Maranatha House

Performance Report

127 - 137 Whiteley Street   
WELLINGTON NSW 2820  
Phone number: 02 6845 3088

**Commission ID:** 0223

**Provider name:** Maranatha House

**Assessment Contact - Site date:** 17 February 2021 to 18 February 2021

**Date of Performance Report:** 19 April 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(f) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | 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)(d) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(c) | Non-compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(c) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | 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 Assessment Contact - Site; the Assessment Contact conducted on 17 and 18 February 2021 - Site 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 Assessment Contact - Site report received 21 March 2021.

# 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

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

The Assessment Team found that overall sampled consumers considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

The Assessment Team interviewed sampled consumers who confirmed that the service respects their privacy and staff knock and wait for an acknowledgement before entering their rooms. However, the Assessment Team observed the consumers’ right to privacy is not always exercised by staff with the use of the communication process implemented by the service’s previous management team.

The service was unable to demonstrate consumer privacy, or personal information was respected or was kept confidential, while using newly implemented communication processes

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)(f) Non-compliant

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

The Assessment Team found that overall feedback from consumers was mostly positive about staff respecting their privacy and keeping their personal information confidential. The Assessment Team observed staff on most occasions to be respectful of consumers privacy. However, the service was unable to demonstrate the implementation of two different communication processes for staff keep consumers’ information private or confidential.

The Assessment Team interviewed sampled consumers and representatives who advised that staff always knock and wait before entering rooms and ensure consumers have privacy when they have visitors or request time alone. One consumer advised that he hears the walkie talkies but doesn’t listen to what is being said as it is not his business.

The Assessment Team interviewed staff who confirmed that they provide the consumers and their representatives with privacy and always knock before attending to care needs, however one consumer’s representative had raised with the service that “sometimes staff knock on the resident’s door, but when entering do not acknowledge residents”.

When the Assessment Team spoke of the communication systems, staff advised that the walkie talkie system works well, as it is a secured line and no one else but the staff can hear the conversations when they are in use. Staff said that no personal information is spoken about on the walkie talkies only that assistance is needed and a room number.

When asked about the WhatsApp application (app) usage and how a consumers’ information is kept private on a personal mobile device the information provided from staff to the Assessment Team was mixed.

Some sampled staff said they have not downloaded the app, and this impacted on their work as they missed out on a lot of information or training as a result of not having it, as the app was used for everything. Another staff member who has the app, said that they do not do anything different to protect the consumers information. However, they did have a lock screen and a password to open the phone.

The Assessment Team followed up on information about the use of the mobile phone application WhatsApp. Information on the use of this app was provided to the Assessment Team via the assessment contact report 6 to 8 July 2020 and from an anonymous complaint received 20 September 2020. The information included that staff had been instructed by the previous management team to download the app on their personal mobile phones. They were further instructed to use it as a communication platform and an information tool for anything related to the service.

The Assessment Team spoke to a member of the management team who explained how the app works and how the service was using it for day to day communication, recording, documentation and as an information tool. While discussing the use of the app a number of gaps were identified in how consumers’ information was being kept safe and private.

The Assessment Team found that the service was not able to demonstrate there was any consultation or consent given from consumers on this use of the app on the staff personal devices. The service was not able to demonstrate any monitoring or review of the correct use of the app and stated they did not regularly view the app groups for appropriate use or content matter.

The management team provided the Assessment Team with information after day one meeting, that a mandatory direction had been sent by email to all staff to ensure regulatory compliance, that the WhatsApp groups must be closed and that all internal communication was to be conducted through sectioned means, i.e. message board, internal emails and staff meetings, and that photos of consumers or clinical photos must be taken on the service’s devices only.

The use of the walkie talkies was discussed with the management team regarding how the privacy of the consumer is being considered when the ear piece is not being used as it was identified when the walkie talkie ear piece is not worn in the ear people can hear information being transmitted over the device, loud and clearly.

The management team explained the purpose of the walkie talkies is to improve the services call bell response times. As the service’s layout is extensive and often the call bell annunciators cannot be seen in all areas of the service. A member of the administration staff will transmit an announcement that a consumer in room “x” needs assistance. This is what can be heard if the ear piece is not worn by staff.

The Assessment Team asked the management team if any consumer had raised concerns about the use of the walkie talkie and were advised there had been no concerns, however it was recorded in resident minutes reviewed by the Assessment Team that the walkie talkie phones ringing while attending to consumers showering is not good or personal.

The approved provider’s response confirmed that the ‘WhatsApp’ group chats have been deleted and that they were unaware of the consumer’s representative comments about acknowledging her consumer.

I have found that the approved provider did not demonstrate that each consumer’s privacy is respected, and personal information is kept confidential.

I have found that the approved provider was not compliant at the time of assessment.

# 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

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

The Assessment Team found that most sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services, but none were offered a copy of their care and services plan. Overall consumers were happy with the care and services and felt all aspects of their needs, goals and preferences were being met and that staff knew what they needed. The Assessment Team also identified that end of life care planning has been adequately addressed for all consumers.

