Laurieton Lakeside Aged Care Residence

Performance Report

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LAURIETON NSW 2443
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**Commission ID:** 2793

**Provider name:** Halenvy Pty Limited

**Site Audit date:** 1 June 2021 to 3 June 2021

**Date of Performance Report:** 27 July 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Non-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) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Non-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** | **Non-compliant** |
| Requirement 6(3)(a) | Non-compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-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) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Non-compliant |
| Requirement 8(3)(b) | Non-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 16 July 2021.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Most sampled consumers considered they are treated with dignity and respect. Most consumers indicated they can maintain their identity, make informed choices about their care and services and live the life they choose.

Consumers described how the service supports them to continue practicing their faith and maintaining connections with their religious communities as well as how the service helps them to maintain relationships of importance to them. However, some consumers/representatives, described instances where staff have acted in a way that comes across as impatient. In addition, the service has not implemented a framework to identify, assess and meet the needs of consumers’ in relation to their identity, culture and diversity. Staff have not received training on the delivery of care and services with dignity and respectful or cultural safety.

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.*

The Assessment Team found that consumers said most of the time staff treat them with dignity and respect. Staff interviewed demonstrated an understanding of consumers identity, culture and life history. Some consumers interviewed did not feel they are always treated with dignity and respect with some staff occasionally being impatient. One consumer did experience a delay in receiving personal care.

In contrast, all staff interviewed spoke about consumers in a way that indicated respect and understanding of their personal circumstances and life journey. This included reference to their spiritual beliefs, cognitive capacity, interests, family background and financial or domestic challenges. The staff has specific examples where they had made lifestyle modifications based on a specific consumer personal struggle. However, the Assessment Team found that are plans did not always reference the same detail of consumers’ background or life story that were demonstrated by the staff interviews.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This included evidence to show care planning samples and action taken to show that they have responded to consumer concerns effectively; including taking disciplinary action when a consumer has raised concerns about the care they have received from staff. With such strong evidence from staff showing deep knowledge about the consumers’ needs, care and interests combined with the evidence supplied by the Approved Provider to show actions taken regarding consumer concerns with staff and with the majority of consumer feedback being positive; the Approved Provider has shown that each consumeris valued and treated with dignity and respect.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated that each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Overall sampled consumers did not consider that they feel like partners in the ongoing assessment and planning of their care and services. The majority of consumers interviewed said they have minimal or no involvement in their care planning process. In addition, most of assessments and care plan documents are not current and reflective of the consumers current care needs.

The representatives interviewed said they are not aware they can have a copy of the care plan, and the only time they have been consulted was when the consumers entered the service and they were asked a few basic questions.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found that the service is unable to demonstrate a consistent process is in place to identify risks to consumers and follow up with the appropriate actions. This includes speech pathologist referrals for a consumer with difficultly eating and risk assessment to determine the appropriateness of the equipment used and restricted practices (formerly known as restraint).

#### The Assessment Team reviewed care planning documents for a sample number of consumers. There were examples of care plans that lacked appropriate considerations and alternate solutions for physical restrictive practices. In addition, some progress notes were not reflective of consumer potential risks and how those risks might be reduced, and a risk section of a care plan did not have anything recorded as well. In addition, consumer feedback did highlight some concerns about the use of physical restrictive practices.

The Assessment Team found that there did appear to be some confusion amongst staff about reducing the risks of restraint practices and risks experienced by consumers with limited chewing and swallowing ability.

The Approved Provider submitted information to address the issues raised by the Assessment Team. It is acknowledged that some of the consumer feedback that was given to the Assessment Team had never been previously raised with the Approved Provider and therefore they had not had the opportunity to respond. However, there was also an acknowledgement by the Approved Provider that they did need to make some improvements and has committed to do so as well as providing evidence of some of the improvements made since the Assessment Team visited. Whilst the Approved Provider has taken steps to address assessment and planning shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) 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 that the service is unable to demonstrate that assessment and planning process identifies the consumers need, goals and preferences due to the consumers and/or their representatives having minimal or no involvement in the process.

The Assessment Team found that some consumers have an advanced care and palliative care plan in place however some of these documents had not been updated recently. There is no review process to update the information to reflect the consumers current needs. In addition, although the advanced and palliative care plans are supposed to be reviewed at the management annual case conference the Assessment Team found that very few had been completed in the last 12 months.

The majority of sampled consumers/representatives interviewed by the Assessment Team said they were not involved in the care planning process and representatives said they could only remember being asked when their consumer entered the service in regard to the advanced care plan but not recently. In addition, staff interviewed by the Assessment Team confirmed that they do complete the care plan reviews however not with the consumers or their representatives.

