Mercy Place Rice Village

Performance Report

7 Moylan Loop   
MARSHALL VIC 3216  
Phone number: 03 5247 2200

**Commission ID:** 4177

**Provider name:** Rice Village Ltd

**Site Audit date:** 15 February 2022 to 17 February 2022

**Date of Performance Report:** 7 April 2022

# Performance report prepared by

Kathryn Spurrell, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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 16 March 2022.
* other relevant information held by the Commission including internal referrals received.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

The Assessment Team recommended Requirement (3)(a) in this Standard as non-compliant. However, I disagreed with their recommendation and found Requirement (3)(a) Compliant, I have provided reasons for my finding in the respective Requirement below.

Consumers and their representatives confirmed their cultural and spiritual identities were respected and catered for. Most consumers considered they were supported to choose how they live their lives and supported to communicate those choices. Consumers said they were supported to take risks they want to take, and their privacy is respected at the service. Consumers advised they are given information they need about their care and supports, and the information is clear and readily understood.

Staff had shared understanding of the cultural, religious and spiritual preferences of consumers and the service supported consumers who wanted to, practice their faith. Care staff explained that they were guided by consumer choice in relation to care preferences, whilst management described how consumer preferences, choices and decisions are elicited through the care planning process. Service staff knew the risks that sampled consumers chose to take and described how safety measures were used to support risk taking. Staff described how the service provided consumers with information they needed to make choices about their daily life and how representatives were kept informed.

The Assessment Team observed that consumers were provided with information through noticeboards, activity calendars, menus and the ‘Welcome Pack’ provided on admission to the service. Clinical and non-clinical risks were identified through assessment processes and reflected in consumer care planning documentation. Care plans reflected consumer preferences, and other documentation confirmed that consumers and representatives are provided with opportunities to make decisions related to care.

Staff described practical ways they respected the personal privacy of consumers, which the Assessment Team observed during the Site Audit. However, it was also observed that the doors to the nurses’ stations were left open throughout the Site Audit. This deficiency was addressed by management when it was brought to their attention and the Assessment Team did find any impact to consumer privacy or confidentiality as a result.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team found most consumer feedback, staff interviews, and observations reflected compliance with this Requirement. However, the Assessment Team received feedback from one consumer and one representative, who said that consumers were not always provided with toileting and continence care in a timely manner. The Assessment Team also received feedback from some staff who reported that consumers were not always assisted with toileting in a timely manner, due to staff shortages. Based on this evidence, the Assessment Team found the service was not compliant with this Requirement.

In their response, the Approved Provider disagreed with the Assessment Team’s recommendation. In relation to the consumer who said that they were not always supported to use the bathroom in a timely manner, the Approved Provider acknowledged that there had been some occasions when consumers had to wait longer than usual for personal care. They stated that while there are sufficient staff hours, the allocation of staff requires further review.

The Assessment Team brought forward evidence that a consumer had been left in a soiled aid for an extended period of time. In its response, the Approved Provider argued that this matter had been previously brought to the attention of the Commission, and the service reviewed call bell data for the consumer at the time the allegation was made, with the review finding the allegation to be unsubstantiated.

### Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider, I have disagreed with the Assessment Team and find the service is compliant with this Requirement, for the following reasons:

* The majority of consumer feedback against this Requirement was positive, with most consumers stating that staff are kind and treat them with dignity, kindness and respect.
* The consumer who reported being left for long periods of time without support to use the bathroom also said that they have ‘only good things to say about staff.’ I acknowledge the consumer’s feedback that they have felt distressed and uncomfortable while waiting to use the bathroom at times and have considered this further in relation to Requirement 7 (3)(a).
* I also acknowledge the staff feedback that sometimes consumers were not assisted to the toilet in a timely manner. However, staff did not specify any specific detrimental consumer outcomes as a result. As this evidence relates more clearly to understaffing, I have also considered this evidence in relation to Requirement 7 (3)(a), where it is more relevant.
* I accept the provider’s response relating to the representative feedback that a consumer had been left in a used continence aid for a lengthy period. As a result, I do not consider this to be evidence of non-compliance.
* The remaining evidence gathered under this Requirement indicates the service is compliant. Staff were observed interacting with consumers in a way that supports their needs and preferences and care plans contained information about consumer background, identity, cultural needs and practices. The organisation has policies, procedures and training that supports staff to treat consumers with dignity and respect and the majority of the evidence put forth by the Assessment Team indicates staff practice aligns with the service’s own requirements.

Based on the summarised evidence above, I find the service Compliant with this Requirement.

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 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

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

The service demonstrated it had established assessment and planning processes in place, with consumers and their representatives confirming their involvement in those processes upon admission, during care plan reviews and in between.