Whilst the organisation has no care planning policy to guide staff on care planning and assessment for consumers, staff were generally able to demonstrate and describe the process.

The Assessment Team generally found evidence of adequacy of care planning and assessment documentation in relation to consumers, however for some consumers, there was missing and incorrect information between the old paper-based system and the new electronic system for some consumer’s recorded needs, goals and preferences, meaning they may not be getting the care that is right for them. There were also inadequacies in care planning and assessment specifically identifying changed behaviour of one sampled consumer.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team identified that the service is currently transitioning between a paper-based system and a new electronic program for recording consumer care and clinical care management. For the care plans sampled, comprehensive information on assessment and planning and the delivery of safe and effective care and service did not always occur due to information gaps between the two systems in consumer’s individual care plans and missing information. Most consumers were happy with their input into the care planning process, but none had not been offered a copy of their plan. While staff were generally able to state how care planning occurs for consumers, there is no policy and procedure on care planning and assessment to guide staff.

The Assessment Team sampled some consumer’s care plans, evidence of ongoing regular care planning and assessments including risks was found. Whilst most of the care needs, goals and preferences for the individual consumers sampled had been entered in the electronic care management system, there was often inaccurate or missing information which may compromise care for consumers. Care staff are now using the electronic care management program to guide care and services, but not all information has been recorded accurately and there is inconsistent information between the two.

The Assessment Team identified that most sampled consumer care plans did not have recorded information in the areas of spiritual, emotional, intimacy, relationships, strategies and leisure activities and this information was mostly not able to be located in the paper-based system. Management said they had identified this gap and would be looking to have this completed in the coming weeks.

The Assessment Team confirmed that for the consumers sampled, registered staff and the care manager complete initial admission assessments to identify consumers' needs, choices and preferences. It was evidenced Medical Officers and other allied health professionals are also involved where necessary during risk assessments. Risk assessments for the sampled consumers had been undertaken to ensure their ongoing care and safety.

The Assessment Team interviewed the care manager who said that she undertook assessments routinely when they were due but also when a consumer’s needs changed. She said that when a new consumer was admitted various assessments were undertaken. These were now set up under with prompts of when to do these for example, falls, mobility and dietary assessments were always completed on day one and the rest over the following 28 days. However, care plans were not always reviewed routinely or when a consumer’s needs changed as was evidenced with one consumer’s escalating behaviours.

Management advised the Assessment Team that they did not have a current Care Planning Policy or guide as they were in the process of updating their policies and procedures.

The approved provider’s response included that there was a care plan policy and provided this as evidence, the provider advised that at the time of assessment only 50% of the information had been migrated from one system to another, however this should be completed by the end of March. They also advised that the inconsistencies noted in the assessment report had since been updated and that care plans are now offered to all consumers and their representatives.

I have found that the approved provider did not demonstrate that each consumer’s 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.

I have found that the approved provider was not compliant with this requirement at the time of assessment.

### 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.*

The Assessment Team found that for the consumers sampled the service demonstrated that most consumers’ tailored needs, goals and preferences were mostly documented. Consumers were generally happy with their care and staff interviewed were able to describe how they gave individualised care. All consumers sampled had advanced care directives or waivers in place and management could describe how they gained end of life information from consumers. Staff were able to describe and demonstrate how they identified and addressed consumer’s needs, goals and preferences including end of life planning.

### The Assessment Team was able to evidence that for the most consumers sampled there were documented needs, goals and preferences and advanced care plans in place, between the service’s out-going paper-based management system and the new electronic system.

All sampled consumers said the service understood what was important to them and this was reflected in their care plans.

The Assessment Team reviewed a list of all current consumers, which records who has advanced care directives, and who does not have one and why and a date this was last reviewed.

This requirement was found to be non-compliant in a previous assessment, however the approved provider has demonstrated that the service addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

I have found that the approved provider is compliant in this requirement at the time of assessment.

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

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

The Assessment Team found that although the service has a system of regular reassessment and incident recording these processes are not always used to determine the effectiveness of planned care. When incidents occur, they are not always recorded and reviewed to consider their impact on the needs, goals or preferences of the consumer.

The Assessment Team experienced great difficulty navigating the service’s outgoing paper-based care planning system and the new electronic program to find the necessary information to review for this requirement. Some parts of consumers care plans were not able to be reviewed.

The Assessment Team identified while the service has a system of regular re-assessment, these processes are not always used to determine the effectiveness of planned care. When incidents occur, they are not always reviewed to consider their impact on the needs, goals or preferences of the consumer.

The Assessment Team found that one consumer’s care plan was last reviewed in late December 2020, with three behaviours last reviewed in mid-December 2020 with strategies and goals for each behaviour. Since this time the consumer has had several recorded incidents of aggression between January and mid-February 2021. While the behaviours have been recorded, the consumers behavioural management plan has not been updated to include physical aggression and there is no review or reassessment of his changed behaviours and no strategies to guide staff in managing the new behaviours.

The Assessment Team identified that there are no organisational policies and procedures to guide aspects of clinical care including behaviour management.

