Maranatha House

Performance Report

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**Commission ID:** 0223

**Provider name:** Maranatha House

**Site Audit date:** 8 February 2022 to 10 February 2022

**Date of Performance Report:** 21 March 2022

# Performance report prepared by

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# 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) | Non-compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | 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) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Non-compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | 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) | Non-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 Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 8 March 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

Most sampled consumers considered that they are treated with dignity and respect, can maintain their identity and their culture and diversity is valued. Consumers can make informed choices about their care and services and live the life they choose. In addition, consumers said they are supported to make choices including taking some risks and that they are given information that is clear and easy to understand, which enables them to exercise choice.

Staff are aware of and deliver care that considers consumers preferences and needs in relation to their cultural and spiritual needs. The staff gave examples of how they help consumers make day-to-day choices and help with access to any support the consumer needs to live their best life. Staff spoke about consumers respectfully and were observed to be respectful in their interactions with consumers. However, one consumer did not feel respected and other consumers were missing important information in their care plan documentation.

The organisation provides consumers with current, accurate and timely information which allows them to make informed choices and understand their rights and the services available to them. However, some consumers do not have appointed decision makers and the legal hierarchy of person responsible is not clear in documentation. Valid consent has not been obtained when required such as consent for chemical restraint and/or psychotropic medications. Case conferences, involving consumers and representatives have also not been held regularly.

The Quality Standard is assessed as Non-compliant as two 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 Assessment Team found most consumers reported that they are treated with dignity and respect with their identity, culture and diversity valued. Staff spoke about consumers respectfully and were observed to be respectful in their interactions with consumers. However, one consumer did not feel respected and another consumer was missing important information in their care plan documentation.

One consumer expressed significant concern about how they were treated by a staff member. This included not treating them with respect and dignity in relation to their preferences but more significantly the feedback provided by the consumer included inappropriate care from a staff member. This was also confirmed by the consumers guardian.

Staff interviewed consistently spoke about consumers in a way that indicated respect and an understanding of their personal circumstances and life journey. Staff demonstrated that they are familiar with most consumers’ individual backgrounds and preferences which influence the way staff complete the day-to-day delivery of care. However, the Assessment Team found that there were instances where staff were not familiar or dismissive of a consumer’s culture and a staff member did not speak respectfully of a consumer whilst being interviewed.

Documents reviewed such as meeting minutes and policies used respectful language to describe consumers and their care needs. However, whilst most care planning documents reflected the diversity of the consumers others did not. There was evidence of care plan documentation with incomplete with profiles and life history.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. It is acknowledged that most of the consumers provided positive feedback regarding being treated with dignity and one consumer providing feedback does not indicate as systemic issue. However, there is a higher risk associated with the level of dignity and respect where inappropriate care is provided. There is evidence to support that the Approved Provider did not act thoroughly to ensure that consumer identity knowledge and care were high quality. In addition, there was evidence to suggest the not all staff interactions with consumers were respectful.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

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

*Care and services are culturally safe.*

The Assessment Team found consumers interviewed did not raise any concerns about their culture and diversity not being valued. Staff are aware of and deliver care that considers consumers preferences and needs in relation to their cultural and spiritual needs.

Staff were able to explain each consumers culture and how they respect each consumers diversity. In addition, the team try to adjust the way care and services are offered so they are culturally safe for each consumer. The Assessment Team observed consumers rooms which reflected their cultural identity and what is important to them.

Some of the care plans for consumers sampled demonstrated they contain an overview of consumer needs, goals and preferences that are respectful of their culture and identity. The care plans describe how the service supports them do the things they want to do. However, not all care plans had information which indicated an understanding of their cultural identity.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. Although the Assessment Team noted that care plans did not consistently capture an understanding of cultural identity for all consumers there is no indication of a systemic issue. In addition, most of the evidence, as seen by the Assessment Team, showed both that consumers felt care and services were culturally safe, and their cultural identities are supported, and staff performed those care and services in a culturally safe way.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated care and services are culturally safe.

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

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

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

The Assessment Team found that consumers sampled felt they have a say in the care and support that is provided to them. The staff gave examples of how they help consumers make day-to-day choices and help with access to any support the consumer needs to live their best life. Some care documentation included details of consumer’s representatives and showed the key decisions that consumers have made about care and services. In contrast, case conferences involving consumers and representatives have not been held regularly and valid consent has not been obtained when required such as consent for chemical restraint and/or psychotropic medications.

Most consumers/representatives said they feel that they get the care they need in the manner they have chosen and are partners in care. In addition, consumers interviewed said the staff support them to maintain relationships with people of their choice. Consumer meetings are also regularly held to involve consumers in decision making and exercise their choice and independence.

Staff provided multiple examples about how they support consumers to exercise choice including with meals, shower times and choice in their preferred time to go to sleep and rise in the morning. Consumers are provided choice to attend the activities program if they wish. In addition, staff described how they assist consumers to maintain relationships with people who are important to them and support the significant people in the consumers lives to adjust to the changes some consumers develop because of conditions they have such as dementia.

However, Management confirmed that only 30 of the 79 consumers have had a case conference in the previous 12 months. The facility manager said there is minimal documentation about consultation although there is frequent informal communication with consumers and family members.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. It is acknowledged that there is evidence to show that consumers feel like they are partners in care and that staff support consumers to exercise choice and independence. However, the Approved Provider does not have a consistent approach to capturing this information and gain regular updates through conferencing processes to identify changed consumer choices. Without a robust consistent process that documents and clearly identifies consumer preferences there is no record of their choices and no formalised way they can communicate their decisions. This in turn could mean these choices and decisions cannot easily be referred to and followed consistently for all consumers. The Approved Provider did acknowledge that improvements were required and would be included as part of their continuous improvement process however does not reflect in the findings of the Assessment Team on the day of the site audit.

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

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

Overall sampled consumers consider that they feel like partners in the ongoing assessment and planning of their care and services. Some consumers said they are involved in care planning.

Assessment and planning, including consideration of risks to the consumer’s health and well-being, does not always inform the delivery of safe and effective care and services. It also does not always identify and/or address the consumer’s current needs, goals and preferences or is based on ongoing partnership with the consumers and others they wish to involve.

Lastly, care and services were not always been reviewed for effectiveness, and when circumstances change or when incidents occur.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found that consumers generally believe staff interact and consult with them. However, assessment and planning, including consideration of risks to the consumer’s health and well-being, does not always inform the delivery of safe and effective care and services. There is no interim care plan system. The entry documentation is not always completed and at times there is limited information about consumers new to the service. In addition, when consumer needs change there is not always assessment to support the delivery of safe and /or effective care provision.