The Approved Provider submitted information to address the issues raised by the Assessment Team. It is acknowledged that the Approved provider has a less formal approach to care doing it via daily interactions. It is also acknowledged that consumers can make a choice about advanced care directives and this is not a requirement however, all consumers should be actively involved and supported in their choices. In addition, the Approved Provider has identified that consumer care plans need to be updated and that care plans are not distributed to consumers/representatives. If the consumer/representatives are not involved in the planning process it is difficult for the Approved Provider to demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences. In addition, whilst the Approved Provider has taken steps to address assessment and planning shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) 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 that the service has access to other services and organisations to assist in the assessment and care planning process for the consumers. However, feedback from consumers and/or their representatives and a review of clinical documentation identified there is minimal documentation to indicate an ongoing partnership with the consumers. The Assessment Team identified referrals, consultation reports and recommendations however these were not always included in the consumers clinical documents and incorporated into the ongoing care plan. Representatives interviewed, some said they are aware of the consumer physiotherapist visits, other said they are aware when they need to transport the consumer to specialist appointments otherwise they are not involved.

A review of the sampled consumer assessments and care plans show minimal involvement with consumers and/or their representatives. Care plans are reviewed three monthly by the registered nurses however, this does not involve discussing the care planning with the consumers/representatives. This was confirmed through consumer and representative feedback. In addition, formal case conferences are held annually where care plans are however the Assessment Team found that only two had been updated thus far and these were due to related to incidents.

For the consumers sampled by the Assessment Team, care planning documents did reflect that at times the physiotherapist and medical officer was involved in assessment and planning process. However, when consumers have been referred to specialist or allied health professional their recommendations have not been followed up by the service to ensure the consumers and/or their representatives have been informed and involved in changes made to the consumers care planning documents.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided more details and supporting documentation in relation to specific consumer documentation sampled and the actions taken to provide the required care. Whilst this has demonstrated that the Approved Provider has engaged with outside organisations and professionals to enhance the care of consumers, the Approved Provider was unable to demonstrate that it works in partnership with the consumer/representatives and/or additional organisations or professionals consistently or effectively to for all consumers.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) Non-compliant

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

The Assessment Team found that the service is unable to demonstrate the outcomes of assessment and planning are communicated and documented in an up to date care plan. Feedback from consumers and/or their representatives confirmed that they have not or had minimal involvement in the assessment, planning and review of the consumers care and services. The majority of sampled consumers/representatives interviewed said they not seen a care plan and did not know they could have a copy. There was also evidence that that some consumers did not have a care plan in place since entry into the service.

Staff told the Assessment Team that they complete the three-monthly care plans reviews however they do not discuss the care plan review with the consumers and/or their representatives. Staff confirmed that they are aware the case conferencing schedule is behind, although said all consumers and/or their representatives are involved in their care planning process.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided details of the implementation of a new electronic software to assist with assessment and planning. It is acknowledged as one issue facing the Approved Provider, and that long term will assist with the ongoing assessment and care plan process. However, the additional information provided did not demonstrate that the Approved Provider has a system in place that ensure that all consumers have care plans that are communicated effectively and consistently and are available to them.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) 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 that the service was unable to demonstrate the appropriate monitoring and review of effectiveness of care and services that are impacted by incidents. Deficits were identified by the Assessment Team with assessments completed at the time of incidents. Further deficits were identified with the completion of incident forms as well as the care and services not being updated and reviewed to ensure the consumer received the ongoing clinical management after an incident.

Representative feedback related to delays in being informed of incidents or being only notified of issues when a multiple of incidents have occurred. In contrast, the Assessment Team found that staff said they would complete a review post incident and after any changes in consumers condition and update the care plans at the time however did not discuss informing family and representatives.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information did not provide any additional evidence to dispel the findings other than to provide contextual information relating to a consumer sampled by the Assessment Team.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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-COMPLIANTPersonal 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Most sampled consumers considered that they receive personal care and clinical care that is safe and right for them. The majority of consumers interviewed said they are able to see a medical officer when needed and some consumers said they have regular physiotherapist visits. However, there was mixed feedback from consumer representatives.

The service was unable to demonstrate an effective approach is in place to ensure consumers are receiving safe, effective clinical and personal care. The Assessment Team identified a lack of clinical oversight as well as deficits in the services chemical and physical restrictive practices, wound and pain management. The service had a fragmented clinical documentation system and deficits were identified in all aspects of the computer based and hardcopy documents.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found deficits in the identification, monitoring and review of psychotropic medications. The Assessment Team also found that staff were not following the services policy regarding the management and monitoring of physical restrictive practices and not detecting consumers impaired skin integrity in a timely manner which is resulting in consumers having pressure injuries. In addition, pain monitoring is not routinely occurring for consumers who have had changes in their conditions.

The Assessment Team identified consumers with a diagnosis of dementia had been classified inaccurately. As a result, these consumers have not been identified by the service as prescribed a medication that is classified as a chemical restrictive practice. In addition, the most of these consumers do not have a current authorisation in place signed by the medical officer and/or their representatives or there is no chemical restriction care plan in place. The Assessment Team also found that physical restrictive practices are not consistently monitored as per the service’s policy. Consumers were not considered at risk with one bed rail in place, therefore there has been no risk assessment completed to determine if the bed rail placement has the potential to cause injury or harm to the consumer.

