Mandalay Retreat

Performance Report

Crn Bay and Wellington Streets   
CLEVELAND QLD 4163  
Phone number: 07 3286 6879

**Commission ID:** 5350

**Provider name:** Senjah Pty Ltd

**Site Audit date:** 6 July 2021 to 9 July 2021

**Date of Performance Report:** 24 September 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** | **Non-compliant** |
| Requirement 1(3)(a) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | 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) | 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) | 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** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Non-compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | 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) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | 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 29 July 2021
* other information and intelligence held by the Commission in relation to the service, including referrals received internally.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Some consumers considered that they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they chose. Consumers/representatives were satisfied that the care and services the consumer received was culturally safe and consumers were supported to take risks that enabled them to live the best life they could. Consumer/representatives reported the service supported consumers to maintain relationships with those important to them, and said the service was effective in communicating and providing information that allowed consumers to make decisions on their day-to-day care or activities they participated in. Most consumers/representatives felt that staff respected the consumers’ privacy.

Care staff were aware of consumers’ preferences, culture, values and beliefs and explained how consumers’ preferences influenced how care was delivered; lifestyle staff provided examples of how consumers’ cultural and spiritual needs were supported. Management said consumers were supported by the service to take risks that improved their quality of life, and assessment of risk-taking activity occurred in consultation with the consumer, their appointed representative and relevant health professionals as required. Staff provided practical examples of how they ensured consumer’s personal privacy was maintained and information was kept confidential. Notice boards throughout the service were observed to display current information for consumers/representatives, which included lifestyle/activity calendars, meeting minutes, and COVID-19 related updates.

However, not all consumers were consistently treated with dignity or respect. Some consumers described feeling disrespected and provided examples of how staff practices; such as rushing the consumers’ care delivery, not attending to their requests for assistance in a timely way or how staff interacted with them, negatively impacted the consumers’ dignity and wellbeing. Some staff were observed treating consumers in a manner that did not demonstrate respect or consideration of the consumers’ dignity.

The Site audit report brought forward information under this Standard that whilst some consumers were satisfied with the care and services provided to them, some consumers described personal care being delivered in line with staff availability and did not express an understanding that care could be delivered in line with their preferences or could be reviewed and adapted as their care needs or preferences changed. I have considered this information under Standard 2 and 7.

The Site audit report included information under this Standard regarding Consumer feedback survey results (May to July 2021) undertaken by the service that were analysed but no corrective actions were evidenced as being taken. I have considered this information under Standard 6.

The Site audit report brought forward information under this Standard regarding one consumer who expressed dissatisfaction regarding how the service provided them with choice on a day-to-day basis, specifically in relation to meals. I have considered this information under Standard 4.

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

## Assessment of Standard 1 Requirements

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

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

The service was not able to demonstrate all consumers were consistently treated with dignity or respect. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 7.

Four named consumers described in various ways feeling disrespected and provided examples of how staff practices had negatively impacted on the consumers’ dignity and wellbeing. This included staff rushing the consumers’ care delivery and how staff interacted with them; such as staff not paying much attention or staff being flippant. Staff not attending or being able to attend to consumers requests for assistance in a timely way; which included attending to the consumers’ toileting and hygiene care needs. The Approved Provider in its written response to the Site audit report findings, did not agree with the consumers’ feedback saying clinical staff had not been kept informed of consumers changed care needs, or when the consumer may require increased support due to ill health; and where consumers had reported they had experienced negative episodes as a result of delayed care delivery (such as incontinence), these were episodes had not been documented in the consumer’s notes. However, the Approved Provider has not reported on how the service will ensure that in future assessment and monitoring processes consistently identify, capture and document consumer’s changed care needs.

The Approved Provider further refuted there was insufficient staff to provide timely care, saying staff rosters were adequate. The Approved Provider stated to test this, they will survey consumers at the end of October 2021 and obtain verbal feedback from a random selection of consumers and on a weekly basis. However, I note as part of its response, the Approved Provider submitted copies of staff meeting minutes dated 12 and 23 July 2021, where management of the service has minuted they are struggling with staffing for both personal carers and registered nurses, having to use agency staff, and the shortage of staff is affecting care for consumers and how clinical staff perform. This information is considered further under Standard 7 Requirement (3)(a).

The Site audit report identified some staff practices that were observed to not be in keeping with the organisation’s policy on respect, choice and diversity. This included staff not attending to a consumer in visibly soiled clothing, not attending to two consumers who verbalised they were cold and transferring a consumer in an undignified manner that was not in line with manual handing practices. Staff members were observed entering consumers’ rooms without knocking, without introducing themselves or acknowledging the consumers, or whilst talking on the phone. Staff were heard using phrases that were not considered respectful of consumers’ care needs, while talking or calling out to each other in communal areas of the service. Some consumers were observed to be dressed inappropriately on several occasions during the site audit. In its written response and through its provision of the service’s Plan for continuous improvement, the Approved Provider informed that identified staff have been interviewed and disciplinary action has been delivered as required; disciplinary processes will continue as needed. Staff will receive further focused education in August 2021 and over the next three months, regarding the importance of showing respect and demonstrating privacy and dignity considerations to all consumers. Recruitment of new staff will also focus on attitude as well as skills and revision of work instructions will be undertaken.

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified. However, I note that feedback provided by consumers regarding staff rushing consumers during care delivery or staff not being able to assist consumers in a timely way, has not been addressed by the Approved Provider with actions to improve this and to ensure consumers receive timely response to their requests for assistance. It is my decision that at the time of the site audit, each consumer was not treated with dignity and respect and, therefore, this Requirement is Non-compliant.

### 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-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Most consumers/representatives were satisfied with the assessment and care planning process at the service, and said staff generally understood what is important to consumers in terms of how their care was delivered. Consumers/representatives reported staff had spoken with them about advance care and end of life planning for consumers. Consumers/representatives described how consumers and the people important to them were included in ongoing assessment and planning and reported the service generally discussed the consumers’ care needs with them. The care plan was provided to consumers/representatives to review and an updated care plan was available on request.

Care documentation demonstrated registered staff completed initial assessments that identified consumers’ needs, goals and preferences. Consumers, their representatives, the medical officer and allied health professionals were involved during the assessment process where necessary. For most consumers, care documentation generally reflected their care needs and preferences and demonstrated the consumer and others were involved in assessment and planning. Care documentation showed assessments and care planning was generally attended to and discussed with the consumers and representatives on a regular basis.

Registered staff described the process of assessment in conjunction with consumers/representatives, when the consumer entered the service and how this informed the development of an individualised care plans. Staff could describe what was important to consumers in terms of how their personal and clinical care was delivered and how they involved consumers in assessment and care planning; this included others involved in the care of that consumer. Staff explained how they approached conversations with consumers about end of life and advance care planning. Management and staff advised a copy of the summary care plan was provided to consumers/representatives at each review. While staff were generally aware of the incident reporting process on the service’s electronic care management system, the Site audit report identified for one consumer who experienced a fall an incident form was not completed to inform management. I have considered this information under Standard 3(3)(b).

The service had policies to guide staff with assessment and planning, together with evidence-based assessment tools available on the service’s electronic care management system for staff to use. However, the service was not able to adequately demonstrate care and services were reviewed regularly for effectiveness, and when circumstances changed or when incidents occurred that impacted on the needs, goals or preferences of the consumer.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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) 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 service was not able to adequately demonstrate care and services were reviewed regularly for effectiveness, when circumstances changed or when incidents occurred that impacted on the needs, goals or preferences of the consumer. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1 and 3.

Information included in the Site audit report indicated care and services were reviewed regularly by the service for effectiveness. I have come to a different decision in relation to this Requirement based on the evidence brought forward under Standard 1, and evidence which supports Non-compliance in Requirements 3(3)(a) and 3(3)(b).

The site audit report that identified staff did not attend to consumers requests for assistance in a timely way; which included attending to the consumers’ toileting and hygiene care needs. The Approved Provider in its written response did not agree with the consumers’ feedback saying clinical staff had not been kept informed of consumers changed care needs, or when the consumer may require increased support due to ill health. However, the Approved Provider has not reported on how the service will ensure that in future assessment and monitoring processes consistently identify, capture and document consumer’s changed care needs. I have considered this information further under Standard 1.