The staff confirmed that assessment and planning is an agreed care plan, following communication. Registered nurses undertake assessments. Staff there is a suite of assessments for consumers in the service; 10 assessment areas on admission however there is no interim care plan until assessments are completed and the care plan is formulated.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidenced was provided. The Approved Provider acknowledged that there was improvement needed in relation to this requirement in their response. This combined with the evidence from the Assessment Team indicates there are improvements required to ensure that consumer assessment and planning is undertaken consistently for all consumers, so it informs safe and effective care and services.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

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

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

The Assessment Team found that assessment and planning does not always identify and/or address the consumer’s current needs, goals and preferences. There is some advance care planning, such as advance care directives for consumers who chose them although end of life wishes were not articulated in files of consumers who have recently died. Care plans do not routinely identify consumer goals although they did identify some preferences.

The service has a process for falls risk assessment following any consumer fall however documentation reviewed found this is not always undertaken and consumer falls risk information is not maintained as current. Pain is also not routinely assessed for consumers who may experience pain. In addition, there was evidence that consumers assessments and plans did not identify consumer’s current needs.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider acknowledged that there was improvement needed in relation to this requirement in their response. This combined with the evidence from the Assessment Team indicates there are improvements required to ensure that consumer assessment and planning assessment and planning identifies and addresses the consumer’s current needs, goals and preferences. Improvements are also required to ensure a better process for advance care and end of life planning in line with consumer’s wishes.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

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

*The organisation demonstrates that assessment and planning:*

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

The Assessment Team found assessment and planning is not always based on ongoing partnership with the consumers and others that the consumer wishes to involve, and it does not always include other organisations and/or individuals that are involved in the care of the consumer.

One representative said they were unable to discuss anything about care with the management team at a recent meeting and was told to go to the GP if they want to discuss the care plan.

There is no system or schedule for case conferences, this was confirmed by management with only a small amount of case conferences being held in the past 12 months. Management said there are many adhoc meetings with family which would not have been called a case conference. The impact of this was seen by the Assessment Team as inconsistent information was given by staff in relation to a consumer’s capacity to make their own decisions.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider acknowledged that there was improvement needed in relation to this requirement in their response. This combined with the evidence from the Assessment Team indicates that a systemic issue relating to an ongoing partnership with consumers/representatives and other care providers requires attention to develop a consistent, effective approach for consumer care.

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

The Assessment Team found that the outcomes of assessment and planning are generally communicated to the consumer and documented in a care and services plan that is available to the consumer. Most sampled consumers had some awareness of their care plan. Those who did not have access to a care plan said they were confident if they asked for it, it would be provided. In addition, the service has implemented the consumers choice on how they want to access to their care plan. Care plans are either displayed on their bedroom wall, in their medication cupboard or in the nurse station.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

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

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

The Assessment Team found that care and services have not always been reviewed for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. The Assessment Team viewed several care plan documents that had not been recently reviewed and/or did not include the changing needs, goals or preferences of the consumer.

For example, two NDIS agreements were reviewed both agreements were dated 2019, for review in 2020. There was no further consultation evident regarding the NDIS arrangements.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider acknowledged that there was improvement needed in relation to this requirement in their response. This combined with the evidence from the Assessment Team indicates that the review process for when care and services require change needs significant improvement.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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.

Overall sampled consumers consider that they receive personal care and clinical care that is safe and right for them. In contrast, consumers do not always get safe and effective personal care and/or clinical care that is best practice, is tailored to their needs and optimises their health and well-being. There are also gaps in the management of high impact or high prevalence risks associated with the care consumers and the service has not been able to refer consumers to services which would support their personal and clinical care including their wellbeing.

The needs, goals and preferences of consumers nearing the end of life are not always recognised or addressed; consumer comfort is not always maximised and there is negative impact on consumer dignity. In addition, gaps were identified in identification and management of consumer deterioration.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found that consumers do not always get safe and effective personal care and/or clinical care that is best practice, is tailored to their needs and optimises their health and well-being. There are gaps in clinical leadership of the service and there is limited guidance to direct staff practices relating to clinical and personal care.

The service does not have a clinical indicator process in place to support monitoring of clinical incidents. The system does not ensure staff are informed of clinical incidents, trends and does not necessarily ensure improvements are made when needed. There is no clinical audit system in place to ensure the quality of clinical and personal care provision. Although a new system is to be commenced shortly it is not yet in place.

The service has a system where consumer care reviews are conducted regularly including a consumer well-being check with observations however, this has not been consistently completed. Areas where there are deficits in personal care provision and clinical monitoring include wound management, restrictive practices, pain management, diabetes management and behaviour/incident management.

There are incidents of consumer aggression which have, resulted in administration of chemical restraint which is not best practice and some incidents have had a direct and clear impact on other consumers. Pain management is not best practice pain is not routinely assessed and/or monitored for consumers with conditions which may result in pain for example pain is not monitored for consumers following incidents or those with wounds. Wound documentation is not current or correct. It is not possible to monitor or trend progress of wounds and/or pressure injuries with the poor documentation system.

As just one example, the Assessment Teamreviewed the care needs for one consumer noting that the care provided does not optimise their wellbeing. They experience pain, insomnia and depression. Although staff are kind and reactive when care needs are bought to their attention there is not a proactive approach to support them and care provided/needed does not appear in progress notes or in the care plan and does not appear to have been reported to the registered nurse or doctor.

Representative feedback confirmed that there were concerns that consumers were not getting safe and effective personal care and/or clinical care. This included concerns relating to lengthy wait times for personal care attendance, wound care, pain management and choking hazards.

The clinical staff said they know care is best practice as there is a staff training schedule to upskill staff. However, the Assessment Team found that staff did not have a good understanding of restraint and/or consent. In addition, the clinical staff did provide some context relating to the concerns raised by representatives however this did not dispel some of the concerns raised in relation to effective personal and clinical care.

The psychotropic medication report was provided to the Assessment Team. The psychotropic medication report was found to under report psychotropic medication usage. In addition, the service currently has minimal guidance material about best practice, policies and/or procedures to direct clinical and personal care. The service is using the peak body policies and procedures which provide generic information although they are currently transitioning to other more detailed and personalised directives.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidenced was provided. The Approved Provider response did not address with clarity any further information to dispel the evidence as presented by the Assessment Team. Therefore, based on this evidence, not all consumers are receiving care that is best practice nor is their care consistently suited to their needs to optimise their health and well-being. In addition, there has been deficits identified in the provision of effective personal care as well.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

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

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

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

The Assessment Team found there were gaps in the management of high impact or high prevalence risks associated with the care of each consumer. Clinical incident information has not been reviewed in a meaningful manner. Although data is available there has only been informal consideration of incidents and clinical trends. While the system is scheduled to change, with reporting to the board, there has not been a system where the clinical team has communicated, collectively, about clinical data and incidents.