A review of the consumers documentation identified deficits in the early detection of all the consumers pressure injuries and the ongoing deficits of the wound management as per the services wound management policy. In addition, the service does not routinely complete pain assessments and monitoring charts for consumers who have experienced falls, surgery, pressure injuries and changes in behaviours.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided clarification in relation to some consumers that the Assessment Team found were chemically restricted. Whilst it is acknowledged that this information has provided evidence to dispel these consumers were chemically restricted, there was no additional evidence supplied in relation to physical restriction. Furthermore, the Approved Provider acknowledged that improvements were required with regards to restrictive practices. This combined with the evidence as seen by the Assessment Team shows that the Approved Provider did not demonstrate that each consumer gets safe and effective personal care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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.

### 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 that the service is unable to demonstrate the management of consumers with high impact or high prevalence risk is managed appropriately. The Assessment Team identified deficits in the management of consumers who have had behavioural incidents, required ongoing observations and the appropriate management of medications. In addition, it was identified to be not in line with the service’s policies.

For one consumer sampled by the Assessment Team showed the service has not considered completing an environmental risk assessment to minimise the risk for leaving the service unsupervised or recorded recommendations from a supporting organisation in a consumer care plan to assist staff with their care. There were also deficits identified in relation to clinical assessments and results of pathology. In addition, a review of behaviour assessment and care plan identified minimal documentation is recorded regarding his history, current behaviours and interventions and recommendations from the mental health specialist reviews.

The Assessment Team found some representatives said when a behavioural incident occurs the service tends to just blame their consumers for the incident. The representatives said they see no changes in their consumer’s behaviour interventions after mental health specialist have visited and/or when they have made suggestions to the management team.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided clarification in relation to some consumers that the Assessment Team found were chemically restricted. Whilst it is acknowledged that this information has provided evidence to dispel these consumers were chemically restricted, there was no additional evidence supplied in relation to physical restriction. Furthermore, the Approved Provider acknowledged that improvements were required with regards to restrictive practices. This combined with the evidence as seen by the Assessment Team shows that the Approved Provider did not demonstrate that each consumer gets safe and effective personal care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that effective management of high impact or high prevalence risks associated with the care of each consumer.

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

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

### Requirement 3(3)(d) 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 that the management of a consumer who has had, and is having exacerbation of their behavioural issues is not being managed appropriately by the service. The service has recognised the behavioural changes and the decline however not responded with a management plan in a timely manner. This has resulted in the consumer having more frequent episodes for which the service has no plan of care in place.

Two care staff met with the Assessment Team and expressed their concern regarding a consumer’s current care need as they were unable to attend to her hygiene with care and dignity because of the exacerbated behaviours and refusal of care.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided clarification in relation to consumers sampled by the Assessment Team. Whilst it is acknowledged that this information included a copy of care plans it does not dispel the findings of the Assessment Team. There is evidence to show that consumer care has been delayed for various reasons however this has had considerable impact on the consumer and must be taken into consideration.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) 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 that the service is unable to demonstrate an effective system for information to be communicated and shared with others. The service uses computer and hardcopy documents and both systems were identified by the Assessment Team to be fragmented, inconsistent and at times inaccurately completed. Therefore, deficits were identified in all areas of clinical documentation. For example, progress notes entries, assessments, care plans and clinical monitoring charts not completed or updated. The recommendations from mental health specialist were not included in the consumers care plans to assist staff in the management of the consumers behaviours. For some consumers there was no care plans in place.

Some of this fragmented communication seen by the Assessment Team included progress notes entries and some clinical observations were on the computer, however the care staff do not have access to this information. Consumers file documents are separate from the care plan folder and all other clinical monitoring charts are in separate folders.

Case conference recommendations are not always included in care plans. The Assessment Team found that case conferences that had been held this year had the requests of representatives to be incorporated into the consumers care plan. This had not occurred and as a result not shared with the other staff members.

The Assessment Team found some consumers said staff don’t listen to them, don’t have enough information to care for them appropriately and some representatives said if they don’t ask the staff what is happening, they are not informed. They said, “one staff member does it this way and then the next one comes in and does it differently”. For example, one consumer said this related to their pressure area care.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided clarification in relation to some consumer care plans and acknowledged that some of these were not completed at the time of the site audit and this had been rectified. However, the Assessment Team did find a fragmented communication system that was not effectively supporting staff to care for consumers efficiently and accurately. In addition, The Assessment Team found that there were direct examples of how this had inhibited care for consumers as well as some unfavourable consumer/representative feedback about how information is communicated to them.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 found that the service is unable to demonstrate effective standard and transmission-based precautions for a consumer requiring quarantine are in place. Staff said the service does not have an antimicrobial policy and were not sure what it meant but when prompted could demonstrate some practices they would put in place to reduce the use of antibiotics.

