suitable quality and quantity. The service has a cook who prepares meals fresh on site. Consumer dietary information is provided to kitchen staff by nursing staff, including changes in dietary preferences. The service has a four-week rotating menu, consumers can provide feedback on the meals through a range of mechanisms, new meals can be introduced based on consumer feedback.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall, sampled consumers considered that they feel they belong in the service, and feel safe and comfortable in the service environment. Consumers interviewed said they feel safe living in the service and their family can visit them anytime and they are made to feel welcomed. Consumers said they can bring in items from their home to make it more homelike, and observations by the Assessment Team confirmed this.

Consumers and representatives confirmed the living environment is clean and well maintained, the furniture and equipment they use are kept clean and safe for their use and they can access outdoor garden area.

Observations of the living environment confirm it is clean and well maintained with appropriate signage and is easy to navigate. There is a secure outside garden area with a rural mural scene painted along one wall, there are numerous plants, raised garden beds and vegetables growing in the area, including a chicken coop.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Overall, sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Most consumers and representatives said they know how to give feedback and feel comfortable to do so, without fear of retribution.

All staff understand their role in the open disclosure process. Staff could explain how they seek feedback from consumers.

Information about how to make complaints internally and externally was available in the service. Quality improvement forms show feedback is reviewed and used to improve the quality of care and services.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

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

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall, sampled consumers considered that they get quality care and services when they need them and from people who kind and caring.

Consumers and representatives interviewed confirmed they think there are adequate staff, that the staff are kind and caring and know what they are doing.

The service could demonstrate that they have sufficient staff to provide care and services. Staff interactions with consumers are kind and caring, and that staff are respectful of each consumer’s identity and culture.

Staff did not demonstrate consistent knowledge to perform their roles effectively in relation to identification and communication of risks to consumers’ representatives, incident reporting processes, mandatory reporting, the correct use of personal protective equipment and antimicrobial stewardship.

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

## Assessment of Standard 7 Requirements

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

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

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

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

### Requirement 7(3)(c) 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 provided information that the service was not able to demonstrate 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 was unable to demonstrate staff effectively manage high impact prevalence risks associated with the care of consumers developing pressure injury, risks associated with smoking for consumers who have a cognitive deficit, consumers who are at risk of weight loss and malnutrition, gaps in wound management processes, risks identified with physical and chemical restraint, staff responsibility for mandatory reporting, medication incident and antimicrobial stewardship in relation to antibiotic usage and trending information. Management were unaware staff and volunteers were working without a current National Police Clearance. While consumers and representatives are satisfied with staff skills and knowledge, not all risks have been explained to them related to restraint.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as an updated criminal history check speed sheet.

The Approved Provider reported they have experience high turnover of staff since April 2020, this is due various reasons, including staff not able to work across multiple aged care facilities, concerns from staff about ongoing viability of employment, natural attrition and performance management. The Approved Provider identified that this turnover has provided challenges for the recruitment and retention of staff. The Approved Provider has implemented strategies to assist in achieving success in recruitment and retention, including three-day orientation being all supernumerary shifts, provision of a comprehensive staff handbook, completion of a range of mandatory training topics, commencement of a forum for education and development of professional practice, and additional training for staff across a range of topics, including but not limited, to COVID-19, restraint and medication management. The Approved Provider indicated training on high impact high prevalence risk has been conducted.

In relation to staff knowledge to perform their roles, I find that staff did not demonstrate consistent knowledge in relation to identification and communication of risks to consumers’ representatives, incident reporting processes, mandatory reporting, the correct use of personal protective equipment and antimicrobial stewardship.

I have considered the Assessment Team’s report and the Approved Provider’s response. I acknowledge the challenges the Approved Provider has experienced in the recruitment and retention of staff and I also note the gaps in staff knowledge to perform their roles effectively.

I find this requirement is non-compliant.

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

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

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

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

# STANDARD 8 NON-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 Assessment Team found the service was unable to demonstrate effective organisation wide governance systems relating to information management, regulatory compliance or workforce governance.

The service could not demonstrate their information management systems support management to readily access the information they need. Staff at the service were unable to locate a range of documents requested, such as the outbreak management plan, clinical incidents forms, mandatory reporting incident documentation. Compliance with legislative requirements in relation to Reportable Assaults and restraint was not demonstrated.

The service was not able to demonstrate effective workforce governance in relation to monitoring regulatory requirements, such as ensuring all staff have police clearances, and ensuring the service has suitably skilled and qualified workforce to undertake their role.

The service could not demonstrate effective clinical governance framework in relation to antimicrobial stewardship and minimising restraint. Management did not have a sound understanding of anti-microbial stewardship and their responsibility in relation to recording infections and monitoring the use of anti-biotics. In relation to minimising the use of restraint, the staff and management did not believe they used physical or chemical restraint at the service.

However, the service could demonstrate some understanding and application of this Standard. Overall sampled consumers considered that the organisation is well run and that they can partner in improving the delivery of care and services. The service was able to demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The service could demonstrate their systems to support communication with consumers about incidents that have caused harm.

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

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team provided information that the service was unable to demonstrate effective organisation wide governance systems relating to information management, regulatory compliance or workforce governance. The service’s information management systems did not support staff to readily access the information they need, and assessment templates were not reviewed and updated in a timely manner.

The service could not demonstrate how their current process to measure compliance against legislative requirements is effective and management confirmed they had identified this gap and are in the process of implementing improvements. The service could not demonstrate it meets the requirements for mandatory reporting under the *Aged Care Act 1997* for allegations or suspicion of reportable assaults and did not maintain a consolidated record of all incidents.