There have been consumer choking incidents of consumers who require specialised diets, when their intake is not in line with requirements. While the incidents were reviewed, and actions were taken there was no systemic review of risk. In addition, there are high prevalence risks relating to aggressive behaviour that are not being effectively managed nor is the high impact risk to other consumers as a result of this behaviour.

The Assessment Team found that staff do not have a good understanding of high impact and/or high prevalence risk for consumers. There was a lack of focus on the clinical aspects of care when risk was discussed. In addition, the medication incident report showed a high risk relating to medication administering errors. Incidents have individual follow up and review however there does not appear to have been any comprehensive review of medication management.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider response did not address with clarity any further information to dispel the evidence as presented by the Assessment Team. Therefore, based on this evidence, the Approved Provider has not demonstrated a consistent system for the effective management of high impact or high prevalence risks relating to the care of consumers.

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

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

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

The Assessment Team found that the needs, goals and preferences of consumers nearing the end of life are not always recognised or addressed; consumer comfort is not always maximised and there is negative impact on consumer dignity.

The Assessment Team conducted a document review and found there was limited end of life assessment or planning evident. There was no involvement of palliative care teams or specialised services or allied health. However, it is evident from documentation staff are compassionate in their care of consumers. There was progress notes documentation regarding pain management; when consumers are identified with pain. Charts such as monitoring charts (bowel, pain, wound) and medication charts were not available in the archive system, to support an understanding of these areas of care provision.

For one consumer sampled staff said that there were no issues relating to a consumer’s end of life however review of documents found a deterioration including falls and a hospital admission. There was no end of life assessment or plan evident to support the consumer. In addition, the consumer’s care directive was not current last being updated 5 years prior to their death. For another consumer the service had not identified as being at the end of his life however progress notes indicate oral intake has been ceased. It was unclear of family have been involved in end of life consultation.

Staff confirmed they have a process to are able to manage end of life comfort in conjunction with addition support of paramedics if required. A staff member did confirm however that there was no specific end of life care documentation that usual documentation such as observation charts and progress notes are used.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. Therefore, based on this evidence as presented by the Assessment Team, the Approved Provider has not demonstrated a consistent system for accommodating the needs, goals and preferences for consumers nearing the end of life. Whilst it is acknowledged that staff are kind and caring during this time the are significant improvements required to the ongoing care needs and preferences for consumers nearing the end of life for their comfort and dignity.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

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

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

The Assessment Team found improvements are required in the identification and management of consumer deterioration.Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is not always recognised and/or responded to in a timely manner.

Care planning documents for one consumer showed a consumerhad a deterioration in his condition as they had begun sleeping lengthy periods. Evidence suggested that staff were making decisions about the prescribed medications without apparent regard to the orders. Another two consumers showed a deterioration of their mental health and aggressive behaviour for a long period of time yet only one of them had only just been referred for mental health review.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. Therefore, based on this evidence as presented by the Assessment Team, the Approved Provider has not demonstrated that deterioration in consumer health condition are responded to in a timely manner, especially in relation to deteriorating mental health.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

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

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

The Assessment Team found that information about the consumer’s condition, needs and preferences is not always documented and communicated within the organisation, and with others where responsibility for care is shared. Deficits were identified with the communication of allied health services, wound and psychotropic medication documentation and reports. Case conferences with consumers and representatives are not routinely held.

The Assessment Team sampled consumer care records and found one consumer’s documents showed they were referred to three allied health professionals however the consumer had only seen one of these health professionals since the referrals were made four months ago. For another consumer there were gaps in communication with the hospital and paramedic services regarding their ongoing care needs. Lastly one consumer’s diabetic direction was not adhered to or escalated to the medical officer as directed.

Representative feedback to the Assessment Team stated at times staff do not seem to document events which they verbally pass on and that staff say things which they do not always follow up on. This was confirmed by staff stating much of consumer and family communication is informal and not demonstrated in documentation. In addition, consents for psychotropic medication administration and possible chemical restraint are not current, they are incomplete and there is no evidence in most cases of consumer or representative consultation.

The clinical manager did highlight some issues with accessing health consultant stating there had been no access to wound consultants to provide support for management of chronic wounds. In addition, the service has improved to the documentation system including the consolidation of the computerised consumer documentation system which should bring about further communication improvements.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. It is acknowledged that the Approved Provider has had difficulties sourcing health professionals locally and that improvement to document keeping are underway. However, based on this evidence as presented by the Assessment Team, the Approved Provider has not demonstrated that communication of consumer needs is effective.

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

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

The Assessment Team found that the service has not been able to refer consumers to services which would support their personal and clinical care including their wellbeing. Services to support behaviour management, emotional and psychological wellbeing have not been regularly accessed. In addition, a physiotherapy service has not been available in the service for several years staff would have to take the residents to the hospital for access to a physiotherapist. However, management said there may be a physiotherapy provider willing to visit the service, but this has not yet commenced. Overall, management expressed frustration regarding access to allied health services.

There has not been a wound care specialist visiting the service for years. However, there are two medical officers from the aboriginal medical service who visit the service. alternate weeks. Staff need to take consumers to visit the speech pathologist in town and the nearest mental health services are in Dubbo who will visit although no one has been seen recently and the psychogeriatrician has not visited over a year.

All referral documents seen by the assessment team were overdue and confirmed in part some of the difficulty the service is experiencing in getting access to allied health services.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. It is acknowledged that the Approved Provider has had difficulties sourcing health professionals locally and that attempts are being made to improve this access for consumers. However, there is evidence that the Approved provider is not actioning referrals in a timely manner. Therefore, based on this evidence as presented by the Assessment Team, the Approved Provider has not demonstrated timely referrals to health professionals for consumer care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services.

### Requirement 3(3)(g) 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 there are processes for the minimisation of infection related risks. This is done through implementation of 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.

The service uses an infection register to monitor infections and there is a consumer and staff vaccination program in place. There has been a recent Covid-19 outbreak at the service with minimal impact to consumers. Covid-19 precautions remain in place. This was supported by several consumers providing favourable feedback with management of the covid-19 outbreak.