The Assessment Team observed deficits in staff members infection control practices relating to a consumer who was quarantine and awaiting their COVID swab results. Progress note entries had no documentation regarding the progress of the swab collection, and the care plan had not been updated to include his need to quarantine and the precautions in place for minimising the spread of infection. In addition, the Assessment Team observed three care staff members enter the quarantine room wearing only a face mask as PPE.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided information about previous compliance with this requirement and noted that staff are trained to don and doff PPE correctly. This decision is based on what the Assessment Team saw on the day of the site audit. In addition, with COVID -19 pandemic the correct use of PPE is vital to the safety of both consumers and staff. Although the swab came back negative for COVID-19 and there was no risk at that point, alternatively, if it had not there would have been very real risk to consumers and staff with the observed level of infection control by the Assessment Team.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that there is a minimisation of infection related risks through implementing:

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

# STANDARD 4 NON-COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The team also examined relevant documents.

Overall sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers described the activities and interests they are supported to pursue within the service. In addition, most consumers gave positive feedback regarding the quality, quantity and variety of the meals.

Care planning documentation of goals and needs is varied in detail between consumers. Some consumers do not have a care plan. Where goals are documented, sampled care plans indicated goals to be generic and not specific to the consumer.

Furthermore, other than verbal communication, the service is unable to demonstrate how this information is shared between staff and where responsibilities are shared.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-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) 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 that the service is unable to demonstrate information is shared within the organisation and to others where responsibility for care is shared. The service has a fragmented information system, with consumers information stored in various locations across the service and not readily available for staff to access.

The leisure and lifestyle staff have a separate set of documents which are stored in a locked room and not accessible by other staff within the organisation afterhours and weekends. The service relies heavily on verbal information shared during discussions with staff during the day. The Assessment Team observed daily handover sheets that only document the consumers name and often just a tick beside their name to guide staff practice in the daily care needs of the consumers.

#### Representatives told the Assessment Team of disappointment in relation to communication from the service specifically in relation to listening to representative concerns that have been communicated to assist with the care of the consumer. In addition, a review of care plans did show that the representative suggestions were not noted.

The Assessment Team found that the service is unable to demonstrate how specialist referrals are shared and hospital discharge forms are accessed in a timely manner and available for staff. This included sharing of information in the management of COVID-19 quarantine and the collection of his pathology in a timely manner which was not communicated comprehensively across all departments of the service. In addition, staff said they don’t have access to consumers progress notes entries, the only documents they have access to is consumer care plans, and observations charts which they record in.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information whilst it did provide some clarification of the details relating to specific consumers however the evidence did not support to change what was found by the Assessment Team. Overall, there still remains the feedback from both consumers/representatives and staff to show deficiencies with communication of consumer care, services, needs and preferences across the service.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The team also examined relevant documents.

Overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. Consumers sampled said they feel at comfortable and safe within the service. Consumers rooms are decorated with their belongings and hallways display photos of recent activities and events for consumers.

All consumers and representatives sampled said the service is very clean and well maintained. The service incorporates some elements of dementia enabling design principles to assist consumers to locate the time and place for meals. In addition, the maintenance system is digitally automated to ensure all preventative maintenance tasks are completed.

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 NON-COMPLIANTFeedback 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – asking them about how they raise complaints and the organisation’s response. The team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Some sampled consumers did not consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. In addition, some consumers and representatives did not know the ways in which they could make a complaint, did not feel they had been heard and understood when they made a complaint and felt that changes were not made at the service in response to complaints and feedback.

The complaints procedure does not have information about open disclosure principles. The service does not have a process for consumers and representatives to make an anonymous complaint. Access to advocates is not included in the complaints procedure and is not displayed in written form at the service. All comments, complaints and issues are not always recorded in the complaints register, investigated and acted upon to achieve a satisfactory resolution pursuant to the service’s complaints procedures.

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

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found that the service does not effectively encourage consumers and representatives to provide feedback and make complaints. The service does not assist consumers and representatives to understand the charter of aged care rights including the right to complain free from reprisal and the right to have their complaints dealt with fairly and promptly. Information about making complaints is limited and not effectively communicated to consumers.

When the Assessment Team interviewed sampled consumers/representatives, some did not know the ways in which they could make a complaint, did not feel they had been heard and understood when they made a complaint and felt that changes were not made at the service in response to complaints and feedback.

The Assessment Team found that complaints are mainly managed via verbal communication and there were differences in how some staff would bring attention to the complaints. In addition, although consumer agreements reference the complaints procedure, this procedure is not given to consumers. The service does not have a process for consumers and representatives to make an anonymous complaint.