The Site audit report brought forward information that three named consumers/representatives did not express an understanding that care could be delivered in line with the consumers’ preferences or could be reviewed and adapted as their care needs or preferences changed. Reviewed care documentation demonstrated while consumers’ preferences were recorded in care plans, this information did not consistently align with consumer feedback; preferences included frequency and timing of consumers’ showers and the time a consumer was assisted/transferred to bed. The Approved Provider in its written response the Site audit report findings said consumers are educated and orientated to the services available upon entry; the service checks regularly if consumers have any concerns they want to discuss and checks regularly with representatives all care is being delivered in accordance with consumer/representatives choices. However, the Approved Provider has not addressed how the service’s monitoring processes will be appraised to ensure consumers’ care and services are effectively reviewed on an ongoing basis to reflect consumers changed and current preferences.

The Site audit report identified care documentation for one consumer did not reflect recommendations following the consumer’s assessment by an external behaviour specialist. The consumer’s care plan had not been updated, care staff were not aware the consumer’s review by the specialist and did not know about the recommended behavioural management strategies to be implemented; which included (but was not limited to) regular behaviour monitoring and pain assessment/monitoring. In its response the Approved Provider reported the consumer’s behaviour care plan has been updated to include the specialist’s advice/report, However, I note the Approved Provider has not provided evidence to demonstrate the consumer’s behaviours are being monitored, or to demonstrate how the recommended strategies, including pain assessment/management, are being implemented, monitored, reviewed and/or evaluated for effectiveness. I have considered this information further under Standard 3.

The Site audit report further identified that for three consumers, review or reassessment of the consumers’ clinical needs were not consistently implemented or completed when the consumers experienced a change in their care needs or following an incident. This included one consumer who experienced increased pain but was not referred or reviewed by the medical officer in a timely way; pain assessment/charting provided by the Approved Provider for the consumer during this timeframe, reflected pain monitoring was not conducted by staff in line with written directives of three times a day. I have considered this information further under Standard 3. One consumers experienced an unwitnessed fall and while staff had initiated some clinical monitoring of the consumer following the fall, no pain assessment was documented, no physical assessment was documented by the registered nurse and neurological observations had not been continued in line with the service’s falls management policy. The Approved Provider in its response reported the consumer had requested not to be disturbed overnight. The Approved Provider further advised staff have been reminded of post fall clinical assessment and management, through education delivered and then reinforced at a staff meeting, both held in July 2021. Further registered staff training staff is to be undertaken by the end of September 2021. I have considered this information further under Standard 3. One consumer had been identified by the medical officer as wanting to leave the service; this was something the consumer had done previously without notifying staff. However, care documentation did not demonstrate the consumer had been assessed and/or strategies implemented to manage the consumer’s potential risk of absconding. In its response the Approved Provider said the consumer’s risk assessment and care plan have now been updated. I have considered this information further under Standard 3.

The above information does not support or demonstrate that at the time of the site audit, care and services were reviewed regularly for effectiveness, when circumstances changed or when incidents impacted on the needs or preferences of the consumer. Therefore, it is my decision this Requirement is Non-Compliant.

# 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

Most consumers/representatives reported consumers got the care they needed. Consumers’ representatives stated the service advised them promptly of any changes in the consumer’s health or wellbeing and, overall consumers felt that their needs and preferences were effectively communicated between staff. Most consumers/representatives were satisfied the consumer had access to a medical officer and other allied health providers when required. Most consumers’ care documentation provided information about the consumer’s condition, needs and preferences. Care documents and progress notes reflected the identification of and response to deterioration or changes in the consumers’ condition. Consumers’ care planning demonstrated involvement of the medical officer, allied health providers and other service providers as required.

Registered and care staff described how they supported consumers who were nearing end of life and gave examples of care delivered that maximised the consumers’ comfort and dignity. Care staff advised they observed consumers for signs they may be unwell and reported these to the registered staff; registered staff could describe actions they would take if a consumer showed signs of deterioration. Staff reported how changes in consumers’ care and services needs were communicated, and registered staff could describe the process for referring consumers to other health professionals. Registered staff informed how they notified the consumer’s representative and medical officer when a consumer experienced a clinical incident, a change in condition or when transferred to or from hospital.

However, the service did not demonstrate that each consumer received safe and effective care which was tailored to their needs and optimised their health and well-being. This was in relation to one consumer who experienced pain which had not been adequately addressed, and one consumer whose care planning directives were not inclusive of specialist recommendations related to their behaviour management; staff were not aware of the recommended strategies and the consumer continued to display challenging behaviours. The service did not demonstrate effective management of high impact or high prevalence risks in relation to ongoing review of consumers who experienced a fall or who might wander. Staff were not consistently reporting falls via the incident management system.

Whilst the service has an outbreak management plan and an Infection prevention and control (IPC) lead, the service did not demonstrate adequate infection control precautions were implemented in relation to; the use of shared slings for mechanical lifting aids between consumers, the use of personal protective equipment by staff, food being served by staff, and infection control processes for environmental cleaning.

The Quality Standard is assessed as Non-compliant as three 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 service was not able to demonstrate that each consumer received safe and effective care, tailored to their needs and that optimised their health and well-being; particularly in relation to pain and/or behaviour management. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 2 and 6.

The Site audit report identified one named consumer with a cognitive deficit and verbal challenging behaviours who had been reviewed by an external specialist; a range of recommendations and strategies had been provided for staff to implement to assist in managing and minimising the consumers behaviours. These strategies included (but were not limited to) assessment and management of the consumers pain and validating the consumers feelings of frustration/agitation. However, the recommendations were not reflected on the consumer’s care plan, care and registered staff were not aware of these strategies to assist in caring for the consumer, and other consumers’ feedback identified the consumer continued to display verbally challenging behaviours throughout the day and night. While Management reported they had provided the specialist recommendations in a letter for staff to read, management did not evidence this had occurred.

The Approved Provider in its written response to the Site audit report findings, refuted the findings saying consumers do receive safe and effective care. The Approved Provider stated the specialist’s advice/report had been uploaded onto the service’s electronic clinical management system, provided to staff at handover, discussed with lifestyle staff for them to implement activities as recommended, and displayed on the staff notice board. The Approved Provider reported staff will be provided with further training and the contents of the specialist’s advice/report will be reiterated with staff. The Approved Provider reported the consumer’s behaviour care plan has now been updated to include the specialist’s advice/report, staff are being reminded through handover notes to reference the report and document behaviours daily, and staff are implementing as appropriate the suggested strategies. However, the Approved Provider in its response has not provided evidence of the consumer’s updated care plan, that the consumer’s behaviours are being monitored, or to demonstrate how the recommended strategies, including pain assessment/management, are being implemented, monitored, reviewed and/or evaluated for effectiveness in managing or minimising the consumer’s behaviours.

The Site audit report identified that while the service has a suite of policies, the service did not have procedures to guide staff in the delivery of clinical care. In its response the Approved Provider stated the service does have a set of current processes that are accessible as part of the online cloud-based suite of clinical guidance material, provided by an aged care peak body since 2019. What is being reviewed/updated are gaps found in these that were part of the ‘old procedures’; this led to a misunderstanding. Current processes and policies are available to staff via the services shared computer drive and are printed and located in nurses stations throughout the home.

For one named consumer with complex pain, the site audit identified staff completed pain assessments/charting and provided regular and ‘as required’ pain relief medication following the consumer’s return from hospital. However, while the consumer had told staff they were still experiencing pain, the consumer reported they had to wait for pain relief medication until their next dose was due. The consumer had not been referred to the medical officer to discuss their pain needs; following feedback by the Assessment Team provided during the site audit, management had arranged for the medical officer to review the consumer. The Approved Provider in its response refuted the findings saying consumers do receive safe and effective care, all consumers have regular pain assessments or a review if they express any change to their condition, and the service has access to allied health professionals to assist staff in identifying and managing pain. However, while the Approved Provider informed the consumer was reviewed by the physiotherapist for pain management, to manage the consumer’s pain until the medical officer could attend, a copy of the physiotherapists suggested pain management strategies has not been provided, nor evidenced as being implemented by staff in pain assessment/charting records that were provided by the Approved Provider for the time frame 6 to 23 July 2021 (other than general repositioning). I note the pain assessment/charting was not conducted by staff in line with written directives of three times a day; specifically, for four days from 9 to 12 July 2021 where time gaps of 17 hours are reflected, where no pain monitoring was undertaken by staff.