The clinical manager said there is an infection register which is reviewed and staff have been provided learning packages about antibiotic stewardship and urinary tract infection management.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated the minimisation of infection related risks through implementing:

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

Most sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Overall consumers staff support them to optimise their independence, well-being, and quality of life. However, documentation is not showing that staff are assessing and identifying consumer’s needs, goals and preferences for their well-being and quality of life.

Consumers said they can attend church services and their spirituality and cultural beliefs are respected. The service demonstrated that services and supports for daily living assist each consumer to participate in their community within and outside the service’s environment. Consumers are supported to have social and personal relationships and do the things of interest to them. However, the service has not demonstrated that supports for daily living promote consumers psychological well-being

Consumers and representatives generally said they felt there is effective communication within the organisation. Staff have knowledge of the consumers in relation to the services and supports for daily living however, the care and service records of some of the consumers sampled have limited information. This gap in the information system is a risk to consumer care as the information available may not be correct, up to date or accurate.

Consumers and representatives provided a mixture of positive and negative feedback about the food. The service provides opportunities for consumers to give feedback about the food, and the feedback is used to adjust the meals to reflect the consumers’ needs and preferences. However, the menu did not have oversight from a dietitian to ensure the nutritional value of the meals is optimal for the consumers. Care plan documentation is inconsistent in outlining the consumer preferences and dietary needs.

Consumers, staff and management interviewed combined with the Assessment Team’s observations indicate that equipment used to support consumer lifestyle activities, catering, cleaning and laundry services are clean, well maintained and fit for purpose. Consumers personal equipment was not always clean, and one consumer was waiting on appropriate equipment which is impacting on their ability to participate in their activities of choice.

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

## Assessment of Standard 4 Requirements

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

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

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

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

The Assessment Team found that consumers said they can attend church services and their spirituality and cultural beliefs are respected. Overall consumers interviewed said they were able to access supports which promoted their spiritual well-being. Consumers knew that church service had started again, and they could attend these services if they wished to. However, the service has not demonstrated that supports for daily living promote consumers psychological well-being.

Care planning documents viewed by the Assessment Team did not include information about their emotional support required to assist them to process grief from the loss of their husband and their diagnosis of cancer. For another depressed consumer grieving for their partner there were no strategies to support their emotional wellbeing including relationships of importance to him. The service also did not facilitate a wife visiting their husband which resulted in a significant incident causing consumer distress.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider did provide some context regarding the Assessment Team findings however this did not adequately address the concerns relating to psychological well-being. It is acknowledged however that staff are supporting consumers daily living with the care they are providing. This however is only one component of the requirement and improvement is needed specifically in relation to consumer psychological well-being.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

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

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

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

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

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

The Assessment Team found that consumers/representatives generally said they felt there is effective communication within the organisation. Staff have knowledge of the consumers in relation to the services and supports for daily living however, the care and service records of some of the consumers sampled have limited information. This gap in the information system is a risk to consumer care as the information available may not be correct, up to date or accurate.

Some consumers sampled had detailed information about their care needs as it relates to services and supports for daily living. Other consumer care plans sampled and reviewed did not provide adequate information to support effective care.

Care staff interviewed said they are updated on the changing condition, needs or preferences of each consumer through handover, staff meetings and informal conversations with other team members. In addition, information in the catering section of the service is detailed and catering staff indicated an understanding of the processes for effectively communicating consumer needs and preferences.

The lifestyle team are verbally able to articulate consumers preferences in relation to lifestyle interests, community engagement, and changes in participation ability and emotional support required. However, this information is not documented in assessment and care planning documentation. It relies on staff recall and staff availability at the service.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. It is noted that there is evidence that staff do communicate with one another and with consumers verbally to provide care for consumers. However, there is improvement required to the documentation that supports this as there is no recourse for staff to check and validate the information that has been shared.

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

The Assessment Team found that from consumer, staff and management interviews combined with the Assessment Team’s observations showed that equipment used to support consumer lifestyle activities, catering, cleaning and laundry services are clean, well maintained and fit for purpose. However, one consumer was waiting on appropriate equipment which is impacting on their ability to participate in their activities of choice.

Equipment used to provide lifestyle services is safe, suitable, clean and well maintained. The service has two mini vans which they use for community outings. The Assessment Team’s observations of the kitchen confirmed they have areas to complete services safely. The kitchen and food storage area were clean and tidy and the equipment is suitable and well maintained. There were sufficient storage containers to store food safely. In addition, the laundry area was clean, and equipment appeared in good working order. Linen supplies appeared sufficient for the number of consumers at the service. However, there was no evidence of a robust system for care staff to routinely clean consumer’s personal equipment.

The lifestyle coordinator said they have never had any concerns about not having enough resources to get the equipment they need for the activities the consumers would like to participate in.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. No additional evidenced was provided. Although the Assessment Team noted that there were some issues relating to a roster for cleaning of personal consumer equipment there was no evidence to support that there was any impact on the consumer. In addition, although there was a consumer that did not have the appropriate equipment it had been ordered and actions had already been undertaken to remedy this prior to the site audit. Therefore, there is no evidence to indicate there is a systemic issue with the standard and maintenance of equipment provided to consumers.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated that equipment is provided, it is safe, suitable, clean and well maintained.

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

Overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. The service provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

The service environment was observed to be safe, clean, well maintained and comfortable. There are systems in place for the cleaning and maintenance of the service environment. Overall consumers interviewed were satisfied the service is safe, clean and well maintained.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

The Assessment Team found that the service environment to be safe, clean, well maintained and comfortable. There are systems in place for the cleaning and maintenance of the service environment. Overall consumers interviewed were satisfied the service is safe, clean and well maintained.

Bedrooms were decorated to meet the preference and comfort of each consumer with some consumers having their own furniture in their rooms. The outdoor gardens were well maintained, and consumers were observed utilising the gardens and courtyards throughout the site audit. Walkways were observed to be well-light and uncluttered and common living areas appeared comfortable and welcoming.

Overall consumers interviewed confirmed they feel safe at the service and they were satisfied with the cleanliness of the service. This included comments regarding staff keeping the place clean and tidy for them, during and after the mouse plague

Care staff explained the process for logging environmental issues with the maintenance on their electronic system. Staff were aware of the need to remove any hazards from the immediate area. The scheduled maintenance spreadsheet confirms all maintenance is up to date or is due to be completed within the scheduled timeframe. The service has a cleaning schedule in place and the service uses checklists for staff to complete and confirm that all required tasks have been attended. The checklists showed that tasks had been marked as complete in accordance with the schedule.