Care planning documentation reviewed by the Assessment Team showed that initial assessments were completed on admission, to inform an initial care plan. A comprehensive care plan was then developed, incorporating the results of detailed assessments conducted after admission. Care plans contained detailed information about consumers’ current needs, goals and preferences however the Assessment Team noted some minor inconsistencies in consumer care planning documentation. No impact to consumers was identified because of those inconsistencies. Sampled care plans demonstrated regular review every three months, as well as in response to incidents and changes in consumer condition and needs.

The service proactively discussed and recorded consumers’ end of life wishes and opportunities for end of life discussions were included as part of the assessment process.

Overall, consumers and their representatives considered the outcomes of assessment and planning were effectively communicated to them in a timely manner and while not all consumers and representatives were aware they could request consumer care plans, those sampled were comfortable to request access to them if needed.

The service uses an electronic care management system (ECMS) and verbal handovers with written handover sheets to communicate the results of assessment and planning processes to those involved in care and services.

Care planning documentation evidenced ongoing partnership with the sampled consumers and other individuals and services the consumer wants to involve, such as allied health professionals, medical specialists and Dementia Support Australia.

## Assessment of Standard 2 Requirements

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

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team recommended Requirements (3)(a) and (3)(g) in this Standard as Non-compliant. However, I disagreed with their recommendations and instead find Requirements (3)(a) and (3)(g) to be Compliant. I have provided reasons for my finding in the respective Requirements below.

The service demonstrated mostly effective management of high-impact and high prevalence risks including falls, skin integrity and pain. Care plans showed use of appropriate cognition, pain assessment and falls risk assessments tools, as well as strategies to minimise risk in those areas. Care plans consistently identified relevant risks for sampled consumers and staff had shared understanding of those risks and the strategies used to manage them.

Care planning documentation and staff interviews confirmed that the needs, goals and preferences of consumers nearing the end of their life were recognised and addressed, with care changing to address pain, comfort, pressure area care and hygiene.

The service had policies and procedures in place that guided staff to recognise and respond to consumer deterioration in a timely manner. Care plans and progress notes evidenced that consumers with behaviours of concern were supported with relevant referrals and staff use individually tailored strategies before pharmacological strategies. Staff were able to give examples of deterioration in consumers and steps taken by staff to respond.

The service had effective systems for recording and disseminating information about consumer needs, goals and preferences throughout the service and to others involved in care. Consumer care and need information was recorded in care plans, progress notes, case conference notes and during shift handovers. Staff were familiar with information sharing that occurs when changes in consumer condition were detected, when incidents occur or when deterioration is detected.

Care plans showed, and consumer and staff feedback confirmed that consumers access relevant health professionals when needed.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service did not demonstrate every consumer received safe and effective personal and/or clinical care that was individually tailored, reflective of best practice and optimised their health and well-being. Relevant (summarised) evidence included:

* A consumer’s recent skin tear was misclassified in care documents.
* Two consumers did not receive therapeutic massages as frequently as required to effectively manage chronic pain.
* A consumer stated they wait on average between twenty minutes and two hours for their pain medication, however on one occasion stated they waited up to five hours.
* Care staff said that clinical staff were busy and not always accessible to them when needed.
* Care staff stated they did not have enough time to provide care needs such as heat packs as required, as they need to prioritise repositioning and the personal care needs of consumers.
* Other care staff said consumers must wait for support to use the bathroom and some end up using their incontinence aids as staff are too busy to assist them in time.

The Assessment Team also brought forward evidence that related to regulatory compliance for environmental restraints, which I have considered in relation to Standard 8, Requirement (3)(c), where it is more relevant.

In their response to the Site Audit report, the Approved Provider gave further context and some acknowledgement of the deficiencies identified by the Assessment Team, as follows:

* Further education had been provided to the staff member who misclassified a consumer’s skin tear.
* Staff shortages because of COVID-19 meant that two consumers did not receive their therapeutic massages as frequently as required for a small period as the relevant staff member was on leave and unable to be replaced.
* In relation to the consumer who said they had waited up to five hours for pain medication, the Approved Provider challenged this evidence, with reference to the consumers’ call bell data for the previous four and a half months. The data did not evidence any wait of five hours, however it did evidence wait times of up to two hours. The response noted the call bell data does not distinguish which calls were made to request medication.
* In relation to care staff evidence that understaffing resulted in consumers needing to wait for personal care, including toileting support, the response acknowledged that staff might experience time pressures because of the industry-wide staff shortages.

The Approved Provider’s response also clarified other examples cited by the Assessment Team. I acknowledge the supporting evidence and information provided in the response and therefore have not considered those examples provided by the Assessment Team.