I acknowledge the actions taken and to be implemented by the Approved Provider to ensure recommendations to guide staff with behaviour management care delivery is provided to and understood by staff in a timely way. However, the Approved Provider has not addressed how it will ensure consumers’ individualised pain management needs are consistently and appropriately monitored and managed, and implemented strategies are reviewed for effectiveness in the future. It is my decision that at the time of the site audit, consumers were not receiving care that was tailored to their needs or optimised their health and well-being; therefore, this requirement is Non-Compliant.

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

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

The service did not demonstrate effective management of high impact or prevalence risks in relation to management of consumers who experienced a fall. Staff were not consistently reporting falls via the service’s incident management system. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 6.

For one named consumer who experienced an unwitnessed fall, the Site audit report identified while staff had initiated some clinical management and monitoring of the consumer following the fall; no pain assessment had been documented, no physical assessment was documented by the registered nurse and neurological observations had not been continued in line with the service’s falls management policy. Management had advised staff were not following observation protocols following falls especially overnight, as consumers were sleeping. Registered staff did not demonstrate an understanding of follow up observations required following a consumer’s fall. The Approved Provider in its written response to the Site audit report findings, refuted the findings saying consumers do receive effective care and reported the consumer had requested not to be disturbed overnight and this should have been documented by staff. However, I note this consumer’s fall had resulted in the consumer experiencing a fracture, which was identified by staff in the morning following the fall when the consumer was observed to be in severe pain and could not move their leg. The Approved Provider reported, and documentation provided demonstrated that staff have been reminded of post fall clinical management and documentation required, through education delivered and then reinforced at a staff meeting, both held in July 2021. Further training for all registered staff is to be undertaken by the end of September 2021.

The Site audit report identified another consumer who experienced an unwitnessed fall; whilst post fall clinical management was provided, an incident form had not been completed by registered staff to report the fall until feedback was provided by the Assessment Team, four weeks after the incident occurred. During a post fall review conducted by the medical officer, the medical officer noted the consumer wanted to leave the service; this was something the consumer had done previously without notifying staff (during which time the consumer had experienced a fall as well). However, care documentation did not demonstrate strategies had been implemented to manage the consumer’s potential risk of absconding. While management had reported they did not consider the consumer a flight risk, the consumer’s representative had discussed the use of an emergency alert with management and had expressed concern no further action had been taken by management. I have considered this aspect further under Standard 6. In its response the Approved Provider refuted the findings, saying consumers do receive safe and effective care. In addition to staff having been reminded of the Falls prevention policy and further training being arranged for staff by end of September 2021, the Approved Provider said the consumer’s risk assessment and care plan have now been updated and the consumer’s representative consulted regarding interventions to manage the consumers potential absconding risk. As part of its Action plan the Approved Provider reflected registered staff are to receive education regarding incident reporting.

The Site audit report identified consumer falls had increased between May and June 2021; management had advised consumer falls are reviewed as part of the service’s quality indicators each month and an increase in falls had been identified. Clinical data identified unplanned transfers of consumers to hospital had increased in May 2021; management had advised the increase in unplanned transfers was related to consumers being transferred following a fall. Management had advised a three month trend analysis was to be conducted including the times of falls and whether strategies in place are effective. The Approved Provider did not specifically address when this analysis is to be conducted as part of their response; however, the service’s Plan for continuous improvement reflected a review of consumers’ fall data is to be undertaken and a falls risk reduction strategy is to be developed to reduce the number of falls.

The Site audit report identified that while the service has a suite of policies, the service did not have procedures to guide staff in the delivery of high impact and high prevalence risks. The Approved Provider in its response provided a copy of the service’s Falls prevention policy and stated the updated policy was recently provided to registered nurses (May 2021) and is available via the service’s shared computer drive. However, I note the policy does not address identifying and monitoring/management of the consumer’s pain needs within the first 24 hours of the fall occuring; this is only referenced as part of observations to be conducted over the week following the fall.

While I acknowledge the actions taken, and being taken by the Approved Provider, at the time of the site audit, high-impact or high prevalence risks for consumers were not effectively being managed. Therefore, it is my decision this requirement is Non-Compliant.

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

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

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

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

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

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

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

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

### Requirement 3(3)(g) 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.*

While staff could demonstrate an understanding of how they minimised the need for or use of antibiotic medication, and ensured they were used appropriately, the service did not demonstrate adequate infection control precautions were implemented. This was in relation to the use of shared slings for mechanical lifting aids between consumers, the use of personal protective equipment by staff, food handled by staff when provided to consumers and infection control processes for environmental cleaning. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 5.

The Site audit report identified in two areas of the service that slings, used in conjunction with a mechanical lifting aid (hoist) to transfer consumers, were shared and staff did not routinely clean the sling between consumer use. In one instance the sling was observed to be visibly soiled; work instructions directed slings to be washed overnight and sprayed with disinfectant every other day. The Approved Provider in its written response to the Site audit report findings, reported a sling audit has been completed and the allocation of slings has taken place, to guarantee adequate slings of required sizes to ensure correct infection control measures are in place. Further education has been provided to staff around infection control and staff have been instructed to clean equipment such as hoists between use by different consumers.

The Site audit report identified staff did not consistently follow Queensland Health guidelines/directives in relation to wearing personal protective equipment; specifically, regarding face masks. Staff were observed wearing cloth masks and not surgical facemasks, wearing facemasks incorrectly or not wearing a mask (within the secured unit), and staff touching their facemasks and not sanitising their hands afterwards. In its response the Approved Provider said staff have received education around infection control, and all staff have been advised cloth masks are no longer allowed as of 7 July 2021. The Approved Provided reported staff working in the secure unit may need to change the accepted use of masks, to assist in maintaining a calm and accepting environment if the sight of a mask triggers behaviours of concern in consumers. However, this directive is contrary to the *Queensland Health Pandemic Response Guidance escalation of personal protective equipment usage in residential aged care and disability accommodation services version 1.4* (August 2021). Guidance is provided regarding additional considerations around use of face masks for staff where consumers may get distressed or alarmed and an alternative option, in very limited and rare circumstances, is where a face shield may be considered. I note the Approved Provider has not evidenced in its response that the service has identified which consumers may be triggered by staff wearing facemasks or strategies trialled or implemented by staff to manage this.

The Site audit report identified high touch-points areas such as entry doors in the secure unit were observed to be visibly dirty and shared equipment was stored in consumers’ communal areas. I have considered this information under Standard 5(3)(b). While colour coded cleaning mops were used to ensure no cross contamination occurred of different room types, it was identified staff used a single bucket when cleaning/mopping different rooms/areas; staff had said there were not have enough buckets at the service to align with the colour coded mop system. The Approved Provider in its response said management identified having a system of colour coded buckets with the existing mop heads, may provide a more comprehensive approach to infection control processes; these buckets have been purchased and are now in use.

Disinfectant wipes were not consistently available in nurse’s workstations to wipe shared equipment, such as phones, keyboards and electronic devices, after use. The Site audit report identified a staff member used the shared phone without wearing a mask and did not wipe down phone after use. Staff were observed to touch or hand to consumers, unwrapped food without gloves. In its response the Approved Provider informed that hand sanitiser and sanitising wipes are readily available, and staff and consumers are encouraged to use these appropriately. Staff have received infection control training and will continue to receive further education around updated use of personal protective equipment, food handling, and infection control cleaning updates as per the service’s Plan for continuous improvement.