The Approved Provider submitted information to address the issues raised by the Assessment Team. This information provided clarification in relation to some the complaints processes available to consumers throughout the service and initiatives that have been undertaken by the services to improve the complaints process. Whilst this information did provide addition clarity around some of the complaints process that was not seen by the Assessment Team on the day of the site audit or the feedback they received from the consumers/representatives sampled.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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.*

The Assessment Team found that Consumers and representatives are not made aware of and have access to advocates, language service and other methods for raising and resolving complaints. The service does not assist consumers and representatives to understand the charter of aged care rights including the right to have a person of their choice, including an aged care advocate, support them or speak on their behalf in relation to making a complaint.

Staff did not describe the advocacy and language services available and they could not remember a time they assisted a consumer to access these services. A staff member said all consumers were able to speak English and did not need language services.

In contrast, the Approved Provider submitted information to address the issues raised by the Assessment Team that provided evidence to support that consumers are aware of advocacy and language services. This included information about location and the number of supporting documentation at the service for advocates and the charter of aged care rights. The Approved Provider also highlighted the fact that although they may not have had recent experience utilising advocacy or language services due to the consumer circumstances that staff would always assist consumers to get the support they need. Based on the provider additional information the provider is committed to inform, support and offer advocates and language service to raise and resolve complaints.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

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

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

The Assessment Team found that appropriate action is not always taken in response to complaints and open disclosure processes are not always used when things go wrong. Not all complaints are registered on the complaints register, investigated and followed up with the consumer and representatives. Consumers and representative feedback did not confirm open disclosure processes were used when resolving their complaints. The complaints procedure does not include information about open disclosure processes.

Representatives feedback included, not having the complaints processes explained, Verbal complaints have been made over a log period and no action has been taken and receiving no response in relation to complaints. The Assessment Team found that very few complaints are logged therefore do not show any resolution or open disclosure. In addition, the Assessment Team found when things go wrong or things change, staff rarely communicate with consumers and seek their input to update the care and services.

The Assessment Team spoke to a staff member who could explain the principles of open disclosure however the other staff interviewed did not. In addition, some principles of open disclosure have not been systematically applied. For example, formal apologies have not been conveyed to consumers/representatives when things go wrong, and enduring guardians have not been informed about the outcomes of investigations and actions put in place to protect the consumer they represent.

Furthermore, the service did not have an open disclosure policy or procedure. Open disclosure or actions and procedures to apply the principles of open disclosure are not described in the complaint’s procedure. In addition, open disclosure is also not linked in the Serious Incident Response Scheme (SIRS) policy and procedure nor is it in line to the complaints procedure.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. This information acknowledged that there were improvements to be made and that some had been undertaken since the Assessment Team was at the service for the site audit. Whilst the Approved Provider has taken steps to address shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

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

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

The Assessment Team’s findings confirm feedback and complaints are not reviewed and used to improve the quality of care and services. The service does not have an effective continuous improvement system including using feedback and complaints information to improve care and services. This has been recently identified by the service and included in a gap analysis action plan.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. This information acknowledged that there were improvements to be made and that some had been undertaken since the Assessment Team was at the service for the site audit. Whilst the Approved Provider has taken steps to address shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that feedback and complaints are reviewed and used to improve the quality of care and services.

# STANDARD 7 NON-COMPLIANTHuman 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

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Some sampled consumers did not consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. While some consumers said staff are kind and caring and provide quality care, others did not think all staff were kind and caring and provide safe quality care and services. Consumers and representatives said there are not enough care staff and the registered nurses are too busy. Consumers said they do not always get safe quality clinical care such as wound management. In addition, staff are not always available to provide personal care in a timely manner and some services are not provided even when repeatedly requested such as preferred meals of choice.

The Assessment Team observed all disciplines of staff to be very busy most of the time and too rushed to provide quality person-centred care. Registered nurses were observed to spend up to two hours doing medication rounds and were regularly interrupted with requests from consumers, care staff and other staff.

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

## 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 that the number and mix of staff deployed does not always enable the delivery and management of quality care and services. There were vacant positions for clinical management roles and staff said there are not enough staff. Because of staffing issues, there was a backlog of key management tasks including care planning and information management.

Some consumers/representatives said there are not enough staff and they do not get quality care and services when they need them. Two representatives said their consumer does not always get safe quality clinical care such as wound management. Other consumers said staff are often busy and there is not enough staff to attend to consumers calling out.

Most care staff and registered nurses interviewed said there were not enough staff to provide quality care and interact meaningfully with consumers. In addition, another staff member said they do not get the opportunity to effectively supervise care staff and correct practices. The Assessment Team observed all disciplines of staff to be very busy at all times and too rushed to provide quality person-centred care.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. This information did refute the claim that the service did not have the right level of staffing, however there was also an acknowledgment that staff were rushed and not completing their roles effectively. The Approved Provider also provided information stating that the staffing vacancies at the time of the site audit have now been filled. Taking this into consideration it remains that the Approved Provider was, at the time of the site audit, unable to demonstrate that the workforce is planned and has a mix of staff that is delivery quality care and services. In addition, both staff and consumers provided feedback to confirm this.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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) Non-compliant

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

Some consumers and representatives confirmed that staff interactions are not always kind, caring and respectful of each consumer’s identity, culture and diversity. Staff do not have enough time to give safe, quality, person centred care and do not have readily accessible information about each consumer’s identity, culture and diversity.