The approved provider submitted information in their response which included behaviour plans for the above-named consumer, however it did not include all of the behaviour incidents and whether the strategies were effective in most instances.

I have found that the approved provider did not demonstrate that care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

I have found that the approved provider was not compliant with this requirement at the time of assessment.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

### Assessment of Standard 3 Requirements

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

The Assessment Team found that overall sampled consumers considered that they receive personal care and clinical care that is safe and right for them.

One consumer and one consumer representative said that they were very happy with the service and they see the doctor and podiatrist regularly.

The Assessment Team found that while feedback from consumers and representatives was positive and they were happy with the care and services provided at the service the Assessment Team found inconsistencies and gaps in care provision, documentation, monitoring and evaluation for sampled consumers, which did not meet the expectations of the requirements assessed.

These inconsistencies and gaps include; where behaviours are not managed and monitored appropriately, where falls and other incidents are not being monitored and evaluated, wound documentation containing incorrect information, deterioration is not recognised and responded to in a timely manner and that staff do not always follow infection control guidelines.

The Assessment Team found that the service has some systems in place to manage high impact high prevalence risk to consumers, however the systems are not effective in identifying key concerns that are leading to deficiencies in care and oversight of consumers with high falls risk and consumers who are at risk of deterioration. Also risks identified in medication administration errors are not always managed and reviewed to ensure they are providing a safe medication service to consumers.

Consumer information is communicated within the service and with others involved in their care. However, information about consumers is not always available or recorded and reported accurately, communicating information has been unsuccessful and there is a lack of overall clinical oversight.

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

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

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

The Assessment Team found evidence that identified risk of harm to consumers, including gaps in escalation and management of out of range observations, falls and behaviour management.

The Assessment Team reviewed sampled consumers care plans and found that monitoring and evaluation of wounds and vital signs is not done according to best practice, tailored to the needs of the consumer and does not optimise health and wellbeing.

The Assessment Team reviewed one consumer’s care plan who had a chronic wound. The wound photos and evaluations were reviewed and indicated gaps and inconsistencies in assessment and documentation of the wound. This consumer also has high blood pressure which directs staff to check her blood pressure daily until further notice. The Assessment Team reviewed the clinical documentation which indicated the consumer’s blood pressure has been out of range on three occasions between 21 January and 2 February 2021, however, this is not being assessed and responded to effectively by clinical staff. On all three occasions, there was no other observation, escalation or follow up documented in clinical notes reviewed by the Assessment Team.

Another consumer was admitted to hospital, following attendance to have a wound review and dressing. This consumer’s wound care flow chart directs registered nurses to conduct an initial wound review, assessment and photograph with measurements. There was no follow up of these wounds in progress notes. This was discussed with the Care Coordinator who said the pressure areas were reviewed by a Registered Nurse and they were just reddened areas, they applied cream and they resolved. This wound review and assessment was not documented in progress notes by the registered nurse.

The Assessment Team found that some consumers experiencing falls were not comprehensively reviewed and managed effectively, which did not reflect safe and effective care.

Most consumers and representatives sampled were happy with the care received at the service.

The Assessment Team reviewed the Schedule 8 drug register, the drugs had not been counted or checked for nine days prior to the assessment contact. This was discussed with the facility manager who said the drugs should be checked daily.

The Assessment Team were provided with a psychotropic drug report from October 2020. A list of consumers who had psychotropic medication reductions listed nineteen consumers who had psychotropic medications reduced or ceased since 18 October 2020. The list included the consumers name, original medications and dosage, the reduced dose and the date of the reduction.

The approved provider did not dispute the findings of this requirement and submitted information in their response which included changes to a number of procedures to improve the compliance of this requirement. These improvements include a requirement for Registered Nurses to documents any concerns with wound care and pressure area in progress notes, alerts for any out of range blood pressure and blood glucose levels to be highlighted to Registered Nurses, Schedule 4-8 medications stock check to be completed daily by two registered clinicians and double signing of Schedule 4 medication now mandatory for all staff and clinicians.

I have considered the approved providers response and their commitment to make changes to address the issues identified in this requirement, however I have found that the approved provider did not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.

I have found that the approved provider was not compliant with this requirement.

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

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

The Assessment Team found that while the service has a system to identify and manage high impact or high prevalence risks associated with each consumers’ care, the system is not always effective in identifying issues and gaps within falls management and medication administration that leave consumers at risk.

The Assessment Team identified that the service did not manage high impact or high prevalence risks effectively. Staff do not routinely use the falls risk information gained by reviewing incident forms and FRATS to implement strategies to prevent ongoing falls.

This included high impact risk of fall with fracture and admission to hospital for one consumer which was not recognised by the service. Prior to the consumer’s fall, the consumer had several falls and signs and symptoms of a urinary tract infection leading up to the fall, progress notes were not documented until three days after the symptoms of the urinary tract infection was noted. The consumer’s blood pressure was noted to be out of range leading up to the fall, however, no follow up was found in the progress notes.

The Assessment Team requested an incident report for the consumer’s fall and admission to hospital. The service said they were unable to provide an incident report as the report was commenced in the electronic clinical documentation system.