While I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified, at the time of the site audit, practises to ensure the minimisation of infection related risks through implementing appropriate precautions, including COVID-19 related precautions, were not effective. Therefore, it is my decision 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

Consumers considered that they got the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they wanted to do. Most consumers/representatives said the lifestyle program supported the consumers’ lifestyle needs and consumers were encouraged to be as independent as possible. Consumers/representatives said staff were supportive when a consumer was feeling low and consumers described how they participated in their community, within and outside the service environment. Consumers/representatives said the consumer's condition, needs and preferences were effectively communicated within the organisation and with others responsible for providing care. While most consumers provided positive feedback regarding the variety and quality of meals offered by the service, one consumer expressed dissatisfaction there were no meal choices for consumers’ requiring modified texture meals; management had said they would further consider how meal options could be provided to consumers on texture modified diets.

Consumers’ care planning documentation included personalised information about the services and supports consumers needed regarding their lifestyle interests and activities of daily living. Care documentation included information that supported consumers’ emotional and spiritual well-being, and information about personal relationships important to the individual. Consumers’ care documentation reflected the involvement of others in the provision of lifestyle supports, including external church/spiritual services for specific individuals and input from representatives. Care planning documentation was reflective of the consumers assessed dietary needs and preferences that generally aligned with consumer and staff feedback.

The lifestyle program was designed and adapted in line with consumer feedback and suggestions, which were discussed at consumer meetings each month. Lifestyle staff advised consumers identified as requiring additional emotional support were visited by volunteers and lifestyle staff, who provided further one-to-one social support. Staff said the service hosted church services from various visiting denominations weekly, and staff were able to describe a number of ways in which they shared information and were kept informed of the changing condition, needs and preferences for each consumer. Lifestyle staff described how they had engaged with consumer representatives, volunteers, entertainers and community groups to develop activities to supplement the lifestyle program offered by the service.

Management advised the service had been actively working to improve the quality and variety of meals and had commenced holding food focus meetings in March 2021, to seek feedback and input from consumers. Where equipment was provided it was observed to be safe, suitable, and well maintained; staff undertook ongoing monitoring to ensure equipment was fit for purpose. However, the Site audit report brought forward information that consumers’ shared equipment such as hoists, which enabled consumers to attend activities, were not being cleaned between consumers. I have considered this information under Standard 3 Requirement (3)(g).

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 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Consumers considered that they felt they belonged at the service and felt safe and comfortable living in the service environment. Consumers/representatives provided examples of how the consumers’ utilised the service environment and what made it a nice place to live. Consumers/representatives said consumers felt safe at the service and believed it was generally well maintained. Consumers confirmed they were able to move freely in and around the service, such as attending the onsite café or accessing the courtyard areas. Consumers said the furniture, fittings and equipment provided by the service was clean, well-maintained and suitable for their care needs.

Staff reported consumers and their family members were encouraged to personalise consumer’s rooms to make them feel at home and comfortable. Management advised a new Maintenance officer was recently appointed and was being on-boarded and supported by management in relation to the service’s systems, processes and maintenance schedules.

The service environment was observed to be welcoming, easy to understand and it supported the consumers’ sense of belonging; their independence, interaction and function. Consumers’ rooms were individualised with personal effects and furniture. Consumer meeting minutes identified maintenance issues were discussed with consumers and maintenance issues reported by staff on behalf of consumers was generally addressed as required.

However, the service was not able to adequately demonstrate cleaning and maintenance monitoring processes were effective in consistently identifying and addressing all cleaning and maintenance issues; nor that the service environment and/or furniture was consistently safe, clean and well maintained, and that there was sufficient equipment available to meet consumer care needs.

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

*The service environment:*

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

While the service was able to demonstrate the environment is designed to enable consumers to move freely both indoors and outdoors, they were not able to adequately demonstrate that the service environment was consistently safe, clean and well maintained.

The Site audit report identified the service environment was observed to be visibly unclean. This included carpets in communal areas that were stained, ceiling fans and bathroom vents were visibly dusty, high touch-point areas such as entry doors to the service’s secure unit were unclean with built up grime, and a balcony was observed to be littered with rubbish and consumers’ personal effects. The Approved Provider in its written response to the Site audit report findings refuted the findings saying the service environment is safe, clean and well maintained. The Approved Provider stated in May 2021 a special cleaner was employed to shampoo the carpets in communal areas to improve the carpet cleanliness, and the cleaner had provided feedback to the service that the carpets seemed to quickly become dirty after cleaning. I note the Approved Provider has not provided any further strategies they are considering to ensure the carpets in the communal areas remain clean. The Approved Provider noted ceiling fans and bathroom vents are part of the deep clean schedule carried out regularly; a recent environmental cleaning audit conducted by the service identified ceiling fans and bathroom vents were not up to cleaning standards and this has now been addressed by the cleaning team. The Approved Provider reported it is planning to have the doors of the secure unit sanded back and repainted. The Approved Provider stated the balcony was littered with rubbish and consumer personal effects as contractors were installing a new kitchen; the area has now been cleaned and pressure washed, as part of a regular cleaning schedule.

The Site audit report identified one of the service’s designated consumer smoking areas was observed to be visibly dirty; a ceramic pot being used as an ashtray and a plastic bag located in leaf litter, were both filled with or contained cigarette butts. A second designated consumer smoking area did not have an ashtray available for consumers to use, and several cigarette butts were observed to have been extinguished inside of house bricks stacked along the wall of the smoking area. The fire extinguisher in the second designated consumer smoking area had not been inspected or tagged in line with Workplace health and safety requirements. Management had said ashtrays were provided and had possibly been removed by a consumer; however, management were not aware the fire extinguisher had not been inspected. The Site audit report further identified that one consumer did not consistently use the service’s designated smoking areas but smoked outside their room on the ground floor balcony; management were not aware the consumer was smoking on their balcony.

This consumer who smoked outside their room had said they felt unsafe walking to the designated smoking area without assistance as the ground was steep and they feared falling; however, staff were often not available to assist them as required. I have considered this aspect further under Standard 7. The Site audit report also identified three chairs in one of the designated smoking area were observed to be visibly weathered. I have considered this information under Requirement 5(3)(c).

In its response the Approved Provider reported the two smoking areas were cleaned during the site audit visit and are now on the service’s cleaning schedule for regular cleaning. Ashtrays are supplied and emptied regularly. The two fire extinguishers, which were new, have now been tested and tagged, bringing them into the current inspection program maintained by the service’s external contractor. The Approved Provider acknowledged one consumer does not always adhere to staff requests to smoke in the service’s designated smoking areas and does on occasion resort to smoking on their balcony. The Approved Provider stated while risk assessments have been completed for the consumer and staff continue to request that the consumer alert staff for assistance, the consumer continues to be non-compliant. However, the Approved Provider has not addressed or demonstrated whether a risk assessment of the environment where the consumer continues to smoke, the balcony off their room, has been completed and what strategies have been implemented to minimise or manage the risk of a fire, which would have the potential to impact the safety of all consumers living at the service.

The Site audit report identified that while three consumers in the secure unit verbalised they were cold, only one consumer was provided with a blanket. The Approved Provider in its response stated that the staff member supervising consumers in the area at the time of the site audit had been notified that the standard of care provided was not acceptable, nor did it align with the service’s core values; the staff member has now resigned.

The Site audit report noted the service’s maintenance logs reflected a number of outstanding items. Management advised a new Maintenance officer had been recently appointed and acknowledged while there were some gaps in the maintenance schedules, the service would develop a corrective action plan to address the outstanding maintenance items over the coming months. In its response the Approved Provider reported the new Maintenance officer is working to manage the gaps in the planned schedule. However, the Approved Provider did not provide a copy of the corrective action plan that was to be developed, to demonstrate how it was addressing, prioritising and monitoring to completion, the outstanding maintenance issues.

While I acknowledge the actions undertaken and committed to by the approved provider, at the time of the site audit management was not able to demonstrate the service provided a consistently safe, clean and well maintained environment for all consumers. Therefore, it is my decision this requirement is Non-Compliant.

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

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

The service was not able to demonstrate that sufficient equipment is provided to support the delivery of safe care and services, or that equipment to support the safe storage of chemicals is replaced, or is able to be locked, as required.