Having regard to the evidence put forth by the Assessment Team and the Approved Provider’s response, I have disagreed with the Assessment Team. I find the service Compliant with this Requirement, for the following reasons:

* I accept that a consumer’s skin tear was misclassified, however I note there was no detrimental impact to that consumer as a result.
* I accept that two consumers did not have therapeutic massages as frequently as required, however I note there was no identified detrimental impact to those consumers as a result. I consider this to be more fitting as evidence of non-compliance in relation to Requirement 7(3)(a), where I have taken this evidence into consideration.
* I accept that a consumer waited for extended periods of time for pain relief medication. I note that the call bell report provided in the response shows several call bell response times exceeding ten minutes. However, I accept there is no evidence that the extended wait times resulted in detrimental outcomes in relation to personal or clinical care for that consumer. I also note the consumer’s pain was otherwise, comprehensively managed. I have considered this evidence further under Requirement 7(3)(a).
* In relation to care staff feedback that time pressures resulted in them being unable to attend to personal care tasks in a timely manner, I do consider this to be evidence of non-compliance with this Requirement. However, I do not consider it is sufficient to overcome the weight of other evidence presented by the Assessment Team, which demonstrated personal and clinical care was individually tailored, optimising of health and well-being and reflective of best practice. I have however, taken this evidence into consideration in relation to Requirement 7(3)(a).

For the reasons detailed above, I find the service compliant with this Requirement.

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

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

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

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

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

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

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

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

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

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

### Requirement 3(3)(g) 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 the service had implemented antimicrobial stewardship practices. However, during the Site Audit, the Assessment Team found the service did not consistently implement COVID-19 infection control practices. Relevant (summarised) evidence included:

* A recent COVID-19 outbreak of unknown origins had occurred within the service, with eight consumers and one staff member testing positive.
* The Assessment Team considered there were insufficient hand sanitising stations throughout the service and deficiencies in the screening of staff and visitors to the service.
* The site-specific IPC lead had not completed the required training at the time of the Site Audit, though there was an IPC staff member employed by the organisation in attendance at the service during the COVID 19 outbreak.
* The observational charts for a consumer who tested positive to COVID-19 had not been consistently completed.
* The Assessment Team could not confirm that all staff had completed mandatory training modules for COVID 19 and other notifiable infections.
* The Assessment Team found there was no system in place for tracking staff members’ booster vaccinations.

In their response, the Approved Provider clarified or refuted much of the evidence put forward by the Assessment Team. The response contained the following arguments and clarifications:

* The Assessment Team’s finding that there was insufficient hand sanitising stations was subjective, noting that a 2021 Assessment Contact visit from the Commission found there were enough hand sanitising stations readily available throughout the service. A review of Commission documentation confirmed this.
* Progress notes supplied with the response demonstrated that regular observations had been carried out on the consumer who tested positive to COVID 19. Observations had been recorded on a dedicated ‘COVID Health Check’ progress note.
* The Approved Provider clarified some information in the Site Audit Report, demonstrating the service has an effective system in place for monitoring the vaccination and booster status of staff.
* The Approved Provider also provided further context and some clarification to information about deficiencies in screening procedures at the service.

I have taken the Approved Provider’s evidence and arguments (outlined above) into consideration and am satisfied with their response. As a result, I do not agree with the Assessment Team’s recommendation and find the service to be Compliant with this Requirement. I also find that:

* The service had a dedicated IPC lead who had recently commenced at the service. Although they were yet to complete training, the service did have access to, and made use of trained IPC staff from the wider organisation. Previous Commission contact with the service in early 2021 confirmed the service had a site-specific IPC Lead at that point. I do not consider that a changeover in staff at the service should lead to a non-compliant finding in this Requirement.
* Although the service recently had a COVID-19 outbreak, it was successfully contained, suggesting that the service’s preparation and planning was effective.
* I acknowledge the staffing issues affecting the industry. While these shortages do not displace the need for staff to be appropriately trained in COVID-19 infection prevention strategies, I have considered the evidence in relation to the lack of training identified by the Assessment Team under Requirement 7(3)(d).

Based on the summarised evidence above, I find the service compliant with this Requirement.

# STANDARD 4 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

The Quality Standard is assessed as compliant as seven of the seven specific Requirements have been assessed as compliant.

Most consumers said that they received the services and supports for daily living that they needed to optimise their independence, health and wellbeing. However, some said the service does not always have enough staff to support them to do the things they want to do, while others expressed complaints about the laundry service, saying that their clothes sometimes went missing or had been damaged.

The Assessment Team noted that staff had a shared understanding of what is important to consumers, which was corroborated through consumer interviews and care planning documents. The Assessment Team witnessed consumers participating in a variety of lifestyle activities and the service’s Religious and Spiritual Manager described their role which supported consumer mental health and emotional wellbeing. Consumers stated they contributed to the development of the lifestyle program, provided suggestions about activities they would enjoy and felt their preferences were reflected in the services they received.