Incident reports were accessed for two falls experienced by the consumer however these did not provide oversight of the incidents, including notifications to representatives or referral to allied health or medical practitioner and follow up information, such as ongoing observations done, review of falls risk and pain assessments, management of urinary tract infection or other care issues or care plan review.

The Assessment Team found that while the service has some systems in place to manage high impact high prevalence risk to consumers, the systems are not effective in identifying key concerns that are leading to deficiencies in care and oversight of consumers with high falls risk, and identification of out of range observations and incidents. Risks identified in medication management by the reporting of errors are not reviewed to ensure they are providing a safe medication service to consumers.

The Assessment Team interviewed Registered Nurses who acknowledged that out of range observations could be a high risk for consumers.

The Assessment Team also identified that a benzodiazepine medication was signed for twice, on 3 February 2021 at 9.37pm by a registered nurse and 9.54pm by a personal care worker. As the medication was a Schedule four medication the register was documented that the second dose was not given. The care coordinator said this was no longer an incident, however this did not investigate the signing of administration of the medication by the personal care worker.

The approved provider did not dispute the findings of this requirement and submitted information in their response which included changes to a number of procedures to improve the compliance of this requirement. These improvements include FRATS to be reviewed and updated post falls, hospital admissions and changes in conditions, specific risk assessment s to be discussed at the Medication Advisory Committee Meetings, and double signing of Schedule 4 medication now mandatory for all staff and clinicians.

I have considered the approved providers response and their commitment to make changes to address the issues identified in this requirement, however I have found that the approved provider did not demonstrate that there is effective management of high impact or high prevalence risks associated with the care of each consumer.

I have found that the approved provider was not compliant with this requirement.

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

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

The Assessment Team found that falls and behaviours are not managed, monitored and evaluated or reported appropriately, and as per best practice. Interventions are not identified in care plans and are not tailored to the needs of the consumer and do not optimise health and wellbeing of the consumer. The service has not responded to deterioration in behaviours, falls and observations in a timely manner.

The Assessment Team reviewed one consumer’s care plan documentation which recorded that the consumer had a falls risk assessment completed in June 2020, indicating he was a high falls risk. Three days later he had a fall, while the registered nurse documented no injury and continue to monitor, advising staff to encourage the consumer to use his four-wheel walker, no record of assessment, observation, escalation or incident reporting were provided in the registered nurses notes. The consumer was very confused, entering other consumers rooms, wandering the floor and trying to get out of the room. During that week, he was found outside the main gate of the service. Staff document they were unsure if the consumer had experienced a fall as they found mud on his body, a head to toe assessment was done by care staff and observations were taken.

The consumer has developed a number of behavioural concerns and has been monitored with a behaviour identification and interventions chart, this indicates his behaviours are not being managed effectively or consistently. There are also gaps identified in documenting behaviours on this chart as they continue to escalate. The Assessment Team observed information in the behaviour identification and interventions chart was inconsistent with information documented in progress notes.

The Assessment Team requested a log of incidents where Discretion Not To Report has been used however, the service said they did not have a log of these incidents.

The management team were unable to provide a policy or procedure in relation to staff supporting staff to recognise and respond to a deteriorating consumer. However, the registered nurse showed the Assessment Team written material in the registered nurse clinic which supported staff to recognise and respond to deterioration or changes in a consumer’s condition.

While the service has processes to identify deteriorating consumers there were gaps identified in the process of escalation of changes in consumers’ condition.

The approved provider advised that the abovementioned consumer’s issues had been previously dealt with and were the subject of two finalised complaints by the commission, however it is noted that these issues continue through to the current assessment visit.

I have considered the approved providers response and although the provider believes this consumer’s issues have been appropriately dealt with, there still appears to be ongoing behavioural issues and a lack of successful interventions, documentation and escalation of clinical information to the registered nurses.

I have found that the approved provider is not compliant with this requirement at the time of assessment as the service have not demonstrated that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found that the service does not have satisfactory systems and processes to minimise infection related risks associated with COVID-19. The service has a document COVID-19 plan to assist staff in the management of social isolation, protective isolation, monitoring for symptoms, recording and reporting suspected cases, management and usage of personal protective equipment.

The Assessment Team reviewed the service’s Outbreak Management Plan provided however, information in the plan was minimal. It was identified that the infection control lead information was not included in the outbreak management plan, management advised this would be added. The service advised the Assessment Team that as far as they are aware staff do not work across multiple sites, there were no rosters included in the plan and no staff listing, this would be added.

The Assessment Team noted that there were also gaps observed in infection control practices including where masks were always to be worn on site, staff members were seen wearing their mask under their noses, and one staff member was seen without a mask talking to consumers in the outdoor area of the service, some staff were seen to be wearing cloth not surgical masks. The digital thermometer was observed to be held close to foreheads of visitors to the service and not wiped between. Desks in the registered nurse and personal carers offices were not seen to be cleaned. A water cooler was in use, however there was no plan in place to ensure this would not be a source of infection, management said it was cleaned daily. Management told the Assessment Team Antimicrobial Stewardship is not currently a focus for the service. All staff have received influenza vaccination.