The service did not have a diversity action plan preceding this site audit. In addition, the service did not provide evidence all staff have received training to the meet the Quality Standards relevant to this requirement such as staff valuing and respecting each consumers identity, culture and diversity. Information about each consumer’s identity, culture and diversity is not effectively assessed and documented.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. After reviewing all the evidence, it appears that the workforce is providing interactions with consumers that are kind and caring. However, the evidence shows that there are improvements to be made in respecting identity, culture and diversity. This is also noted by the Approved Provider. Whilst the Approved Provider has taken steps to address shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that 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 found that whilst the staff have the qualifications required for their roles, there are deficiencies in management, registered nurses and care staff knowing how to provide and implement information management and care systems to effectively perform their roles in providing safe quality care for consumers. Registered nurses lack clinical knowledge to oversee falls management and pain and wound management effectively as well as knowledge to reduce physical and chemical restrictive practices.

The Assessment Team heard about staff recruitment processes, position descriptions and duty statements, orientation and education processes, supervision and staff performance management systems ensure staff are competent and are appropriately qualified. In addition, the service has duty statements and documented core competencies for different staff roles. There are systems in place to ensure all registered nurses’ professional registration is current, all care staff appraisals are up date and all care staff competencies are completed annually.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. The Approved Provider acknowledged there were some deficiencies to be able to meet this requirement however, they have committed to a continuous improvement process, some of which has already been completed. Whilst the Approved Provider has taken steps to address shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

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

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

Evidence considered by the Assessment Team demonstrated there has been limited education for staff about the requirements of the Aged Care Quality Standards (Quality Standards) and most staff have not attended all Quality Standards training sessions over the last two years to deliver the outcomes required by these standards.

A number of staff said they have not had enough training in relation to the Quality Standards. These included areas such as open disclosure, antimicrobial stewardship, SIRS including the understanding of reportable incidents.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. It is acknowledged that the Approved Provider has experienced some difficulties with training as pre COVID-19 this was all done face to face and it has taken time to develop alternatives. In addition, it is acknowledged that the Approved Provider has had difficulty in hiring and retaining qualified staff. However, the Approved Provider has also acknowledged there were some deficiencies to be able to meet this requirement however, they have committed to a continuous improvement process, some of which has already been completed. Whilst the Approved Provider has taken steps to address shortfalls it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Some sampled consumers did not consider that the organisation is well run and most said they do not partner in improving the delivery of care and services. In addition, some consumers and representatives have not seen a care plan or not partnered in care planning or were not engaged in the development, delivery and evaluation of care and services. They said they did not know about consumer and representative meetings or food focus groups and have not been surveyed over the last year.

The service was unable to demonstrate how consumers are engaged and supported in the development and delivery of their care and services. Consumers and representatives said they have not been assisted to understand the charter of aged care rights including the right to have control over and make choices about their care, and personal and social life, including where the choices involve personal risk.

The service did not provide evidence of effective risk management systems and clinical governance.

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

## Assessment of Standard 8 Requirements

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

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

Management did not provide evidence that consumers and representatives were engaged in the development, delivery and evaluation of care and services at a service and organisational level. Most consumers said they did not know about consumer and representative meetings or food focus groups and have not been surveyed over the last year. In addition, the management were not able to demonstrate any other consumer engagement apart from the food focus groups and consumers and representative meetings and were unable to show how the information was feed into the organisations governance system to improve the delivery of their care and services.

Furthermore, a review of the continuous quality improvement plan (at the time of the site audit) identified no actions have been identified from consumers and/or representatives to show they are engaged in the development, evaluation in planning the delivery of care and services at the service. The actions are all management driven.

The Approved Provider submitted information to in relation to what was seen by the Assessment Team. This information, whilst it did provide some further avenues to seek consumer engagement it did not demonstrate that these were methods that we successful in the development, delivery and evaluation of consumer care and services nor was there evidence of a meaningful collaborative relationship with consumers that was effective. It is acknowledged that the Approved Provider has taken recent steps to improve the engagement process it is however, not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

### Requirement 8(3)(b) Non-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 that the service’s board of directors do not yet demonstrate they are accountable for and promote safe, inclusive and quality care and services. The Board acknowledges that there are a number of additional areas of documentation in relation to standards that need to be introduced to ensure clarity of compliance with the standards. A gap analysis action plan has recently been completed containing improvements across all eight of the Quality Standards.

The service did not have a diversity action plan preceding this site audit, and cultural care plan is yet to be developed and staff are planned to be educated and implement relevant practices over the next three months.