Consumers confirmed their spiritual, emotional and psychological well-being was supported at the service, for example, through regular attendance at Mass, being supported to talk and visit with family and being supported to garden with other consumers during the weekly gardening session.

The service demonstrated they support consumers to be a part of the community inside the service and external to it, with consumers reporting they enjoyed the regular trips into the community with family and friends and visits from the local Rotary Club. Staff knew the relationships and activities that were important to sampled consumers and the Lifestyle Coordinator outlined the activities in place to support relationships and wellbeing, such as the service Happy Hour and the regular live music.

The service has adequate systems in place to record and disseminate information about consumers’ condition, needs and preferences. Information is captured through care plans and lifestyle plans and is accessible to staff via the electronic care management system and through handovers. Dietary needs and preferences are available to staff where food is prepared and served.

The Assessment Team gathered mixed consumer feedback regarding the quality and quantity of food provided at the service, however, noted improvement efforts undertaken by the service, which included the establishment of a food focus group.

Lifestyle equipment was found to be clean, well-maintained and safe, with staff confirming management was responsive to requests for lifestyle items. The service had preventative and reactive maintenance systems in place to ensure lifestyle and daily living equipment are safe and suitable.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The non-compliance is in relation to Requirement (3)(b). Reasons for my decision are detailed in the relevant Requirement below.

Consumers interviewed said they felt at home in the service and found it an enjoyable place to live. Consumers enjoy the natural light and the gardens and confirmed they had been supported to personalise their rooms. Consumers confirmed that furniture, fittings and equipment were kept clean, well-maintained and were suitable for them.

The Assessment Team observed consumers independently moving about inside the service, which has wide corridors, railing and signs to enhance consumer mobility and independence. There are indoor and outdoor common areas for consumers to socialise and relax. The service appeared generally clean and well maintained with appropriate furnishings.

Equipment was observed to be operational, clean and safely stored. The service demonstrated it had effective scheduled and reactive maintenance and cleaning programs in place. Staff could describe the maintenance and cleaning schedules and processes for requesting maintenance issues be addressed.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

Although the Assessment Team found the service to be generally clean and well maintained, they found deficiencies which prevented free movement of consumers and which posed safety risks. Relevant (summarised) evidence included:

* Doors into the garden locked from the outside, raising concerns consumers’ free movement may be restricted.
* Chemical and cleaning rooms were observed to be kept open, unlocked and unattended, despite signs saying they should remain closed.
* Cleaning trolleys were left unattended.

The Assessment Team also referred to other evidence which I have discussed in relation to Standard 3 Requirement (3)(g), where that evidence is more relevant.

In their response to the Site Audit report, the Approved Provider acknowledged some of the deficiencies identified by the Assessment Team and outlined actions being taken to rectify the issues, including:

* Re-designing a garden space for the sole use of consumers in the memory support unit. This would eliminate the need for self-locking doors, which were installed to prevent consumers from the memory support unit entering one of the non-secure houses and then exiting the service. The response acknowledged this as a deficiency to be rectified.
* Regularly checking that cleaning and chemical rooms are kept locked and trolleys are kept secure, as well as installing additional signage.

The Approved Provider’s response also addressed other evidence put forth by the Assessment Team, that I have discussed in relation to Standard 3, Requirement 3 (3)(g) and Standard 8, Requirement (3)(c).

### I acknowledge the service’s response to the Site Audit Report and the steps they are taking to address the deficiencies identified by the Assessment Team. However, I find that at the time of Site Audit the service failed to properly secure cleaning chemicals, posing a safety hazard to consumers and others in the service environment. I also find that the use of self-locking doors between the garden area and the houses restricted consumers’ free movement from the garden space to the various residential houses, which did not enable consumers to move freely between indoor and outdoor areas.

For the reasons outlined above, I find the service non-compliant with this Requirement.

### 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

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

The non-compliance is in relation to Requirements (3)(c) and (3)(d). I have provided reasons for my finding in the respective Requirements below.

Consumers and representatives said they felt comfortable to provide feedback or make complaints directly to staff, management or the organisation’s head office, if they felt the need. Consumers provided examples of times they had complained and outlined how they would complain if the need arose, including by discussing their concerns directly with the Clinical Care Manager, staff or with head office. However, it was noted that some consumers felt that action was not taken in response to complaints.