The approved provider submitted information in their response including that the deficiencies noted in the outbreak management plan had been rectified, and that the staff member observed by the Team to be not wearing a mask had been counselled by the management and staff had been directed to wear only the supplied mask. The provider advised that digital thermometers will be cleaned between uses and desks and the water coolers were added to the cleaner’s duties and the water coolers were to be replaced with individual bottled water delivered to consumer’s rooms.

I have considered the approved providers response and their commitment to address the issues identified in this requirement, however I have found that the approved provider did not demonstrate that they adequately minimise infection related risks through implementing standard and transmission based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

I have found that the approved provider was not compliant with this requirement.

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team found that overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The service environment was mostly clean and well maintained. However, staff were unable to illustrate an effective cleaning process was in place of consumers’ shared equipment. The service was unable to demonstrate there is process in place to monitor or review the current cleaning practices. As a result, it was found that the current cleaning process of cleaning consumers’ equipment was not effective and was putting consumers at risk with poor cleaning and infection control practices.

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

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

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

The Assessment Team found that the service was unable to demonstrate it has an effective way of identifying, monitoring or reviewing equipment the consumers’ use is safe or well maintained.

The Assessment Team observed several items of equipment were unclean throughout the service. This included a sling that was observed to be hanging across a dirty stand aid lifter, the sling was covered in hair, strings of cotton and marked with a white spotted dried substance. This was brought to the attention of the management team who instructed a staff to remove the sling and have it washed. The tables and floor of the dining area were seen to have not been cleaned after breakfast service. Some of the tables were observed to have a sticky substance on them and crumbs were observed under the tables.

Management advised the Assessment Team that they are currently conducting a precautionary deep clean of the consumers rooms and belongings, due to the local hospital advising the service, a recent consumer admission from the service to the hospital showed a potential scabies infection for the consumer.

The Assessment Team observed other furniture to be soiled, the exit lighting was observed to have many dead bugs lying in the bottom of the plastic casing.

A stand aid lifter was observed in the hallway positioned in front of rooms and the foot plate of the lifter was heavily incrusted with an unknown substance.

On observation of other areas of the facility, a large water stain was observed on the ceiling in the dining area. The Assessment Team were advised that the air-conditioning system had a blockage in the pipes and the air conditioner overflowed. The leak was fixed and repainted however the system leaked again couple of days prior to the assessment contact. This was observed to be dried and repainted by the second day of the assessment visit.

The fire sensor in the dining room was observed to be marked with what looked like fly or bug droppings. The Assessment Team observed absorbent cloth protectors were used on two of the single seat vinyl lounge chairs. When the Assessment Team asked staff and management how often the cloth protectors are changed from the lounge chairs, no one could answer as to who’s responsibility it was to change the protector, but it is not changed in between each consumer. A gas heater cord was observed to have been not plugged into the wall, but the power cord was observed to be on the floor across the walk way.

The Assessment Team interviewed a consumer’s representative who said that the consumers equipment and room is generally clean, neat and tidy.

The Assessment Team interviewed the maintenance officer, who advised he keeps a maintenance schedule of equipment to service, review and clean. The Assessment Team asked to see the maintenance schedule for the equipment used by the consumers. However, these schedules were not provided to the Assessment Team.

The Assessment Team was advised that call bells and pendants are checked weekly to ensure they are functioning. The Assessment Team was provided with a call bell audit report, however when the Assessment Team asked to see a maintenance log for the call bells, this was not provided.

The approved provider submitted information about the issues raised in the report. The approved provider advised that the Assessment Team identified tables not cleaned in the dining room, however that was before the breakfast in the dining room was finished. The approved provider advised that the issues of cleanliness had been acted on immediately, with cleaning of chairs, exit signs, footplate on lifter and lifting sling.

I have considered the approved providers response and their efficient response to the issues identified in this requirement, however I have found that the approved provider did not demonstrate that furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

I have found that the approved provider was not compliant with this requirement.

# 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

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

The Assessment Team found that overall sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken.

Consumers stated they know how to make internal complaints but did not know external complaints services were available.

Staff were able to demonstrate an understanding of how to assist consumers with making internal complaints. However, some staff did not have the knowledge on how consumers in Allworth or the Heights wing could make an anonymous complaint or how they could assist consumer with how to make external complaints.

The service did not provide all wings of the service an opportunity to make anonymous complaints as there was only one secured feedback box which was not accessible to all consumers.

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

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found that while there is a system for encouraging and supporting consumers to provide feedback and make complaints, the service did not have a system in place across the service for anonymous complaints to be made. Some staff were not able to demonstrate an understanding of what external services are available for consumers to make a complaint or how to contact these services.

The Assessment Team interviewed consumers and representatives and said they are encouraged to provide feedback and make complaints. Consumers’ stated they could discuss concerns with management and staff or raise the concerns during a resident meeting. However, none of the consumers interviewed knew that external services are available to contact or where to get the information.

The management team advised the Assessment Team that they have an open-door policy where consumers can come to them at any point to raise concerns, or the service offers other methods such as resident meetings, the feedback forms and the services email.