The Approved Provider submitted information to outlining improvements, progress and continuous improvement in relation to this Quality Standard. Whilst, the Approved Provider has taken recent steps to improve the governing body promoting a culture of safe, inclusive and quality care and services it is however, not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

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

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

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

The Assessment Team found the service does not demonstrate it has effective information management systems, continuous improvement systems, workforce governance, regulatory compliance and feedback and complaints systems in place.

#### In relation to information management, the Assessment Team was told of a recent gap analysis undertaken by the service identified there is a requirement for the information management system to be reviewed and improved. Actions include to identify a plan with priority areas, resources are to be allocated to this plan and work around care plans, internal communications, consumer handbook update, meetings agendas and archiving. These actions and strategies are to be included in the plan for continuous improvement.

The Assessment Team found that management did not provide evidence of an effective continuous improvement system or written procedures about how the system is governed by the proprietors. Opportunities for improvement were not always recorded on the plan for continuous improvement. In addition, the Assessment Team’s findings confirm feedback and complaints are not reviewed and used to improve the quality of care and services.

#### In relation to financial governance management explained to the Assessment team that they approach the Board and approvals for expenditures over the budget are discussed and approved as required. The service is using grant funds from the Australian Government Department of Health to implement a new person-centred software information technology system to improve information management and recording consumer care planning documentation which can be accessed by care staff. In addition, improvements are being made to workforce governance, including the assignment of clear responsibilities and accountabilities

#### The Assessment Team was advised that information about changes to legislation are received from their peak body, the Commission and the Department of Health. For example, the serious incident response scheme legislation was communicated to staff through meetings, toolbox talks and at shift handovers. In addition, improvements have been identified and are being improved in relation to feedback and complaints.

The Approved Provider submitted information to outlining improvements, progress and continuous improvement in relation to this Quality Standard. Whilst, the Approved Provider has taken recent steps to improve governance systems, however, it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that effective organisation wide governance systems relating to the following:

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

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

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

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

#### The Assessment Team found evidence reviewed did not demonstrate there were effective risk management systems and practices in place at the service. There are not enough staff to support consumers to live the best life they can. High impact and high prevalence risks are not effectively managed for consumers and effective responses are not always implemented when consumers are neglected or abused. In addition, the service was unable to provide a documented risk management framework, including policies describing how high impact or high prevalence risks associated with the care of consumers is managed, the abuse and neglect of consumers is identified and responded to and consumers are supported to live the best life they can.

#### The Board advised the Assessment Team that the facility manager has incorporated recent changes for SIRS reporting into the incident management system however the Assessment Team found the reports do not account for category incident levels. This does not support an effective incident management system.

The Approved Provider submitted information to outlining improvements, progress and continuous improvement in relation to this Quality Standard. Whilst, the Approved Provider has taken recent steps to improve risk systems and practices, however, it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that effective risk management systems and practices, including but not limited to the following:

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

### Requirement 8(3)(e) 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 service did provide a documented clinical governance framework however, the service was unable to provide policies relating to antimicrobial stewardship, minimising restrictive practise or open disclosure. Staff in general had not been educated about these topics however, open disclosure education was provided to some staff on June 2021. In addition, management were not able to provide examples except that improvements have been implemented in relation to minimising the use of restrictive practices.

The Approved Provider submitted information to outlining improvements, progress and continuous improvement in relation to this Quality Standard. Whilst, the Approved Provider has taken recent steps to improve the clinical governance framework to sure it encompasses antimicrobial stewardship, minimising restrictive practise and open disclosure, however, it is not reflective of the service’s standard at the time of the site audit.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated that aclinical governance framework, including but not limited to the following:

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

# Areas for improvement

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

### Requirement 2(3)(a)

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

* Continue to implement continuous improvement plan as supplied to the Aged Care Quality & Safety Commission (the Commission).
* Review all processes and policies in relation to environmental restrictive practise and ensure staff are trained so they can place into practice.

### Requirement 2(3)(b)

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.

* Continue to implement continuous improvement plan as supplied to the Commission.
* Ensure that there is development of a formalised process for consumers and their representatives to actively contribute their needs, goals and preferences including end of life planning.
* Ensure that all care plans are reviewed and updated in a regular, timely manner.

### Requirement 2(3)(c)

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.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Ensure that the service develop an effective and consistent method to work in partnership with consumers and their representatives in assessment and care planning.

### Requirement 2(3)(d)

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.

* Continue to implement continuous improvement plan as supplied to the Commission.
* Ensure the new electronic system for assessment and planning is implemented as quickly as possible and applied to all consumers so that all consumers have an up to date care plan.
* Ensure consumers/representatives are offered a copy of their care plan regularly.

### Requirement 2(3)(e)

*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.*

* Review processes for consumer care and services to ensure that they are actively being reviewed when circumstances change or where incident impact consumer needs, goals and preferences.
* Ensure when reviewed that this translates into improvement of care and services for the consumer and that this is well documented.