The Site audit report identified a bottle of cleaning chemical was located on a shelf in a shared toilet of the secure unit, accessible by consumers. Staff had reported that three of five cleaning trolleys in use were not able to be locked to secure chemicals safely; however, a request by staff to purchase new cleaning trolleys had been declined by the service. Staff said additional keys to lock the cleaning trolleys had been requested as at the time of the site audit, only two keys were available for six cleaning staff to use. The Approved Provider in its written response to the Site audit report findings stated the bottle of cleaning chemical located in the shared toilet had inadvertently been left there by cleaning staff. The cleaning team have received education around safe storage of chemicals and will receive this information ongoing at their weekly meeting, to reinforce the safety issues around chemical storage. Additional, adequate keys for the cleaning trolleys have been ordered and are on site for use. The Approved Provider stated equipment will be replaced if it is deemed unsafe and trolleys are on order; at times there has been significant wait times for ordered equipment due to insufficient supply.

The Site audit report noted that while new furniture was observed in communal sitting areas, some furniture in the secure unit was observed to be worn; one dining chair had a tear across the cushion, and furniture provided in one designated consumer smoking area was observed to be weathered. In its response the Approved Provider refuted these findings saying furniture at the service is fit for purpose. While the Approved Provider acknowledged the chair in the secure unit was torn, they said this was a result of an incident and was being retained for evidence. However, the Approved Provider did not clarify why the chair was still located in the secure area for use by other consumers and not put away in storage. The Approved Provider stated there is currently a planned refurbishment of the service that included chairs; however, there is significant wait times due to unavailability of supplies.

The Site audit report noted shared equipment such as hoists, weigh chairs and wheelchairs were being stored in communal areas used by consumers, including the cinema and sitting areas. Staff had advised equipment was stored in these areas due to a lack of storage areas available. The Approved Provider in its response stated staff have adequate storage areas and have been instructed not to use communal areas for storage. Staff have received education on safe and correct storage of equipment and this is regularly reinforced at team meetings. Upon investigation staff reported they had lost their keys to the storage areas and staff had not, at the time of the site audit, reported these keys as missing; new and sufficient keys have now been purchased. However, the Approved Provider has not addressed how the service’s environmental monitoring systems did not identify this deficiency in storage practice by staff, or monitoring processes are to be rectified.

The Site audit report detailed that staff reported there was insufficient equipment available to enable them to carry out their duties in a safe and effective way, that meets the needs of consumers. Staff advised the service did not have enough slings available for each consumer who requires the aid of mechanical lifters for transfers, resulting in slings being shared. I have considered this further under Standard 3(3)(g). Staff said the service did not have enough buckets available to align with the colour coded mop system, resulting in one bucket being used when cleaning/mopping different areas. I have considered this further under Standard 3(3)(g). The service’s morning Huddle meeting minutes had identified the need for the service to purchase new trolleys for the kitchen as staff had reported the trolleys were rusty and broken. While multiple trolleys had been requested, this was declined, and one trolley was approved. In its response the Approved Provider refuted the findings saying an audit of equipment and its usage has been carried out and found to be adequate with all equipment in a fit and proper state. The Approved Provider stated management had no knowledge of, and had not viewed, any rusty or broken kitchen trolleys and believes this to be untrue.

The Site audit report identified while an Inventory and equipment audit was completed in March 2021, the analysis and outcome; which management said were conducted by the Quality coordinator who also then oversees the corrective actions completed to address any identified deficiencies, were not included with the audit or provided. Reviewed hazard forms reflected corrective actions taken or the dates these were implemented, were not documented. The Approved Provider in its response said all outstanding audit actions have now been completed; however, the Approved Provider did not demonstrate or evidence this as part of its response. The Approved Provider stated the analysis of audits will in future be tabled at Heads of department meetings and results will also be included in the monthly management meeting. The Approved Provider did not address how hazard forms will be monitored in future to ensure required actions are implemented, any risk associated with the hazard are managed appropriately and actions taken are reviewed for effectiveness.

I acknowledge the actions undertaken and committed to by the Approved Provider, to address some of the deficiencies identified. However, at the time of the site audit the service was not able to demonstrate furniture, fittings and equipment were safe, clean, well maintained and suitable for the consumer. Therefore, it is my decision this requirement is Non-Compliant.

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers/representatives said management acknowledge their concerns and supported them to make complaints. Most consumers/representatives reported they were comfortable raising concerns with staff or management and consumers who had difficulty communicating had access to representatives to help them provide feedback.

Staff said they endeavoured to resolve any concerns raised by consumers where possible and reported these concerns to registered staff or management. Management advised advocacy services had visited the service and provided information to consumers. The service had hard copy feedback forms, external complaints and advocacy information on display. The service had a consumer handbook that outlined internal and external complaints mechanisms and advocacy services available to consumers.

However, some consumers/representatives were not satisfied that appropriate action had been taken, or in a timely manner, to address the concerns they had raised. The Site audit report identified actions taken by the service in response to complaints had not been effective and an open disclosure process was not always used when things went wrong. The service did not adequately demonstrate that feedback and complaints were consistently reviewed and used to improve the quality of care and services for consumers.

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

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

The service was not able to adequately demonstrate appropriate and timely action was taken in response to complaints and an open disclosure process was used when things go wrong. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 3.

The Site audit report identified three named consumers had submitted an undated written complaint to management that was received by the service 31 May 2021, in relation to one co-consumer’s verbally disruptive behaviour; the co-consumer’s behaviour included calling out at night and disrupting the consumers’ sleep. While the complainants had received an initial written response from the service advising of actions taken to address and review the co-consumers health, two complainants said they had heard nothing further and the situation had not improved. Both complainants advised in various ways the co-consumers behaviour had a significant negative impact on their health and wellbeing; their concerns had been raised on numerous occasions with management, but their complaints had not been resolved. The Approved Provider in its written response to the Site audit report findings stated all three consumers had been offered alternative rooms, which the consumers had declined. However, while the Approved Provider confirmed the co-consumer’s health issues were being addressed and said the service will continue to liaise with the three consumers to seek a suitable alternative, the Approved Provider has not addressed how it will ensure complaints are dealt with promptly in the future including ongoing communication required while a complaint is being followed up and resolved appropriately.

The Site audit report provided details of a named consumer representative who said concerns they had raised and suggestions they had made following an absconding incident where the consumer had also experienced a fall, had not been addressed by the service; the representative was concerned about a reoccurrence and the ongoing safety of the consumer. In its response, while the Approved Provider reported the consumer’s family has now been consulted about the implementation of a pendant alarm or a transfer to the secure unit of the service; the Approved Provider has not addressed how it will ensure complaints are dealt with promptly in the future; including evidencing clear timeframes and taking into consideration ongoing communication required while a complaint is being addressed, followed up and resolved appropriately.

The Site audit report identified another consumer representative had said they were concerned that raising complaints would negatively impact the care and service’s the consumer received. While the Approved Provider said in its response no consumer’s representative has any basis for feeling that raising a complaint will negatively impact the care and services a consumer receives, the Approved Provider has not addressed how they will confirm consumers/representatives are reassured; and ensure that consumers/representatives aren’t afraid that the organisation will treat the consumer badly after a complaint is made.

The Site audit report identified that while the service has an open disclosure policy, the policy was not consistently followed. Management were not able to demonstrate that an apology had been given after two complaints were lodged (April and May 2021) by a consumer representative following two incidents experienced by the consumer. Registered staff were not aware of the service’s open disclosure policy. In its response the Approved Provider reported a refresher course on open disclosure for management and staff will be delivered in the near future and will be based on the Aged Care Quality and Safety Commission’s resources including the Open Disclosure Framework and Guidance material.

I acknowledge the actions the Approved Provider has taken, and is to take, to attend to the deficiencies identified. However, it is my decision that at the time of the site audit, appropriate and timely action was not taken in response to complaints, and an open disclosure process was not used when things went wrong; therefore, this requirement is Non-Compliant.

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

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

The service did not adequately demonstrate feedback and complaints are consistently reviewed and used to improve the quality of care and services. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1, 3 and 7.