The Assessment Team interviewed some staff who were asked how consumers in two of the wings without a secured feedback box could make an anonymous complaint, staff could not provide an appropriate response. Management said that these would be put in place immediately, however, these where not observed to be in place at the end of the final day of the assessment contact.

The management team was unable to provided policies and procedures on complaint and feedback management and the resident handbook as requested by the Assessment Team.

The approved provider advised in their response that there are now feedback posters, blank forms and boxes on each wing that are checked daily. The provider also submitted a copy of their policies and procedures for feedback and complaints.

I have considered the approved providers response however I have found that the approved provider did not demonstrate at the time of assessment that all consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. I have found that the approved provider was not compliant with this requirement. STANDARD 7 COMPLIANT/NON-COMPLIANT  
Human resources

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

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

The Assessment Team found that overall sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The Assessment Team interviewed sampled consumers and/or representatives who said staff know what they are doing and don’t require further training.

While the service was able to demonstrate the right staff ratio, it was not able to demonstrate the staff skill mix was adequate. With no system to monitor and review the impact to consumers.

The service was not able to demonstrate staff were competent and knowledgeable to perform their roles with no system to ensure staff remain competent in their role. The Assessment Team identified a lack of training and education needs analysis with minimal training and education of the new quality standards and no evidence of training and education provided on key aspects relating to, elder abuse, compulsory reporting, antimicrobial stewardship, open disclosure, risk management and identification of a deteriorating consumers.

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 Assessment Team found that whilst the service advises they have the right staff consumer ratio and it was observed to have in the last two-week period all shifts covered. The service was not able to demonstrate the staff are delivering the care and services to the consumers within a timely manner.

The Assessment Team interviewed consumers and representatives who said they feel there is enough staff, however they are not easily able to be found when needed.

The Assessment Team interviewed staff who stated there are often times where they are working understaffed as there has not been a staff replacement of shifts. However, stated they are feeling they are mostly able to complete all of their work within a timely manner.

The Assessment Team reviewed the staff rosters and unfilled shifts over a two-week period and noted all shifts were filled. The service currently employees 140 staff members. The service is actively recruiting five new RN’s and has vacancies for two more personal care assistants. The service has had eight previous employees rehired.

The Assessment Team identified that the service does not have 24-hour RN supervision over the weekends. RN’s are only rostered on a Saturday and Sunday morning as GP’s often complete their visits on these days. When asked about the RN supervision not being 24 hours seven days a week, the Assessment Team was advised that the “Board directed it is not financially sustainable to have an RN coverage in the afternoon and night on the weekends.”

If staff during these periods are needing assistance they are to call the RN on call, the facility manager or 000.

The management team advised the Assessment Team that they have introduced a non-ongoing supervisor’s role. No formal qualification was required to be employed within this role, and the Assessment Team were advised the supervisors were handpicked to take on this leadership role just from their experience.

The Assessment Team reviewed call bell data for the period November 2020-January 2021, it was noted that there was minimal analysis included.

The approved provider submitted information in their response advising that it is the goal of the service to have 24-hour RN coverage and the RN team have recently expanded from two RN’s to five and are currently recruiting for a sixth RN. Theservice also advised that the supervisor roles were temporary, and they intended to be appointed through a merit selection and interview process. The service also noted that the call bell response times are audited by the General Manager and the current average response time is 4 minutes and 28 seconds (at the time of audit the information provided was that greater than 25% exceeded 9 minutes).

I have considered the approved provider’s response and have found that whist the service is looking to improve the numbers of qualified RN staff in particular on weekends. At the time of assessment, the approved provider did not demonstrate that the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

I have found that the approved provider is not compliant with this requirement.

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

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

The Assessment Team found that the service was not able to demonstrate the workforce is competent, and members of the workforce have the knowledge to effectively perform their roles. There are significant gaps across Standards 2, 3, 6 and 8 which indicate the workforce do not have the appropriate skills and knowledge.

The Assessment Team interviewed sampled consumers and/or representatives who said staff know what they are doing and did not identify any areas where further education and training is require.

The Assessment Team interviewed staff and asked if they had any training or education on the new quality standards, two of the staff responded that they had not had any training in relation to the standards.

The Assessment Team identified that all of the staff have current police checks in place, however when discussing volunteer police checks it was unclear as to whom monitored or reviewed that the police checks are valid. No one in the management team knew if the service kept a record of the police checks at the service. A member of the administration team provided a folder to the Assessment Team it showed 19 volunteers names. Ten of the volunteers had expired police checks and nine did not have a record of an expiry date. It was explained that some of the volunteers that visit the service come through a registered volunteer service but was unsure of the organisations name.

The Assessment Team identified that all of the RNs hold a current registration.

The Assessment Team reviewed one personal carer’s staff file and noted that the staff medication competency records showed last completed competency in 2016, however the competency was incomplete with categories not being marked off as being complete but having a signature on the bottom of the document.