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

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

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

Consumers/representatives said they can speak with any of the management team to raise concerns or make a complaint. However, this was not the case for all consumers/representatives, with some feeling they are not encouraged to raise concerns, and do not feel as though they are enabled to openly discuss their raised concerns.

The Assessment Team observed the limited written internal complaints to generally be managed well. However, verbal complaints raised through resident meetings or conversations with the management team, are not accurately logged in the feedback and complaints register. As result information on complaints is incorrectly reported to the board and improvements are not always seen by the consumers and representatives.

The service is unable to demonstrate complaints are managed and investigated with an open disclosure approach. The service inaccurately records complaints, preventing the service to identify complaint trends. There is no process to monitor or review complaint resolutions, or how complaints are used to improve consumers care and service needs.

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.*

The Assessment Team found that the service has a system for encouraging and supporting consumers to provide feedback and make complaints. Most of the consumers and representatives interviewed, provided feedback they have received encouragement and support when making a complaint or raising concerns. In contrast, some consumers/representatives that did not feel supported to make a complaint, and this has had impact of them.

Most consumers and representatives interviewed stated they were aware of ways they could suggest an improvement or make a complaint, through the resident feedback box, talking to staff, or discussing concerns during resident and representative meetings.

Staff interviewed by the Assessment Team demonstrated a basic understanding on the services complaint process relevant to their role. The management team advised consumers are provided information and reminded on the services complaints process in several different ways. These include discussing complaints on entry into the service and is provided in writing through the resident handbook and consumers are reminded of the complaints process during resident and representative meetings.

The Assessment Team observed complaints brochures, posters on how to make external complaints where observed to be displayed in each wing of the service. Feedback forms and suggestion boxes have been placed in each wing of the service making is easily accessible to all consumers and representatives. In addition, the services consumer handbook includes information on how to raise both internal and external complaints.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider felt that the Assessment Team had predominantly seen that they encouraged and supported consumers/representatives to provide feedback and make complaints. Considering the evidence and the intent of this requirement the Approved Provider has many options to support consumers/representatives to provide feedback and complaints. There is no evidence provided that would indicate a systemic issue with consumers/representatives making complaints.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated 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 Assessment Team found the service was unable to demonstrate appropriate action or investigation is taken in response to all feedback and complaints, or that open disclosure is always used when things go wrong. Staff do not understand the definition or application of open disclosure, with the service not having provided education.

There was mixed feedback from consumers but generally have not needed to raise any complaints to the service and if they did they felt their concerns would be listen to and addressed appropriately.

Staff were able to provide generalised information on the services complaints’ procedure. Personal carer advising they escalate it to the team leader or to the registered nurses. The registered nurses advised they will manage complaints independently where possible but will also inform the management team of the complaint.

The service has policies and procedures detailing the organisations complaint management process. The organisation has been working with an aged care consultancy agency to improve current policies and procedures. The management team advised the new policies and procedures will be implemented promptly, including training and education to all staff on what open disclosure means and how the service implements an open disclosure approach during the complaint process.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. The Approved Provider did provide some context regarding the Assessment Team findings however this did not adequately address the concerns relating to the staff’s understanding of open disclosure and providing additional evidence to dispel that the Approved Provider has taken appropriate action is taken in response to complaints.

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

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

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

The Assessment Team found the service was not able to effectivity demonstrate there are processes in place to ensure feedback and complaints are being monitored, reviewed or being used to improve the quality of care and services for the consumers. The service was also not able to demonstrate verbal complaints or concerns are managed, resolved, monitored and reviewed. This reduces the ability to understand consumer feedback and ensure they are satisfied with care and services received.

The management team advised the service separates internal and external complaints in the register, but that all complaints are attempted to be managed and resolved within 30 days. The management team stated due to consumers feeling comfortable talking with them about their concerns, it does not result in a formal complaint being lodged. There have only been 2 formal internal complaints registered for 2021 /2022. However, the service cannot track trends in complaints therefore no trends analysis is being done.

The service demonstrates they manage written complaints within a timely manner and with positive outcomes. However, they do not monitor, or review changes have been effective, and consumers are satisfied with the outcome.

During discussions with the management team and 2 members of the board, it was advised the board has implemented changes to the service after suggestions and feedback from consumers. However, the Assessment Team did not observe any documents outlining the how concerns were raised by the consumers to initiate the following changes to the service as suggested. In addition, the service’s written complaints are lodged but verbal complaints are not recorded. There is no process on capturing this information, no analysis can be completed to assist in improving the service. As a result, information sent to the board is not accurate and does not reflect the correct number of complaints received.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. In the submitted response the Approved Provider committed to improving how the complaints and feedback is recorded and managed to facilitate improvements. Therefore, the service needs to make improvements so that the Approved Provider is using feedback and complaints to improve the quality of care.

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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.

Overall sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. Consumers/representatives interviewed said most staff are kind, caring and their interactions with staff are gentle and respectful. However, one consumer advised there is a staff member who does not speak nicely and can sometimes be rough with the consumer. However, consumers and representatives stated the service is often short staffed especially during evening shifts and weekends, staff seem to be always very busy and often have to wait for long periods of time for their call bells to be answered.

A review of the training records showed staff are not consistently provide with training in areas identified as lacking skillset in reaching positive outcomes for consumers.

While some consumers were satisfied with the staff and their delivery of care. Other consumers say they ring the call bell and often waiting long periods of time to have their care needs met or have been encouraged not to use the call bell at all. Clinical care staff do not currently have the skill to deliver the care for consumers demonstrating challenging behaviours and complex clinical care needs.

The Quality Standard is assessed Non-compliant as three 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 most consumers and representatives were not satisfied with current staffing, stating staff are rushed, overworked. This adversely impacts consumer health, wellbeing and dignity where continence needs are not met and safety issues when staff assistance is not available when needed for personal care.

Consumers and representatives voiced their concern of how busy staff are and there does not seem to be enough, especially in the afternoon, evenings and night shiftsand as a result theyhave grown accustom to the long call bell response times. One consumer said that they are discouraged from using the call bells unless absolutely necessary.

Staff advised they felt they are managing the workload assigned to them and are completing the tasks in the allocated timeframes. Staff said there has been times where shifts cannot be filled, and they work short staffed, however this has improved, and it does not happen as often. When they are short staffed the rest of the staff will pick up the extra workload to ensure consumers are being cared for. Staff said registered nurse day to day cover is difficult. The human resource manager said there has not been any unfilled shifts since August 2021. However, the Assessment Team did observe there is no longer registered nurse coverage during the night shifts with them being on call. The Assessment Team was advised there is still a shortage of registered nurses in the area. The management team stated they are looking into different models of care and other ways to entice registered nurses to work in the area.