The Site audit report identified three consumers/representatives who advised they were not aware of any improvements made because of complaints provided to the service; this was specifically in relation to complaints made about a co-consumer’s verbally disruptive behaviour and regarding concerns raised following a consumer’s absconding incident. Management were not able to demonstrate effective actions had been taken in a timely way and communicated to the complainants to successfully resolve the concerns raised. I have considered this information under Standard 6(3)(c).

The Site audit report identified that although analysis and results were provided for a Consumer feedback survey (May to July 2021), evidence of corrective actions were not provided. The survey identified the service did not receive results in line with benchmarking in relation to providing activities for consumers that afford satisfaction and consumer’s satisfaction with the quality of food. The Approved Provider in its written response to the Site audit report findings reported because of the surveys the service has reviewed and redesigned the lifestyle program to incorporate more variety and activities for consumers; however, this is not reflected on the service’s Plan for continuous improvement and the Approved Provider has not provided any evidence to demonstrate the improvements made. The Approved Provider stated a food focus group also provides consumer feedback, and as a result of consumer feedback and survey results, the service has changed some food suppliers to increase the quality of meals. I note the creation of the food focus group was reflected on the service’s Plan for continuous improvement and I acknowledge most consumers reported satisfaction with the variety and quality of meals offered by the service at the time of the site audit. The Approved Provider further reported in its response the service will undertake to ensure that analysis of surveys are documented, and any agreed improvements are actioned.

The site audit report identified the service’s incident management system did not include information evidencing how consumers’ incidents, particularly in relation to falls, were used to consistently improve the quality and care and services. I have considered this information under Standard 3(3)(b).

The Site audit report identified through interview with management and review of documentation, the service’s complaints register did not include information that demonstrated how complaints were used to improve the quality of care and services, and management could not demonstrate how information from complaints was used to make improvements to safety and quality systems. The Approved Provider in its written response to the Site audit report findings refuted the findings saying a complaints register is used to capture complaints to assist with trending and analysis; the service used the information from complaints to make improvements to safety and quality systems and the service regularly reviews and improves how they manage complaints. However, the Approved Provider has not provided evidence to demonstrate how complaints received by the service have been used to contribute towards the service’s Plan for continuous improvement; this includes reviewing the service’s complaints processes to ensure complaints are dealt with promptly, ensure ongoing communication is provided as required while a complaint is being addressed, followed up and resolved appropriately.

In coming to a decision I have also taken into consideration information brought forward in the Site audit report regarding feedback and complaints from consumers/representatives and staff, in relation to insufficient staff at the service to provide safe, quality and timely care and services to consumers, which ensured consumers were treated with dignity and respect. Evidence to support Non-compliance brought forward under Standards 1(3)(a), 3(3)(a) and 7(3)(a). On review of the information above, it is my decision that the service has not demonstrated that feedback and complaints are consistently reviewed and used to improve the quality of care and services. Therefore, this Requirement is Non-compliant.

# 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

Some consumers considered that they received quality care and services when they needed it and from people who were knowledgeable and capable. Consumers/representatives said staff were generally kind, caring and gentle when providing care to consumers. While some consumers/representatives advised there were adequate staff to meet consumers’ care needs, consumers who require assistance from staff to mobilise said they had to wait to have their call bell answered. Consumers/representatives said they generally felt confident that staff were sufficiently skilled to meet consumers’ care needs.

Management reported they determined whether staff were competent and capable in their role through observation of practice, and feedback from consumers and senior staff; staff were required to have appropriate qualifications for their role. The service had job descriptions that specified core competencies and lines of reporting for each role. Staff advised they discussed any areas of education they needed to support their ongoing professional development with their supervisor. Management stated staff who administered medications were required to complete a competency that included practical and theoretical components.

The organisation had a staff performance framework that included a probationary period following commencement of employment, and annual performance appraisals were conducted for all staff.

However, the service was not able to demonstrate that the number of staff was planned to enable the consistent delivery and management of safe and quality care and services; there were insufficient care staff to meet consumers’ needs in a timely manner. The service did not adequately demonstrate the workforce is trained and supported to deliver quality care and services.

The Quality Standard is assessed as Non-compliant as two 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 service was not able to demonstrate that the number of staff was planned to enable the delivery and management of safe and quality care and services; there were insufficient staff to meet consumers’ needs in a timely manner. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1 and 5.

The Site audit report identified six consumers who had reported in various ways their dissatisfaction with the number of staff available to assist them with their care needs in a timely way. The consumers’ concerns included staff being very busy and not being able to attend to consumers when they had requested assistance, or staff not answering the call bell; consumers having to wait for staff to attend to their toileting and hygiene needs or for staff to administer clinical therapies, and staff rushing consumers when delivering care. Consumers were also concerned that there were not enough staff at night to attend to a consumer with verbally challenging behaviours that was having a negative impact on other consumer’s ability to sleep; consumers reported the meal service was sometimes disturbed by the co-consumer’s verbally disruptive behaviour as well; however, said staff did not always attend to the consumer when the consumer called out. Another consumer was identified as not smoking in the designated smoking area; the consumer reported they felt unsafe walking to the smoking area unaided and said staff were often not available to provide assistance.

The Site audit report further identified three consumers/representatives who described personal care being delivered for consumers in line with staff availability and did not express an understanding that care could be delivered in line with their preferences. The consumers/representatives spoke about showers being provided for consumers in line with staff availability; in either the morning or afternoon, or three times a week rather than second daily as reflected in the consumer’s care plan, or consumers being assisted to bed at a time when staff were available, but which was not the consumer’s preference. These consumers/representatives had advised they were satisfied to work with staff.

The Site audit report identified staff had stated they were rushing to complete tasks and did not have time for quality one-to-one interactions with consumers. Staff reported they often worked short of staff members as vacant shifts were not replaced; staff on duty extended their shift where possible to cover for these vacant shifts. Reviewed rosters for April to June 2021 demonstrated vacant shifts for care and registered staff, had not been consistently filled. Management acknowledged they were not always able to fill vacant shifts with agency staff and stated they were recruiting for care and clinical staff.

The Approved Provider in its written response to the Site audit report findings refuted the findings saying staff rosters have been reviewed and the Approved Provider believed there are adequate staff to allow personal care to be delivered in line with consumers choice and preferences. The Approved Provider reported the service is consistently and constantly working to recruit and fill any staff vacancies; the service is working with agencies and recruiters to fill as many vacant positions as possible. The Approved Provider stated they understood staff frustration of not being able to spend one on one time with consumers if they are having a busy day, but this was due to circumstances well beyond the control of the Approved Provider, which included industry staff shortages. The Approved Provider informed that consumers are educated and orientated to the services available upon entry and the service checks regularly with consumers/representatives to ensure all care and services are being delivered in accordance with consumers’ preferences.

As part of its response the Approved Provider submitted copies of the service’s staff meeting minutes dated 12 (Morning huddle) and 23 (Registered staff) July 2021, where the service’s management had minuted they were struggling with staffing of both personal carers and registered nurses, and shortage of staff was affecting care for consumers. However, other than an ongoing commitment to the recruitment of staff, the Approved Provider has not addressed or demonstrated how it monitors the sufficiency of staff based on consumer/representative and staff feedback or adapts to the changing needs of the consumers. This includes ways to promptly identify and manage issues and risks, including high impact and high prevalence risks such as falls, challenging behaviours and non-compliance with fire safety regulations, that might result from not having a sufficient workforce.

While I acknowledge the Approved Provider’s response, in reviewing the above information it is my decision that at the time of the site audit the service was not able to demonstrate the workforce number deployed enabled the delivery and management of safe and quality care and services for consumers. Therefore, this Requirement is Non-Compliant.

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

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

### Requirement 7(3)(c) Compliant

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

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

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

The service did not adequately demonstrate the workforce is trained and supported to deliver quality care and services. The Site audit report identified while consumers/representatives were generally satisfied with the skills of staff providing care, consumers/representatives said new staff do not always know what they are doing. The Approved Provider in its written response to the Site audit report findings provided an example of orientation training provided to a registered nurse in July 2021 (list of training, completed date and staff signature). While this demonstrates the detail of information delivered to new staff, the orientation training list is only partially completed and no other explanation or information has been provided by the Approved Provider in relation to onboarding training provided to new staff.