Although none of the sampled consumers or representatives were aware of the availability of advocacy services, the Assessment Team observed information about advocates, translation and interpreting services and the Commission displayed throughout the service. Information on the service and organisational complaints and feedback process was also displayed. The service has a Feedback Management Procedure and a Feedback Form. The Assessment Team observed feedback boxes distributed throughout the service.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

The Assessment Team found that while the service used an open disclosure process when things go wrong, they do not always take adequate action in response to complaints. Relevant (summarised) evidence included:

* A consumer reported waiting for pain medication on average between 20 minutes and two hours. Information in other Requirements showed the consumer had complained about this to staff and staff were aware of the consumer’s previous complaints, but management was not. Staff conceded there were times when the consumer had to wait for their pain medication and that when things go wrong, they would offer the consumer an apology. However, staff did not describe following any formal steps taken to ensure the consumer’s complaints were responded to by the service.
* A consumer complained about not receiving enough food at two recent meal times. The consumer said they had not had any response to their complaint from management. When asked about the consumer’s complaints, staff said they had recently experienced a decline in mobility and as a result were taking meals in their room. Staff said the consumer had also raised concerns about staffing levels and they had personally apologised for how the staffing levels impacted the consumer’s care and services. However, staff did not describe following any formal steps taken to ensure the consumer’s complaints were responded to by the service.
* Three consumers put forth by the Assessment Team in relation to this Requirement and Standard 4, Requirement (3)(a) raised concerns about clothes going missing, a garment being ruined and receiving other consumers’ clothing from the laundry. All three consumers complained about the laundry service being cut from daily collections to weekly and it was noted laundry staff were unaware of complaints.

In its response, the Approved Provider did not acknowledge any deficits identified by the Assessment Team and disagreed with their recommendation. While they provided clarifying information, the provider did not offer any documentary evidence to support their arguments. Relevant (summarised) arguments and the relevance of those arguments to my decision, are outlined below:

* The Approved Provider argued that the consumer who said they wait for long periods for pain medication did not complain about the issue. However, the provider’s response did not acknowledge information presented across other Requirements which stated the consumer had raised complaints previously, staff had acknowledged those complaints and staff conceded the consumer was required to wait at times for their pain medication. Whilst the evidence shows the consumer received an apology, there is no evidence that management was aware of the complaints, or that there had been an adequate response given to that consumer.
* The response asserted that the consumer who had complained about not getting enough food had received a response from food services staff who had discussed the complaint with catering management. The consumer was told they could request more food if what they were offered was insufficient. The approved provider’s response did not contain any evidence to support this had occurred, or any evidence the complaint had been addressed according to the service’s procedure for feedback and complaints. Consequently, I accept the consumer’s own feedback that they did not receive a response from service management about their complaint and I take this as evidence of non-compliance with the Requirement.
* The Approved Provider disagreed with consumer feedback about the laundry service and provided clarifying information about specific consumer examples put forth by the Assessment Team. The written response did not refer to the changes already implemented at the service level, to respond to consumer complaints, namely that those who complained were having their laundry collected according to the previous system. As the service responded to these laundry complaints appropriately, I do not consider this to be evidence of non-compliance with this Requirement. I have considered it in Requirement (3)(d), where it is more relevant.
* The Approved Provider’s response did not address the staff interview evidence, except to say that they considered it showed the service always takes action in response to consumer complaints and feedback. I am not satisfied with the Approved Provider’s response and I find there was a lack of staff feedback that outlines specific steps being taken by the service, to find solutions to problems raised in complaints. I have specifically taken note of the staff evidence acknowledging complaints were made by the consumer who waits for their pain medication and the consumer who complained about insufficient food and short staffing. I consider both of those pieces of staff feedback to indicate non-compliance with the Requirement, because there is no evidence to show those complaints were formally addressed, after staff apologised to the consumers.

For the reasons outlined above, I find the service to be non-compliant with this Requirement.

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

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

Consumer feedback in relation to this Requirement was mixed, however most consumers and representatives considered the service did not use feedback and complaints to improve the quality of care and services. Relevant summarised consumer feedback included:

* Three consumers complained about the laundry service.
* Several sampled consumers said they are either:
  + Not aware if changes are made as they do not get feedback from management or
  + They consider that changes are not made in response to feedback and complaints, although an immediate solution and apology would be forthcoming from staff.
* Despite action taken by the service in response to the complaints, consumers remained unsatisfied with regards to food, the laundry service and staffing levels.
* The service documented complaints on a register but actions taken by the service are documented separately, on feedback forms.

In its response, the Approved Provider disagreed with the Assessment Team’s findings and recommendations. Relevant (summarised) arguments and the relevance of those arguments to my decision, are outlined below:

* In relation to a consumer who said the service tends to find a solution to feedback but that they can’t remember any changes being implemented as result, the Approved Provider argued this meant that continuous improvement actions were taken but the consumer was not involved in those actions. I am not satisfied with the service’s response and I find this is evidence of non-compliance with this Requirement, as an effective feedback and complaints system will have established processes to notify consumers of the outcome of their complaint and the resulting improvements made to the service.
* In relation to two other consumers who said, respectively, that they don’t know if the service actions feedback as they do not hear back about changes made and the other, who said that feedback is not always actioned, the response argued only that those consumers had ‘never raised a complaint.’ I am not satisfied with the Approved Provider’s response, as it is not clear how the Approved Provider can be sure those consumers did not raise a verbal complaint directly with staff, given there was no effective process prior to Site Audit, for recording and responding to verbal complaints. Consequently, I find this to be evidence of non-compliance with this Requirement.
* In their response, the Approved Provider did not acknowledge evidence which showed that the service had no existing system for recording and responding to verbal complaints and feedback. Because the service appeared not to be responding to verbal feedback and complaints and using that information to improve care and services, I find this reflects non-compliance with the Requirement.
* In relation to the laundry service complaints, I acknowledge my previous decision in Standard 6, Requirement (3)(c) that Site Management made changes to the laundry service delivery in response to consumer complaints. I consider this shows that site management found an immediate solution for consumers who made a complaint about the changes to the service. However, the Approved Provider’s written response did not acknowledge the validity of those consumer concerns, despite the fact they were held by multiple consumers. The written response conveyed the impression the clear trend in complaints about the laundry service was not welcome or used to drive continuous improvements at the service. As such, I consider the evidence and the Approved Provider’s response to reflect non-compliance with this Requirement.
* In relation to the complaints about food, the response outlined that the service had implemented a food focus group in late 2021, in response to consumer complaints. The response outlined specific changes made to the menu as a result of the Food Focus Group and provided copies of several consumer surveys showing overall satisfaction with meals in the period leading up to the Site Audit. As a result, I consider the service’s establishment of a Food Focus group and efforts to measure effectiveness of the results, as evidence of compliance with this Requirement.

The Approved Provider’s response also described difficulties faced by the service in filing shifts, which I have considered in relation to Requirement 7 (3)(a) where it is more relevant.

Overall, I find that the lack of an established system for capturing, documenting and responding to verbal complaints, the lack of continuous improvement efforts in response to the clear trend of laundry service complaints and the lack of a consistent process to inform consumers of continuous improvement actions taken in response to feedback and complaints, are all reflective of non-compliance with this Requirement.

For the reasons outlined above, I find the service to be non-compliant with this Requirement.

# 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

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

## The non-compliance is in relation to Requirements (3)(a) and (3)(d). I have provided reasons for my finding in the respective Requirement below.

Consumers considered that staff were kind, helpful, dedicated and professional in their interactions and Assessment Team observations showed most interactions between staff and consumers were kind, caring and respectful.

Consumers mostly said that permanent staff have the necessary skills and competence to delivery the care they need.

The service is supported by the wider organisation in relation to screening and recruitment, whilst the organisation’s Head Office monitors staff registrations for currency. The service had standard human resources frameworks in place, including position descriptions and core competencies for roles. The service required new staff have three buddy shifts on commencement at the service, where training needs are identified.

The service demonstrated it monitored staff performance with regular performance appraisals, and it took action with both permanent and agency staff, when performance issues are identified.

## 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 the service does not always have adequate numbers and mix of staff to provide safe and quality care and services. They identified detrimental consumer outcomes as a result. Relevant (summarised) evidence included:

* The Assessment Team received negative feedback from eleven consumers regarding short-staffing at the service. Consumers outlined poor outcomes they had experienced, including, for example being left waiting for assistance with personal care and toileting, not receiving pain medication on time, not being able to move from bed to bathroom safely, not being able to eat meals or being left to sit in their room all day.
* Interviewed staff repeatedly raised concerns about inadequate staffing at the service, providing examples of poor consumer outcomes as a result.
* Staff outlined that they are rushed in their work, have on average six minutes to provide personal care to each consumer and although a recent change saw carer hours decreased and nursing hours increased, care staff said that Registered staff are often too busy to be available to them.
* Staff outlined they had been injured as a result of having to rush delivery of care.
* Call bell reports for six sampled days in January 2022 showed that 26 calls went unanswered for over one hour. In that month, 12-15% of evening and night call bells were not answered within 15 minutes. The service did not provide day time call bell data to the Assessment Team.
* Roster review confirmed staff feedback that there is short-staffing between 2pm and 4pm. Rosters showed that there is one care staff rostered on between 2pm and 4pm in the high care wing and in another wing, where seven consumers require two-person assists for personal care.

In its response, the Approved Provider acknowledged the accuracy of some Assessment Team findings but disagreed with the non-compliant recommendation. Relevant (summarised) arguments and the relevance of those arguments to my decision, are outlined below.

The response acknowledged the service had been unable to fill shifts and at times had worked without a full quota of staff. The provider argued, however, that the rosters were well planned but shifts cannot be filled due to poor availability in the industry overall. The response described the service’s difficulties in recruiting new staff owing to COVID isolation rules and international border closures.