The call bell response times as reviewed by the Assessment Team did have response time mostly within the expected time frames. However, there was still many calls that exceeded the excepted response time. In addition, the service was not able to demonstrate what investigation has been completed to determine the causes of the long response times, what the outcome of the investigation was or what impact the long wait times have had on the consumers involved.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidence was provided. In the submitted response the Approved Provider gave clarity around some of the circumstances e Assessment Team’s observations. It is also acknowledged both the difficulty in finding and retaining trained clinical staff and issues with call bell system which is currently being serviced. However, it is clear that consumers/representatives feel that the number of staff, especially in the evenings, nights and weekends are not of a suitable number to facilitate the delivery quality care.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

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

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

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

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

The Assessment Team found that the service has started to provided training and education however, staff still do not have the knowledge and competency to effectively perform their roles. Deficiencies in staff knowledge have been identified in completing care planning documentation, best practice personal and clinical care and in clinical monitoring, managing high-impact and high prevalence risks, minimising restraint and clinical oversight.

Most consumers/representatives interviewed said staff know what they are doing and did not identify any areas where further education and training is required. However, one consumer said that some staff are trained better than others and a representative stated staff need to be trained better in swallowing issues.

The management team said they determine the capability and competency of staff through observations made while walking around the service and from feedback provided by consumers the registered nurses, supervisors and other staff. In addition, the management team advised the organisation staff position descriptions are being reviewed and developed and will be brought in line with the service’s new clinical governance framework.

A member of the clinical team said training and support has improved, she said the new clinical document systems have made positive changes. All staff interviewed said they were happy with the training provided by the service. Conflicting information was received on each title, position descriptions and stability of the current clinical care team.

The management team described the recruitment process, orientation, mandatory, and other training and clinical care performance supervision for staff by registered nurses and management. The organisation has had a review of the orientation package for new staff members. On implementation all current staff will be also be introduced to the new package.

The Approved Provider submitted a response relating to the findings of the Assessment Team with additional evidence. In the submitted response the Approved Provider provided some context and training information. However, there remains concern in relation to some areas of care including clinical oversight. It is acknowledged that the Approved Provider is addressing this through new IT systems however the staff are the ones responsible for the personal and clinical care for consumers and need to be suitably trained and qualified to perform their roles. This would also include clear roles and position descriptions.

I am of the view that the Approved Provider does not comply with this requirement as it has not demonstrated 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 Assessment Team found that the service has implemented a new online training platform to staff. However, the findings of this requirement do not support the workforce is trained, equipped and supported to implement best practice in a range of areas in clinical care, including but not limited to wound management, behaviour management, the use and understanding of restrictive practice, identifying and responding to decline of consumers physical and mental health and clinical information management.

Generally, consumers and representatives did not raise any concerns on areas staff are needing to have further training and education in. There was one consumer who stated some staff are needing more training than others, and a representative raised concern in staff understanding and training in clinical areas.

Staff interviewed confirmed they had completed all allocated online mandatory training. Registered nurses said if they identified extra training was required for staff they would raise it with the management team. However, at present there are no identified areas needing improvement. In addition, staff advised they can request extra training during staff meetings or personal development appraisals in areas of interest to them, to assist with improving on how care and service are provided or to upskilling into another position of the service.

The service has implemented an online training platform for staff to complete. This includes annual competencies and mandatory training topics that staff must undertake.

The management teams, clinical care team, the board, registered nurses, enrolled nurses, supervisors have attended face to face training with the aged care consultancy agency. They have also partnered with and another external training organisation.

While the service has completed some training through the online platform, the findings and examples throughout this report do not support the workforce is trained, equipped and supported to implement best practice in relation to wound management, minimising the use of restrictive practice, behaviour management information management and documentation.

The Approved Provider submitted a response relating to the findings of the Assessment Team with additional evidence. In the submitted response the Approved Provider provided some context and training information. It is also acknowledged that the Approved Provider has put in a significant amount of work including a new online training system to improve staff expertise. However as noted by the Approved Provider they have not had enough time to ensure this is embedded to its optimum level. Therefore, the Assessment Team findings show the need for improvement especially in relation to wound management, minimising the use of restrictive practice and behaviour management.

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

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

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

The Assessment Team found that the service has implemented systems that ensure regular assessment, monitoring and review of staff performance. Consumers are regularly involved in feedback on staff performance and are encouraged to report any misconduct. Registered nurses monitor staff practices and ensure corrective actions are undertaken promptly and/or education organised.

Staff interviewed confirm they have participated in performance appraisals in the middle of the 2021 and are satisfied the training program provides them with the education they need to competently complete their roles and develop their performance. Discussions are held regarding goals, expectations and further education. Staff said they are satisfied with the outcomes of their appraisal.

Review of the staff appraisal showed the service has a system in place to ensure staff are competent and their skills for their role evaluated annually. All staff appraisals are current. In addition, all registrations, criminal checks and visas were observed to be current and in accordance to legislation.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated 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

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).

Most sampled consumers consider that the organisation is well run and that they can partner in improving the delivery of care and services and the management team provided examples of how they are engaging consumers in the development, delivery and evaluation of care and services. However, while most consumers and representatives said the service is well run, consumers and representative were not able to provide any examples of how they are involved in the development, delivery and evaluation of care and services. Some said the management team need to be more approachable, while others said the management team don’t listen and there needs to be better communication between staff.

Review of information management systems showed the service does not consistently review or update documentation that staff access to identify changes in consumer care and services. It was also observed some documentation had been amended to reflect different clinical care outcomes.

The service was not able to demonstrate they are consistently accountable for delivery of care, that reflects the acuity and management of high impact high prevalence risks in consumer care. At the time of the site audit there was no effective clinical, risk or organisation wide governance systems in place. The service has new clinical/organisational governance teams, systems and frameworks. However, had only been approved by the board the week prior to the site, and not yet been implemented in the service.

The Assessment Team identified the service does not always have a clear understanding of their regulatory reporting responsibilities and the importance of reporting in a timely manner nor the effective management of high impact high prevalence risk in clinical care and services.

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.*

The Assessment Team found, from the consumers sampled, that they were not able to give examples of how they were involved in the development of delivery and evaluation of care and services. In addition, there was a lack of ongoing partnership with the consumers, representatives and others in relation to assessment, planning and review of care and services.

Management said that it involves consumers in the design, delivery and evaluation of services through surveys, information sharing, feedback forms and resident meetings. In addition, there was the services’ feedback and complaints management system, however, is currently not adequately recording verbal feedback and complaints or evaluating the concerns consumers have about their care and services.