The Site audit report identified a consumer’s representative said staff ask the representative for clinical guidance; following an injury sustained by the consumer, staff had telephoned the representative to ask whether the consumer should be transferred to hospital. In its response the Approved Provider said, and care documentation demonstrated, the consumers’ family have requested they be actively involved in the consumer’s care since the consumer’s entry to the service. Historically the family had been contacted at their request, to inform them of any incidents and this was usual practice for this consumer and their family.

The Site audit report identified while staff reported management provided tool box training, and read and sign education information, staff said they did not always retain the information. Staff could not describe education topics covered, could not provide details about recent Serious incident report scheme (SIRS) information they had been provided with and read, the service could not provide evidence of providing this SIRS training to staff and staff did not have a shared understanding of the SIRS legislative requirements and how it related to their roles. The Approved Provider in its response said staff have been given education around recent changes such as SIRS and provided Inservice group attendance record documentation to demonstrate face to face SIRS education was provided to some staff (49) over a two day period, in March 2021. However, the attendance record evidenced by the Approved Provider reflects 47 staff have not attended this training, 39 of whom are care or registered staff. The Approved Provider said they are investigating alternative education delivery strategies as it understands different staff learn at different rates and find different training methodologies more efficient.

The Site audit report noted staff said they discussed any areas of education they needed to support their ongoing professional development with their supervisor, and staff who administer medications were required to complete a competency that included practical and theoretical components.

In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1, 3 5 and 7. While I acknowledge in its response the Approved Provider has referenced the service has an orientation and training program for staff, the Approved Provider has not evidenced how the service monitors and reviews its training processes, to ensure all staff are trained and supported to meet the outcomes required by these Standards. I acknowledge that additional education and training is to be provided to staff in relation to deficiencies identified in the Site audit report; including privacy, dignity and respect; falls management, incident management, infection control, appropriate use of personal protective equipment, safe storage of chemicals and equipment, and open disclosure. However, it is my decision that at the time of the site audit, the workforce was not adequately trained and supported to deliver the outcomes required by these standards and, therefore, this Requirement is Non-compliant.

### 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

Management said, and reviewed documentation demonstrated, there were processes to support consumer engagement in the development, delivery and evaluation of care and services that included surveys, meetings, consumer input to the activities program and the implementation of a food focus group.

However, the service was not able to adequately demonstrate the governing body consistently promoted a culture of safe, inclusive and quality care and services, and were accountable for their delivery. Information included in the Site audit report reflected deficiencies were identified in six of the eight Quality Standards: including consumer dignity and choice, ongoing assessment and care planning, provision of personal and clinical care, the organisation’s service environment, feedback and complaints, human resources and organisational governance.

The service did not have effective organisation wide governance systems and was not able to demonstrate they were meeting their regulatory obligations in relation to security of tenure. The service did not have effective risk management systems and practices. While the organisation provided policies in relation to managing risks associated with the care of consumers, staff had not been educated about the policies and were not able to provide examples of their relevance to their work; registered staff did not have a shared understanding of the service’s incident management system. The service was not able to demonstrate the clinical governance framework supported a shared understanding by staff and the consistent practice, of open disclosure.

The Quality Standard is assessed as Non-compliant as four 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) 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 service was not able to demonstrate the governing body consistently promoted a culture of safe, inclusive and quality care and services, and were accountable for their delivery. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1, 2, 3, 5, 6 and 7.

Information included in the Site audit report reflected deficiencies were identified in six of the eight Quality Standards; these deficiencies included where the organisation was not able to adequately demonstrate consumers were treated with dignity and respect (Standard 1); that consumer’s care and services were regularly reviewed (Standard 2); or that consumers were receiving safe and effective personal and clinical care, high impact or high prevalence risks were being effectively managed and infection related risk were being managed through effective infection control practices (Standard 3). The organisation did not adequately demonstrate the service environment, as well as furniture, fittings and equipment was safe and well maintained (Standard 5); that appropriate action was taken in response to complaints and an open disclosure process was used, and complaint feedback was reviewed and used to improve quality of care and services (Standard 6); or that the workforce was planned to enable the delivery and management of safe and quality care and services, and that the workforce was trained and supported to deliver outcomes required by these Standards (Standard 7). The organisation was not able to adequately demonstrate effective organisation wide governance systems, an effective risk management systems and practices or an effective clinical governance framework (Standard 8).

The Site audit report identified that while an external consultant had been engaged to undertake a gap analysis against the Quality Standards, management could not demonstrate what actions had been taken to address deficiencies identified in the gap analysis report. The Approved Provider in its response to the Site Audit report findings stated the management team took note of the identified deficits identified in the gap analysis and has incorporated them into the service’s Plan for continuous improvement (PCI) to be actioned when appropriate. While the Approved Provider provided one example in relation to a recommendation made by the consultant for lockable cleaning trolleys, which is reflected on the PCI and the Approved Provider said is under consideration, the Approved Provider has not provided any further information, or documented on the service’s PCI submitted as part of their response, that reflects actions to be implemented to address deficiencies identified in the report.

The Site audit report brought forward information that consumer representatives, who wished to remain anonymous, felt management did not listen to them when they provided feedback. Management was unable to demonstrate engagement from the governing body in improvement processes in relation to clinical incidents or consumer/representative feedback, or provide examples of changes made in the last six months driven by the governing body as a result of consumer feedback, experience and incidents. I have considered this information under Standard 8(3)(c).

While I acknowledge the Approved Provider’s response, in reviewing the above information it is my decision that at the time of the site audit the service was not able to demonstrate the organisation’s governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery. Therefore, this Requirement is Non-Compliant.

### 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.*

Organisation wide governance systems were found to be ineffective. In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 2, 3, 6, 7

In relation to information management, the Site audit report identified that although staff had access to the service’s electronic care planning system, used to guide the delivery of consumer care and services, assessment and care planning information did not consistently reflect input from external specialist services; this had resulted in the care plan for a consumer with challenging behaviours not having recommended strategies documented to assist staff in managing the consumer’s behaviours. While consumers’ preferences were recorded in care plans, this information did not always align with consumer feedback; preferences included frequency and timing of consumers’ showers and the time a consumer was assisted/transferred to bed. The Site audit report identified that following an incident where a consumer experienced a fall, an incident form had not been completed by staff to inform management. I have considered this evidence which supports Non-compliance under Requirements 2(3)(e), 3(3)(a) and 3(3)(b).

In relation to continuous improvement, the Site audit report identified the service’s complaints register did not include information that demonstrated how complaints were used to improve the quality of care and services, and management could not demonstrate how information from complaints was used to make improvements to safety and quality systems. I have considered this evidence which supports Non-compliance under Requirements 6(3)(c). The Site audit report identified that management was unable to provide examples of changes made in the last six months driven by the governing body because of consumer feedback, experience and incidents. The Approved Provider in its written response to the Site audit report findings refuted these findings saying the service’s directors provide background advice to staff in relation to strategic direction which has a focus on quality care and services. The Facility manager has reporting responsibilities to the directors on a weekly and monthly basis. The Approved Provider informed of two examples to demonstrate how the governing body has directed changes to be affected because of consumer feedback, experience and incidents. These included the purchase of new furniture to replace existing furniture in communal areas and provision of new kitchenettes for consumers, and the implementation of the consumer food focus group that was formed to review menus and the food service; this resulted in suppliers being changed across the organisation to increase food quality and some menu items have been modified. I acknowledge the Approved Provider’s response and note the service’s Plan for continuous improvement reflects other improvements initiated in 2021 as a result of surveys or feedback received, including the purchase of two water coolers and installation of double power points a kitchenette to minimise consumer wait times for hot water.