The Approved Provider argued that representative feedback about consumer call bell wait times was not reliable as representatives are not privy to that information. I am not satisfied by the provider’s response to this feedback, as I consider a visiting representative is more than capable of observing how long a consumer might wait for their call bell to be answered. Consequently, I have considered this as evidence of non-compliance with the Requirement.

While I acknowledge the difficulties experienced in the industry at present, I do not accept the provider’s argument, as they did not address specific evidence of inadequate rostering practices in the high- care wing and another wing where multiple consumers require two-person transfers. The response also did not respond to evidence about a recent reduction in carer hours, described by staff. Lastly, I note that while site management advised there had been a roster review and there may be an increase to rostered hours, the Approved Provider’s written response indicates this will not occur. As a result, I accept the Assessment Team’s finding that there was not always a sufficient number or mix of staff at the service during the period of accreditation.

In reaching my decision, I have also considered evidence presented in relation to Standard 3, Requirement (3)(a), regarding the consumer who reported waiting for extended periods of time for their pain medication and the two consumers who did not receive their therapeutic pain massage as a frequently as required. I have also considered the care staff evidence that at times they are not able to provide heat packs as set out in care plans. I take this as evidence of non-compliance with this Requirement.

The Approved Provider’s response satisfactorily addressed other evidence put forth by the Assessment Team, which is not relevant to my decision.

For the reasons outlined, I find the service is non-compliant with this Requirement.

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

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

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

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

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

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

The Assessment Team found that the service does not recruit, train, equip and support staff to deliver the outcomes required by these Standards. Relevant (summarised) deficiencies put forth by the Assessment Team included:

* Care staff said they could not recall their Serious Incident Response Scheme (SIRS) training, however were aware of how to respond to an incident. Care staff also said they were too busy to attend to online training modules.
* Of the 117 personnel at the service at time of Site Audit, less than half had completed COVID-19 infection control, continence care and emergency procedures training modules. Not all staff had completed Manual Handling, Elder Abuse and SIRS training.
* Restrictive Practices training was targeted only at clinical staff, but all staff were able to attend the online trainings. Evidence of attendance at the training was not observed.
* As set out in Standard 3, Requirement (3)(g), staff had not completed mandatory training modules for COVID 19 and other notifiable infections.

In their response, the Approved Provider satisfactorily addressed evidence relating to training needs of agency staff, which I have not considered in my decision. Other evidence that is relevant to my decision is outlined below.

The Approved Provider acknowledged staff feedback that they were too busy to complete training and mandatory competencies. The provider argued that this was a result of prioritising during the pandemic and that the organisation has had to identify critical priorities and those which can be deferred. The response identified that mandatory competencies have been identified as something that can be deferred. Staff training records were provided, which confirmed the Assessment Team findings that numerous modules were not completed by staff members. The response stated that where specific deficiencies in a particular staff member are identified these are addressed with training or further education.

While I acknowledge the Approved Provider’s response and their need to prioritise, the current recruitment difficulties in the industry do not negate the need for staff to be properly trained and supported to deliver the outcomes required by these standards. The response did not convey any plans to address this deficiency nor did it acknowledge the necessity of staff training for the delivery of safe and quality care.

As a result, I find the service does not comply with this Requirement.

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

## The Assessment Team recommended Requirements (3)(c) and (3)(e) in this Standard as non-compliant. Based on the Assessment Team’s report and the Approved Provider’s response, I find the service to be non-compliant with Requirement (3)(c) and compliant with Requirement (3)(e). I have provided reasons for my findings in the respective Requirements below.

Consumers provided mixed feedback on their level of involvement in development, delivery and evaluation of care and services, although management outlined that consumers were invited to contribute through Resident and Relative meetings, the Food Focus Group and the consumer-run kiosk.

The service was supported by the wider organisation and the governing body, which was accountable for the delivery of safe, inclusive and quality care and services. The governing body satisfies itself the service is performing against the Quality Standards through monthly meetings with service management, the annual Quality Health Checks and through the organisation’s High-Risk program. Management provided examples of involvement from the service’s governing body, which addressed safety and quality in the service.

The service demonstrated it had functioning and effective risk management systems in place, incidents were monitored and trends identified to inform care and services. There is a documented risk management framework with polices relating to high impact and high prevalence risks, identification of and response to abuse and neglect, incident management and supporting consumer quality of life. Staff knew how these policies applied to their roles and gave examples to demonstrate their understanding, though they noted that they were not always able to spend one-on-one time with consumers, to support them to live the best life they can.

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

The Assessment Team found that effective organisation-wide information management, continuous improvement, financial and regulatory compliance governance systems were in place at the service. However, the service’s workforce management and feedback and complaints governance systems were found to be ineffective. The Assessment Team supported the non-compliant recommendation with reference to:

* Their non-compliant recommendation in Standard 7, owing to short-staffing that resulted in detrimental consumer outcomes and lack of staff training. (Refer to Requirements 7 (3)(a) and 7 (3)(d) for detailed discussion).
* Their non-compliant recommendation in Standard 6, owing to lack of consumer satisfaction with the service’s response to complaints and feedback and deficiencies in how the service uses complaints and feedback to drive improvements at the service. (Refer to Requirements 6 (3)(c) and 6 (3)(d) for detailed discussion).