The management team said the organisation has implemented consumers representation in the recruitment of two new board members as well as the service a forming a resident committee comprising of six consumers. This committee is used to collect and present items to the board, committees or a platform to involve consumers in the development, delivery and evaluation of care. They also have a board member who chairs and writes the minutes for the ‘resident and representative’ meetings. The board member is a direct contact between the consumers and the board.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidenced was provided. The Approved Provider submission provided extra details and clarification as to how they engage consumers in the development, delivery and evaluation of care and services and are supported in that engagement*.* Although the Assessment Team noted there were some issues with recording and trending of complaints and that consumers sampled could not recall how they were involved in the development of delivery and evaluation of care and services this is not enough evidence to indicate a significant issue when compared with very specific information from the Approved Provider was able to demonstrate how they involve consumers. The Approved Provider was able to demonstrate a range of avenues for engaging with consumers to ensure they have input into the development, delivery and evaluation of their care and services.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

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

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

The Assessment Team found that the board demonstrated an understanding what is required by the organisations governing body to promote a culture of safe, inclusive and quality care and services after receiving training on their responsibilities. However, due to lack of clinical and organisational governance safe, inclusive and quality clinical care and services are not being provided to consumers. In particularly in relation to the identified areas of ongoing assessment and planning, personal care and clinical care, service and supports for daily living, feedback and complaints resolution, staff skill mix, information management, effective management of risks around reportable incidents, managing high impact high prevalence risks associated with consumer care, and clinical governance.

The service reports submitted to the board by the management team do not demonstrate effective oversight and/or accountability across seven of the eight standards. For example, the clinical data reported is minimal and not analysed, with limited to no discussion about those matters in the board meeting. The Assessment Team was advised this will be improved once the clinical governance framework has been implemented.

The organisation’s board members have a range of different experience, with the two new members being recently appointed. One of the new board members is a pharmacist, while the other is a registered nurse with experience working with first nations people and clinical governance.

The board provided examples of changes made to the service, driven by the board, in the last six months because of consumer feedback. The service has purchased new reclining lounges and furniture, a quote has been completed on an amplifying system for consumers to hear during ‘resident and representative meetings’, quotes have also been obtained for a movable soundproof wall to be built to reduce the noise in the lounge and dining room, coming from the kitchen.

The organisation has been working with an aged care consultancy agency to assist with redeveloping policies, procedures and frameworks that has been tailored to the needs of the organisation. The board has been present in all the training conducted by consultancy agency.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. It is acknowledged that the Approved Provider has made improvements to the governing body and board member make up, so they can form a governing body that is accountable for the delivery of care and services to consumers. However, the evidence as seen by the Assessment Team indicates tthere needs to more improvement made to this accountability.

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

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

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

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

The Assessment Team found that the service was not able to demonstrate they have effective organisation wide systems which they can access to ensure information management, continuous improvement, regulatory compliance and feedback and complaints are adequately implemented to enable safe quality care and services for consumers.

The service has information management systems to ensure information is accessible by appropriate staff members to help them in their roles. While the system shows how the organisation maintains, stores, shares and destroys information and how it controls privacy and confidentiality, the Assessment Team identified deficits in the currency of the information and accuracy of information. In addition, some staff were unsure as to where to access the service’s policies and procedures, while others stated they are in folders.

While the service has a care planning system that identified the needs and preferences in clinical and personal care for consumers, it was identified it has limitations in recording goals and other information.

Review of the continuous improvement plan appeared to be staff and management driven and lacked initiatives based on consumer and representative feedback and suggestions. Management confirmed opportunities for continuous improvement include feedback from consumers, representatives and staff, complaints feedback. However, the Assessment Team could not identify where consumer and representative input is encouraged, acknowledged and used to drive improvement activities in care and services at the service. It was also not able to be identified how the service monitors and reviews the improvements made to the care and services of the consumers.

The service has a financial governance system for the procurement of services and equipment that is central to the organisation. The requests to meet the identified needs of consumers are at the forefront of the service’s delivery of care and services. Management has oversight on expenditure and budget allocation which is consistently reviewed to ensure that the service has access to adequate levels of funding to maintain effective and adequate care and services.

The service was not able to demonstrate workforce governance they regularly review and assess the needs of consumers regarding the planning and deployment of the workforce skill mix. In addition, the service was not able to demonstrate it adequately trains staff in the clinical practices which may pose risks for consumers in the delivery of clinical care and services.

In relation to regulatory compliance the management team advised information on regulatory changes is initially identified by the management team. Updates are sourced from various government bodies as well as industry peak organisations. Information is then provided to all staff where relevant, through communication systems and meetings.

While there are systems in place to address serious incidents for consumers, the service was not able to demonstrate it consistently manages their regulatory responsibilities in a timely manner. During the site audit an allegation was not investigated or reported to the serious incident response scheme.

The service was not able to demonstrate it has systems and processes to actively identify all complaints and improve results for consumers in a way that follows the principles open disclosure.

The Approved Provider submitted a response relating to the findings of the Assessment Team. The Approved Provider submission provided extra details and clarification particularly in relation to an incident report seen by the Assessment Team during the site audit. Whilst this did present the Approved Provider point of view it did not provide any additional evidence to support their claims. In addition, the Assessment Team found there were no effective organisation wide systems which the service can access to ensure information management, continuous improvement, regulatory compliance and feedback and complaints. It is acknowledged that the Approved Provider has continuous improvement in place for most of the areas in this requirement however there are still significant improvements to be made as seen by the Assessment Team.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated effective organisation wide governance systems relating to the following:

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

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

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

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

The Assessment Team found that the service has policies and procedures for each of the key areas above. The organisation has new policies and procedures tailored to the service needs. However, the board only endorsed the new policies and procedures three days prior to the site audit so the service has not had an opportunity to implement or train staff with the new policies and procedures.

The service’s risk management processes are not effective for managing high impact high prevalence risks that support consumers to live the best life they can. Systems and processes are not in place to effectively deliver safe care and services in respect of consumer’s ongoing assessment and care planning information being effectively recorded and shared to manage high impact high prevalence risks.

The governing body did not provide evidence that it effectively promotes a culture of safe inclusive quality care and services including managing high impact high prevalence risks. Some of the risks not being well managed include restrictive practices pain management and behavioural strategies.

The Approved Provider submitted a response relating to the findings of the Assessment Team however the information did not address this requirement. Therefore, based on this evidence as presented by the Assessment Team, the Approved Provider has not demonstrated effective and consistent risk management systems.