### Requirement 3(3)(a)

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

1. is best practice; and
2. is tailored to their needs; and
3. optimises their health and well-being.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Ensure that restrictive practices are reviewed and updated continuously so that they are reduced and used as a last resort.
* Ensure that alternatives are explored as a first point of call before considering the use of restrictive practices.
* Review, update policy and procedures in relation to best practice for wound care, falls, post-surgery care, pressure injuries and changes in behaviours.

### Requirement 3(3)(b)

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

* Continue to implement continuous improvement plan as supplied to the Commission.
* Review the management of high impact, high prevalent risks and ensure that daily practices, documentations and rectification uncover and reduce the risks to consumers.

### Requirement 3(3)(d)

*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.*

* Continue to implement continuous improvement plan as supplied to the Commission.
* Look at reviewing and improving behavioural management strategies.
* Look at strategies to improve the timeliness of response to consumer deterioration under all circumstances and also consider how to overcome some of the more common reasons that might prevent this from occurring.

### Requirement 3(3)(e)

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.

* Continue to implement continuous improvement plan as supplied to the Commission.
* Review communication across the organisation, service and external professional services to ensure that it is effective, timely and accurate.
* Seek feedback from staff to establish a consensus of how best to provide communication to enhance the care for consumers.

### Requirement 3(3)(g)

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.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Revisit training of donning and doffing for all staff.
* Ensure that isolation arrangements for potentially infectious consumers is consistent and effective so there is no risk for other consumers.
* Provide training for staff on reducing the use of antibiotics.

### Requirement 4(3)(d)

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

* Seek feedback from staff to ensure they have access to the information they need to provide high quality care.
* Review and improve all processes for communicating consumer condition, need and preferences so that consumers are receiving the care they need
* Ensure that information expressed by families and representatives is documented and available to enhance the care of consumers. If the Approved Provider believes this information to be not applicable then this must be discussed, resolved and documented with family and representatives.

### Requirement 6(3)(a)

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

* Seek feedback from consumers/representatives to find out the way they would like to provide feedback and complaints.
* Continue and imbed the new strategies identified to encourage feedback and complaints.

### Requirement 6(3)(c)

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

* Continue and imbed the new strategies identified to encourage feedback and complaints. These include:
	+ - Review complaints policy and procedure including principles of open disclosure
		- Complete education plan for staff to ensure they attend training in relation to complaints, open disclosure and SIRS.
* Ensure that all complaints and feedback are documented and responded to with open disclosure principles.

### Requirement 6(3)(d)

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

* Ensure that the gap analysis is utilised to imbed a process for the analysis of trends in complaints and feedback. This should then feed into continuous improvement.

### Requirement 7(3)(a)

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.

* Improve staff training to develop efficiencies and quality of care based on the Staff Education plan 2021, as provided.
* Review and evaluate call bell wait times to be used for continuous improvement so that the right staffing levels can be maintained.
* Ensure recruitment processes are efficient to select competent staff to provide quality care.

### Requirement 7(3)(b)

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

* Improve staff training to develop knowledge of culture and diversity based on the Staff Education plan 2021, as provided.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Improve ways for consumers to share their life stories with staff.

### Requirement 7(3)(c)

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

* Improve staff training to develop expertise based on the Staff Education plan 2021, as provided including wound and pain management as well as physical and chemical restrictive practices.
* Continue to implement continuous improvement plan as supplied to the Commission.

### Requirement 7(3)(d)

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

* Improve staff training across Aged Care Quality Standards based on the Staff Education plan 2021, as provided.
* Continue to implement continuous improvement plan as supplied to the Commission.

### Requirement 8(3)(a)

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

* Continue to implement continuous improvement plan as supplied to the Commission.
* Ensure that the methodology used to engage consumers is accessible, communicated effectively and allows consumers to provide meaningful inputs.

### Requirement 8(3)(b)

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

* Continue to implement continuous improvement plan as supplied to the Commission.
* Review improvements to ensure they are imbedded and working well to promote a culture of safe, inclusive and quality care and services and ensures the governing body is accountable for their delivery.
* Ensure that all aspects of how this requirement is achieved is clearly documented.

### Requirement 8(3)(c)

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.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Review improvements to ensure they are imbedded and working well to ensure effective governance systems.
* Ensure that all aspects of how this requirement is achieved is clearly documented.

### Requirement 8(3)(d)

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

1. managing high impact or high prevalence risks associated with the care of consumers;
2. identifying and responding to abuse and neglect of consumers;
3. supporting consumers to live the best life they can
4. managing and preventing incidents, including the use of an incident management system.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Review improvements to ensure they are imbedded and working well to strengthen the risk management systems and practices.
* Ensure that all aspects of how this requirement is achieved is clearly documented.

### Requirement 8(3)(e)

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.
* Continue to implement continuous improvement plan as supplied to the Commission.
* Review improvements to ensure they are imbedded and working well to strengthen the clinical governance framework.
* Ensure that all aspects of how this requirement is achieved is clearly documented.