The Assessment Team identified incidents of reportable assault against staff and other consumers by a consumer, that was not reported in accordance with legislation. The service was not able to provide any documentation of staff being educated about elder abuse and compulsory reporting. When staff were asked what compulsory reporting is they had basic to no understanding of what it is. These incidents show it has not been effective in ensuring all staff are competent

The Assessment Team requested to review the service’s 2020 training and education records including all staff mandatory training. The management team advised that all training was conducted online over WhatsApp and any other documentation had been deleted from the service’s electronic files. The only record of any training was Quality Standards Training in January of 2020 where 42 staff out of 140 had completed the training.

The review of consumers’ care and service records identifies staff do not have a clear understanding of behaviour management, identifying deteriorating consumer, regularity compliance and infection control.

The approved provider advised that facility wide training will occur in April 2021 on the Quality Standards and Elder Abuse. The provider also advised that the volunteers criminal history checks are provided in February every three years and any new volunteers must provide them before commencement.

I have considered the approved provider’s response and have found that whist the service will be providing additional training, the staff did not show any awareness of compulsory reporting and that the training records did not appear to be current. At the time of assessment, the approved provider did not demonstrate that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

I find that the approved provider is not competent with this requirement.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team found that the service does not have all the necessary systems in place for effective organisational oversight. The organisation’s governance systems are mostly undocumented, unplanned and not monitored or reviewed for effectiveness. The organisation currently does not have a strategic plan, most organisational policies are not current, there is no robust information, continuous improvement, complaints and feedback, workforce and regulatory compliance governance systems. There is no risk management framework in place. The organisation has an adequate system financial governance system in place.

The Assessment Team found that overall, the organisation’s governance systems do not support the delivery of safe and quality care for consumers. The systems mostly do not assess, monitor or drive improvement in the quality and safety of care and services they provide

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

## Assessment of Standard 8 Requirements

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

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

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

The Assessment Team found that the organisation’s governance systems are mostly not documented or integrated. There is no strategic or business plan to guide short-term or long-term operational and strategic processes and direction. Information management has not always been effective around the security of consumer personal information and with the significant loss of organisational information.

Organisational policies are not consistently used as a guide and there is confusion within the organisation over their currency and use. There is no developed system for continuous quality improvement or complaints and feedback, and no evidence staff education has been conducted in the past 12 months. Changes to regulatory compliance, such as for restraints and antimicrobial stewardship, has not been identified or included as a focused key governance area.

The Assessment Team interviewed the CEO who advised that the previous CEO had left abruptly with other key personnel in September 2020 and that a significant amount of information stored on the service’s computer system was deleted by the outgoing management team.

The CEO further advised that the service did not have a business plan or strategic plan in place to guide the organisation. He said the organisation was still developing its organisational governance frameworks and that he was preparing a proposal to the organisation’s board of management next month to engage an external consultancy firm to assist in developing such plans.

There was no clear direction and some confusion regarding the use of organisational policies to guide staff. The Assessment Team asked management for a list of their policies and was told there were none. The CEO then advised a suite of policies had been purchased but they had not yet been tailored to the organisation and the old policies “were out of date” and not used. However, through the course of the audit some policies were made available to the Assessment Team with management still stating they “were out of date”. In interview, management could not give a definitive answer as to whether they were still being used or not. Some care staff stated they are still using the full suite of older policies for guidance which are available to them in the nurse’s stations. However, the financial policies were viewed to be current and used as a guide by the finance team.

Board meeting minutes sampled indicate that there is information flowing between the CEO and board regarding operational matters, however most key governance areas are not captured or reported on.

The CEO advised the Assessment Team that since his appointment in September 2020 he had introduced several new initiatives to improve the service’s information management practices.

The Assessment Team interviewed staff who said they can mostly access the information they need on consumer care through the new electronic system although some information is still paper-based and there are some discrepancies between the two. The nurse’s station was observed to have handover documents and information for the management of critical incidents and management of emergency situations.

The Assessment Team asked the management team how opportunities for continuous improvement are identified, and were provided with a plan for continuous improvement, however the document had no reference to the quality standards and no process for the monitoring, review or effectiveness of the listed “matters identified”.

The Assessment Team asked the management team about their system for reportable assaults. They stated they have had no reportable assaults in the past six months and there was “no reportable assaults register as they hadn’t had any reportable assaults”. They also advised they did not have a list of “discretion not to report” incidents register. The care manager provided an Abuse of Residents policy last updated 10 December 2019. In review, the policy had conflicting information for time frames and who to report to.

The Assessment Team asked the CEO how the complaints and feedback system operated, the CEO stated they used feedback forms, a dedicated email, feedback boxes and a register. When asked if he reported complaints to the board, he stated they formed part of his report. When sample minutes and board reports were reviewed by the Assessment Team, it was noted some complaints did form part of the CEOs general narrative report, but the information was not detailed. There was no information or evidence provided to the Assessment Team on how complaints and feedback were investigated, reviewed, monitored, what timeframes they had set or any link to their continuous quality improvement plan.

The approved provider submitted a response and advised that the service has introduced a complete suite of policies and procedures and they are currently mid cycle through their current five-year plan.