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

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

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

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

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

The Assessment Team found the service did not have an operational clinical governance framework with the new clinical governance framework pending implementation. Therefore, there has not been a clinical audit system or clinical indicator system in place to effectively monitor and report areas requiring improvement. The management team stated the pending implementation of the clinical governance framework and changes to the policies within the framework will assist with changes in the way care and services are planned and delivered.

Staff were not able to confirm they had been educated about the policies and were not able to explain their relevance to their work. For example, one care staff member was unclear of open disclosure.

The service has high usage of psychotropic medication and chemical restraint. The clinical care team did not have a sound understanding of restrictive practices. In addition, discussion with consumers and representatives and review of documentation did not reflect that open disclosure in all incidents and complaints.

The service has a developing antimicrobial stewardship program including systems to monitor infections and antibiotic use.

The Approved Provider submitted a response relating to the findings of the Assessment Team. No additional evidenced was provided. The Approved Provider submission provided information about their commitment to open disclosure but acknowledged that the service does need to implement and continuously improve these areas. Therefore, based on this and the Assessment Teams findings there was not fully functioning clinical governance framework at the time of the site audit.

I am of the view that the Approved Provider complies with this requirement as it has demonstrated 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.

# 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)(a)

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

* Review consumer records and speak with consumers to ensure their identity is captured. Ensure that consumers needs are met in relation to supporting their culture and identity.
* Investigate the feedback relating to the provision of inappropriate care and escalate ensuring that all mandatory reporting requirements are met.
* Ensure staff are treating all consumers with respect and dignity.

### Requirement 1(3)(c)

*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.*

* Complete continuous improvement plan as advised.
* Ensure there is a robust process for care case conferences for every consumer to ensure that the consumer is making decisions about their care, preferences and needs.
* Review formal process for recording the use of restrictive practices.

### Requirement 2(3)(a)

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

* Ensure that assessment and planning is improved as part of the Service’s continuous improvement plan as advised.
* Review and ensure that assessment processes are consistent for all consumers.
* Ensure that all improvements are applied in practice consistently.

### Requirement 2(3)(b)

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

* Ensure that assessment and planning is improved as part of the Service’s continuous improvement plan as advised.
* Review and improve planning and assessment in relation to consumers current needs including pain and falls management.
* Review and improve processes for advanced care and end of life planning.
* Ensure that all improvements are applied in practice consistently.

### Requirement 2(3)(c)

The organisation demonstrates that assessment and planning:

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

* Develop a clear process to partner with consumer’s in their ongoing care. This should also include other they wish to involve and other care and service providers.
* Ensure that all improvements are applied in practice consistently.

### Requirement 2(3)(e)

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

* Improve the review process for and deliver safe and effective clinical care when circumstances change or when incidents occur.
* Ensure that the review process is consistently used to improve care and services.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(a)

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

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

* Review, improve and deliver safe and effective personal care. This may involve looking at staffing levels as well as how the care is provided in practice.
* Review, improve and deliver safe and effective clinical care. This would include but is not limited to the areas of wound management, pain management, restrictive practices and behaviour/incident management.
* Review staff training to ensure that it is delivery information relating to best practice.
* Review and reduce the use of psychotropic medications in relation to restrictive practices and ensure staff are fully trained to understand their appropriate use.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(b)

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

* Develop and implement a robust system for the effective management of high impact and high prevalence risk.
* Risks associated with behaviour management need to be addressed as a matter of priority both to the consumer exhibiting the behaviour and the impacts to other consumers.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(c)

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

* Review and seek consumer/representative feedback on processes relating to end of life so they can be improved and implemented.
* As a matter of priority ensure all consumer end of life and advanced care directives are up to date.
* Review records for those who have passed away to look for improvements in relation to shared care processes for consumers nearing the end of life.
* Make end of life processes and procedures a part of the service’s continuous improvement plan
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(d)

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

* Review all processes in relation to recognition of consumer deterioration with particular focus on identification and how this is communicated to the relevant care staff and health professionals. Attention is required in the area of mental health.
* Ensure that all improvements are applied in practice consistently.

### Requirement 3(3)(e)

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

* The Approved Provider needs to continue to implement improvements in electronic information management.

### Requirement 3(3)(f)

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

* The Approved Provider needs to have a plan of action to address the issues facing the service accessing allied health professionals.
* Ensure referrals are enacted in a timely manner even where services are difficult to access.

### Requirement 4(3)(b)

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

* The Approved Provider needs to improve the daily living for each consumer in relation to psychological well-being, particularly in relation to grief support.

### Requirement 4(3)(d)

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

* The Approved Provider needs to continue to implement improvements in electronic information management and ensure that staff are fully trained in the sue of that system.

### Requirement 6(3)(c)

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

* Ensure that the service is recording the appropriate action or investigation that is taken in response to all feedback and complaints.
* Review the complaints and feedback process to ensure open disclosure is always.
* Ensure staff are all familiar with open disclosure to ensure that it is readily used.

### Requirement 6(3)(d)

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

* Continue to develop and implement methods for capturing both internal and external feedback and complaints so they can be used for improving the quality of care.

### Requirement 7(3)(a)

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

* Continue to look for ways to attract and retain qualified staff.
* Look at rostering particularly for evenings and weekends to try to ensure better staff coverage.

### Requirement 7(3)(c)

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

* Identify knowledge gaps for staff to improve their competency in identified areas.
* Review and develop a training plan based on the needs of the staff as identified.
* Continue to look for ways to attract and retain qualified staff.

### Requirement 7(3)(d)

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

* Continue to imbed and improve training system.
* Look at training needs in relation to wound management, minimising the use of restrictive practice and behaviour management.

### Requirement 8(3)(b)

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

* Ensure the board is analysing the clinical data reported and discussions and outcomes are recorded and actioned.
* Continue improvements to clinical governance framework.

### Requirement 8(3)(c)

Effective organisation wide governance systems relating to the following:

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

* The Approved Provider needs to continue to implement improvements and solidify them into strong robust processes.
* Ensure as a matter of importance that governance systems are developed and improved for information management, continuous improvement, regulatory compliance and feedback and complaints.

### Requirement 8(3)(d)

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

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

* The Approved Provider needs to continue to implement improvements for risk management systems and practices.
* Continue to implement or train staff with the new policies and procedures.

### Requirement 8(3)(e)

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

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

* Improve and commence training for staff on minimising restraint and open disclosure.
* Continue to develop and implement an antimicrobial stewardship program including systems to monitor infections and antibiotic use.
* Continue improvements to clinical governance framework.