In relation to workforce governance, the site audit report identified the service was not able to demonstrate that the number of staff was planned to enable the delivery and management of safe and quality care and services; there were insufficient staff to meet consumers’ needs in a timely manner. The service did not adequately demonstrate the workforce is trained and supported to deliver quality care and services. I have considered this evidence which supports Non-compliance under Requirements 7(3)(a) and 7(3)(d).

I relation to regulatory compliance, the site audit report identified that in response to a serious incident involving two consumers residing in the secure unit, where one consumer died after being pushed over by the other consumer, the governing body directed management to not allow the perpetrator to return to the service from hospital. This direction was not consistent with approved provider responsibilities under the *User Rights Principles 2014* that described how approved providers must not take action to make the consumer leave the residential care service, or imply that the consumer must leave the service, before suitable alternative accommodation was available. In its response the Approved Provider reported it believes it has fulfilled its obligations under the *User Rights Principles 2014,* Division 2, Responsibilities of approved providers of residential care—general, section 6 Security of tenure—when approved provider may ask or require care recipient to leave residential care service;as the consumer did cause intentional serious damage to both property and another consumer, the consumer is to be prosecuted in a court of law as a result, and the consumer has been provided with suitable other accommodation at the hospital. The Approved Provider said it does not have an obligation to accept back from hospital a consumer who poses a threat to staff and other consumers, if the service does not have the resources to adequately care for that consumer. However, the *User Rights Principles 2014,* also specifies under Division 2, Section 6 (3) that the Approved Provider must not take action to make the care recipient leave the service, or imply that the care recipient must leave the service, before suitable alternative accommodation is available that meets the care recipient’s long‑term needs; as assessed an aged care assessment team, or at least two medical or other health practitioners, and that the accommodation is affordable by the care recipient. The Approved Provider has not addressed or demonstrated that alternative and affordable accommodation to meet the consumer’s long-term needs was made available, prior to notifying the consumer they could not return to the service following their transfer to hospital.

In relation to feedback and complaints, the Site audit report brought forward information that consumer representatives, who wished to remain anonymous, felt management did not listen to them when they provided feedback. The Approved Provider in its response refutes this saying management seeks feedback to enable them to know where there may be dissatisfaction and areas of care and service delivery may benefit from review. The Approved Provider noted it was difficult to provide a response to an anonymous complaint as there is no way to provide feedback to the complainant. The Site audit report further identified the service was not able to adequately demonstrate appropriate and timely action was taken in response to complaints and an open disclosure process was used when things go wrong. The service did not adequately demonstrate feedback and complaints are consistently reviewed and used to improve the quality of care and services. I have considered this evidence which supports Non-compliance under Requirements 6(3)(c) and 6(3)(d).

I acknowledge the Approved Provider’s response. However, in reviewing the above information it is my decision that at the time of the site audit the service was not able to demonstrate effective organisation wide governance systems. Therefore, this 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*
4. *managing and preventing incidents, including the use of an incident management system.*

In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 2, 3 and 7.

The Site audit report identified that the service did not have effective risk management systems and practices. Although the service had a risk management plan that included risk identification, a risk rating matrix and actions to address risks, the last entry in this plan was October 2020; management had confirmed the service did not have a current risk management plan. The Approved Provider in its response to the Site audit report findings refuted the findings saying the service does have an effective risk management system, including an incident management system used to identify risks to consumers or drive continuous improvement. The Approved Provider stated all the information is present in other documentation and the service’s risk management plan has now been updated; however, the Approved Provider has not provided evidence to demonstrate this.

The Site audit report noted while the organisation provided policies in relation to high impact or high prevalence risks associated with the care of consumers was managed, the abuse and neglect of consumers was identified and responded to, consumers are supported to live the best life they can and incidents are managed and prevented, staff had not been educated about the policies and were not able to provide examples of their relevance to their work. In its response the Approved Provider stated all staff are told about the location of the service’s policies at orientation, staff are then expected to take responsibility for their own learning. The Approved Provider said they will review this process for future education around provision of access to the policies.

Information brought forward by the Site audit report identified while a consumer experienced an unwitnessed fall, an incident form had not been completed by registered staff to report the fall until feedback was provided by the Assessment Team, four weeks after the incident occurred. The service’s risk monitoring process had not identified this oversight. I have considered this information further under Requirement 3(3)(b).

The Site audit report identified that while staff could describe the processes for reporting abuse and neglect of consumers, registered staff did not have a shared understanding of the service’s incident management system or the newly introduced serious incident response scheme (SIRS). I have considered this information under Requirement 7(3)(d). The Site audit report further identified the service had not documented its incident management system procedures and staff did not consistently record dates, times and details of incidents as required under the *Quality of Care Principles 2014* amendments Schedule 1 – Incident management and prevention; this included documentation in relation to an incident that resulted in the unexpected death of a consumer which contained inconsistencies, including the time the incident occurred. The approved Provider in its response informed the incident included late entries but no inconsistencies; however, the Approved Provider has not provided evidence to demonstrate this.

While I acknowledge the Approved Providers response and actions to be undertaken, at the time of the site audit the service did not have effective risk management systems and practices. Therefore, it is my decision 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.*

In coming to a decision on compliance for this Requirement, I have considered the information contained in the Site audit report, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 3.

The Site audit report found the service did not have an effective clinical governance framework. The report identified that while the organisation provided policies in relation to antimicrobial stewardship, minimising the use of restraint and an open disclosure policy, management and staff interviewed were unable to provide examples of how care and services are planned, delivered and evaluated as a result of the implementation of these policies. The Approved Provider in its written response to the Site audit report findings refuted the findings saying the service does have an effective clinical governance framework that demonstrates a shared understanding and consistent practice of open disclosure. The Approved Provider stated all staff are told about the location of the service’s policies at orientation, staff are then expected to take responsibility for their own learning in the first three months of employment. The Approved Provider said they will review this process for future education around provision of access to the policies.

The Approved Provider reported clinical governance is an integrated set of leadership behaviours, policies, processes, responsibilities, relationships, planning, monitoring and improvement mechanisms that it uses to support clinical care for consumers. While the Approved Provider said its clinical governance framework is integrated into functions reportable to the governing body through weekly and monthly reporting, the Approved Provider has not provided any evidence to demonstrate the reporting the governing body requires, or decisions and improvements made because of such reporting, including how the governing body ensures the effectiveness of the service’s clinical governance framework.

I acknowledge the Site audit report identified that during the site audit, management and staff were able to discuss strategies they implemented to minimise the use of restraint under Requirement 3(3)(a), and processes to manage antimicrobial stewardship under Requirement 3(3)(g). However, the Site audit report identified the service could not demonstrate open disclosure was consistently practised, or how management engaged with consumers/representatives and explained the steps the organisation had taken when things went wrong or to prevent incidents that had the potential to cause harm from reoccurring. In its response the Approved Provider reported a refresher course on open disclosure for management and staff will be delivered in the near future and will be based on the Aged Care Quality and Safety Commission’s resources including the Open Disclosure Framework and Guidance material.

While I acknowledge the Approved Provider’s response, in reviewing the above information it is my decision that at the time of the site audit processes relating to open disclosure were not well understood by staff and were not consistently being practiced. Therefore, 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.

* Each consumer is to be treated with dignity and respect.
* Care and services are to be reviewed regularly for effectiveness, when circumstances change or incidents impact on their needs.
* Each consumer is to get safe and effective personal and clinical care that optimises their health and well-being.
* Effective management of high impact or high prevalence risks.
* Minimisation of infection-related risks.
* The service environment is to be safe, clean and well maintained.
* Furniture, fittings and equipment are to be safe, clean and suitable for the consumer.
* Appropriate action is to be taken in response to complaints and an open disclosure process is used.
* Feedback and complaints are reviewed and used to improve the quality of care and services.
* The workforce is planned to enable the delivery and management of safe and quality care and services
* The workforce is trained and supported to deliver the outcomes required by these Standards.
* The organisation’s governing body promotes a culture of safe and quality care and services and is accountable for their delivery.
* Effective organisation wide governance systems that include management of regulatory compliance, workforce governance and feedback and complaints.
* An effective risk management that includes managing high impact or high prevalence risks.
* An effective clinical governance framework that includes open disclosure.