Whilst I acknowledge that the approved provider has faced some issues with the deletion of information by the previous management team and they are currently introducing new policies and procedures. I have found that the provider does not at the time of the assessment have effective organisation wide governance systems relating to; information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.

I have found that the provider is not compliant with this requirement at the time of assessment.

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

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

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

The Assessment Team found that the service mostly does not have effective risk management systems and processes in place in relation toidentifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can.

The Assessment Team found that consumers may be at risk as there are insufficient processes in place to encourage staff to report circumstances of abuse and neglect and to know how to manage high impact or high prevalence risks. Most staff have not received any training and there are no up to date policies to guide them in these circumstances.

The Assessment Team were not provided with a documented risk management framework, including policies describing how high impact or high prevalence risks associated with the care of consumers is managed, the abuse and neglect of consumers is identified and responded to and how consumers are supported to live the best life they can.

Management advised the Assessment Team that they use their code of conduct, criminal record check system and mandatory reporting tool to guide how they respond to elder abuse. An Abuse of Residents policy dated 10 December 2019 was given to the Assessment Team, but management stated it was out of date and needed to be revised. Upon review, it was noted to include incorrect information.

The Assessment Team interviewed staff who said they were not aware of any risk management framework or policies for managing high impact or high relevance risks for consumers or had knowledge of ways in which the organisation sought to monitor, review or evaluate these. The staff member advised that they had not yet undertaken training with the organisation in risk management or abuse and neglect for consumers.

The approved provider advised in their response that the policies were available but had not yet been updated and the new Risk Management Policy is now on the electronic system.

Whilst I acknowledge that the approved provider has committed to implementing a new Risk Management Policy and updating old policies and procedures to make these available to staff. The new Risk Management System has not been evaluated to see if it assesses and identifies high prevalence risks and how they are monitored and managed. I have found that the provider does not at the time of the assessment have effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can.

I find the approved provider is not compliant with this requirement.

# Areas for improvement

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

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

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

* Ensure staff that are attending to consumers acknowledge the consumers after entry to the consumer’s room.
* Ensure staff that are attending to consumers have secure phase two communication devices and these ear pieces are worn or device is turned down when undertaking personal care for consumers to ensure consumers personal care is respected and confidentiality is maintained.

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

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

* Ensure consumer’s care plans are up to date, reviewed and record care needs and relevant information in the areas of spiritual, emotional, intimacy, relationships, strategies and leisure activities.
* Develop and implement care planning policy and provide a copy of care plans to consumer and/or their representative.

### 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.*

* Ensure that when incidents occur, or circumstances change, care plans are reviewed to include the needs, goals and preferences of the consumer to reflect the changes.
* Ensure consumers behavioural management plan is reviewed or reassessed to include changed behaviours with inclusion of strategies to guide staff in managing behaviours.
* Develop and implement organisational policies and procedures to guide aspects of clinical care including behaviour management.

### 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.*

* Regularly review that Schedule 4-8 medications stock check is completed daily by two registered clinicians and review that double signing of Schedule 4 medication occurs for all staff and clinicians.
* Ensure that wound care documentation is accurate and escalated to RN when concerns are identified.
* Escalate any out of range blood pressure and blood glucose levels and monitor the alert system that notifies RN’s of out of range levels.

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

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

* Ensure that falls risk information gained by reviewing incident forms and FRATS to implement strategies to prevent ongoing falls.
* Provide staff with education on identifying and escalating high impact and high prevalence risks including but not limited to; out of range observation levels and behaviour management including review of strategies for risks to consumers.
* Ensure that all staff complete progress notes promptly and escalate issues to RN.

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

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

* Ensure interventions are identified in care plans and are tailored to the needs of the consumer and optimise health and wellbeing of the consumer.
* Increase staff awareness to recognise deterioration and ensure that falls and behaviour concerns are managed, monitored, evaluated and reported appropriately.
* Regularly review medication management to identify the reporting of errors to ensure staff are providing a safe medication service to consumers.

### 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*

* Increase staff awareness of antimicrobial stewardship.
* Update and review the outbreak management plan.

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

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

* Regularly review all areas for cleanliness and ensure that the equipment is safe, clean and maintained for the consumer.
* Regularly review the maintenance schedule to ensure that maintenance is completed in a timely manner.

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

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

* Enhance staff awareness of processes to support consumers and their representatives to provide feedback and make complaints.

### 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.*

* Ensure that there are qualified staff to respond to consumers safe and effective care.

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

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

* Regularly review staff and volunteers police checks.
* Increase staff competency by increasing education and training in Quality Standards, elder abuse, compulsory reporting, behaviour management, identifying deteriorating consumer and infection control.
* Increase staff awareness of changes to regulatory compliance, such as for restraints and antimicrobial stewardship.

### 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*

Develop and implement new organisation governance framework systems and related policies for abovementioned governance.

* Communicate new policies to staff through training on operational requirements for consumer and clinical care relevant to their roles.

### 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.*

* Develop and implement Risk Management Framework.
* Identify, evaluate, monitor and manage high prevalence or high impact risk to consumers.
* Provide education and processes for staff to identify and respond to abuse and neglect of consumers.