The service could not demonstrate effective workforce governance in relation to monitoring regulatory requirements, such as ensuring all staff have police clearances, and ensuring the service has suitably skilled and qualified workforce to undertake their role.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report, as well as chief executive officer reports, polices and procedures, meeting agenda, the legislative compliance register, meeting minutes, external consultants progress report, information on the serious incident report scheme, and a food safety audit report.

In relation to information management, the Approved Provider identified this was a known area of risk, work to manage this risk had commenced and additional funding is been sourced to complete improvement actions, including but not limited to, an electronic heath care records system. I, however, note the deficiencies as identified by the Assessment Team, including staff unable to locate information during the Site Audit and a range of assessment templates that have not been reviewed and/or updated to reflect best practice.

In relation to mandatory reporting, the approved provider provided context to some of the named consumers identified by the Assessment Team, and also acknowledged there had been delays in the completion of incident forms and reporting of incidents. I note that the Approved Provider had not met their regulatory requirements for some of the noted incidents.

I also note that at the time of the Site Audit, criminal history clearance checks were out of date for some staff and volunteers. The Approved Provider explained this had occurred due to staff leave.

In relation to workforce governance, I note that staff did not demonstrate consistent knowledge to perform their roles effectively.

I note the Assessment Team identified the Approved Provider did demonstrate understanding and application of this requirement in relation to continuous improvement, financial governance and feedback and complaints.

The Approved Provider is implementing improvement actions, including, applying for a grant to improve information management, implementing legislative compliance improvement processes, all staff to complete training on mandatory reporting (completed), update the mandatory reporting register, provide training to staff on the serious incident reporting scheme and incident reporting.

I have considered the Assessment Team’s report as well as the Approved Provider’s response and I find that at the time of the Site Audit, the Approved Provider did not demonstrate effective governance with information management, regulatory compliance and workforce governance.

I find the requirement is non-compliant.

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

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

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

The Assessment Team provided information that the service was not able to demonstrate effective risk management systems and practices in relation to managing high-impact or high-prevalence risks for consumers who are restrained and for consumers who are at risk of malnutrition. The service was not able to demonstrate effective risk management systems to identify and respond to abuse and neglect of consumers. The service was not able to demonstrate effective risk management systems to support consumers to live the best life they can for consumers who chose to smoke. Incidents are not always completed in line with their incident reporting process.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as antibiotic use records, medication advisory committee agenda, copies of contracts with external providers, and an infection control report.

The Approved Provider identified they have undertaken significant work toward identifying appropriate support for clinical governance for medication management. Contracts have been signed with an external provider and a medication management advisory committee has been established. Staff education, auditing and high-risk medication use are all included in the contract.

In relation to managing high impact or high prevalence risks associated with the care of consumers, I note the Approved Provider did not have effective processes to consistently identify and communicate risks to consumers to the consumers’ representatives. However, I am satisfied that consumers were not physically restrained, and that potential malnutrition was being monitored.

In relation to identifying and responding to abuse and neglect of consumers, I find that the Approved Provider did not have effective processes for the consistent identification and reporting for mandatory reporting.

In relation to supporting consumers to live the best life they can, I accept the consumer and representative feedback provided during the Audit that consumers were generally supported to live the best life they can.

I have considered the Assessment Team’s report and the Approved Provider’s response and I find that at the time of the Site Audit, the Approved Provider was not able to demonstrate effective risk management systems and practices.

I find this requirement is non-compliant.

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

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

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

The Assessment Team provided information that the service could not demonstrate effective clinical governance framework in relation to antimicrobial stewardship and minimising restraint. Management did not have a sound understanding of anti-microbial stewardship and their responsibility in relation to recording infections and monitoring the use of antibiotics within the service. In relation to minimising the use of restraint, the staff and management did not believe they used physical or chemical restraint at the service. However, the service could demonstrate their governance relating to open disclosure framework.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report, as well as antibiotic use records, medication advisory committee agenda, copies of contracts with external providers, and an infection control report.

The Approved Provider identified they have an antimicrobial stewardship policy. An infection control coordinator is responsible for monitoring all infections and maintaining records of infections. There is an antimicrobial register for recording anti-biotic use. Contracts have been signed with an external provider and a medication management advisory committee has been established. Staff education, auditing and high-risk medication use are all included in the contract.

The Approved Provider has additional improvement actions planned, including developing an action plan for meeting high risk medication management requirements that can be monitored through the medication advisory committee.

In relation to Antimicrobial stewardship, whilst I acknowledge the Approved Provider has a policy and staff dedicated to manage stewardship, I note that at the time of the Site Audit, the Approved Provider was not able to demonstrate effective antimicrobial stewardship, there was not trending or monitoring of antibiotic usage, pathology testing for antibiotic use was not consistently conducted and some staff did not demonstrate knowledge of effective stewardship.

In relation to minimising restraint, I accept the named consumers were not being physically restrained at the time of the Site Audit, however, I also note the deficits identified by the Assessment Team in the management of chemical restraint, including identification and assessment of medications that may be a chemical restraint. I also note the revised policy on restraint is not reflective of current legislation.

In relation to open disclosure, I find the Approved Provider was able to demonstrate effective process for open disclosure.

I have considered the Assessment Teams Report and the Approved Provider’s response and I find at the time of the Site Audit, an effective clinical governance framework was not demonstrated.

I find this requirement is non-compliant.

# Areas for improvement

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

* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.
* Ensure Minimisation of infection related risks through implementing: standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.
* Ensure the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Ensure effective organisation wide governance systems are established
* Ensure effective risk management systems and practices are established
* Ensure an effective clinical governance framework is established.