In addition, I have considered evidence presented by the Assessment Team under Requirement 3 (3)(a) and Requirement 5 (3)(b) which indicates the organisation’s regulatory compliance governance system is ineffective. Specifically, the Assessment Team listed deficiencies in the service’s compliance with restrictive practices regulations. Relevant summarised evidence included:

* Documentation review showed that most informed consent forms consumers subject to restraint are were due at the time of site audit or were overdue, including for a sample of consumers in the Memory Support Unit.
* The service lacked a restrictive practice register.
* The use of self-locking doors between the garden area and the houses restricted consumers’ free movement from the garden space to the various residential houses. While the self-locking doors were intended to ensure the safety of consumers, they were applied indiscriminately to all entering the garden space, resulting in restraint to free movement of consumers in the service.

In their response, the Approved Provider disagreed with the Assessment Team’s findings, provided clarifying information and context. The relevant (summarised) arguments, and their relevance to my decisions, are outlined below.

The response argued that feedback and complaints relating to understaffing and workforce issues are beyond the service and organisation’s control. As outlined in my decision under Standard 7 Requirements (3)(a) and (3)(d), I disagree with the Approved Provider arguments relating to understaffing and workforce training. I find that it is unclear how the organisation, and the Governing Body, ensure workforce planning at the service level meets the needs of consumers, particularly in relation to rostering practices and filling shifts that are vacant owing to unplanned leave. I also note that training of staff had not occurred in relation to numerous mandatory topics, including recent legislative reforms. The Approved Provider’s response did not acknowledge these deficiencies or provide a plan to address them going forward. and its regulatory compliance governance system. I consider this evidence reflects deficiencies in the organisation’s workforce governance system.

The response did not acknowledge any deficiencies in responding to and capturing verbal complaints and did not provide any information about service’s current process for handling complaints and feedback, or the oversight provided by the Governing Body and the wider organisation in that respect. As such, I accept the Assessment Team’s findings that there is not an effective, organisation wide governance system for feedback and complaints.

In relation to regulatory compliance issues identified in other parts of the Site Audit report, the provider’s response outlined that verbal consent had been provided for every consumer before the Site Audit and a medical practitioner had assessed and authorised the restraints. As the legislation does not require documented informed consent, I do not consider this to be evidence of non-compliance.

I also accept, as argued by the Approved Provider, that there is no legal requirement for a restrictive practice register. However, I note that the service had indiscriminately used environmental restraints in the form of self-locking doors between the garden and the houses. I find the organisation’s existing system for ensuring regulatory compliance either failed to identify this restrictive practice was in use at the service, or did identify this but failed to ensure it was rectified prior to the Site Audit. I acknowledge the provider is now considering redesign of the garden to address the deficiency, however I find this evidence demonstrates the regulatory compliance governance system was ineffective at time of Site Audit.

Lastly, I note that SIRS training had not been completed by all staff and that restrictive practices training was not required for non-clinical staff. These deficiencies were either not identified or not rectified through the organisation’s regulatory compliance governance systems, prior to Site Audit and the response gave no plan to address the shortcomings. Consequently, I consider this as evidence of non-compliance.

For the reasons outlined above, I find the service to be non-compliant with this Requirement.

### Requirement 8(3)(d) 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.*

### Requirement 8(3)(e) 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 had a clinical governance framework which included documentation relating to antimicrobial stewardship and minimisation of the use of restraints. The service also has a documented open disclosure policy. The Assessment Team found that staff and management of the service could demonstrate antimicrobial stewardship strategies used at the service and that there was an understanding amongst staff of ways to minimise restrictive practices. The Assessment Team also found the service practices open disclosure when things go wrong. However, the Assessment Team referred to their findings previously outlined under Standard 3, Requirements (3)(a) and (3)(g), to suggest that further clinical oversight is required at the service. Consequently, the Assessment Team recommended non-compliant in relation to this Requirement.

In their response, the Approved provider disagreed with the Assessment Team’s findings and referred to their previous responses to Standard 3, Requirements (3)(a) and (3)(g). They also outlined their objections to other evidence put forth by the Assessment Team, which is not relevant to my decision.

Having regard to the Assessment Team’s evidence, the Approved Provider’s response, the specific wording of this Requirement and my findings in relation to Standard 3, Requirements (3)(a) and (3)(g), I do not agree with the non-compliant recommendation. Instead, I find the service to be compliant with this Requirement, for the following reasons.

I find that the Service is compliant with the wording of this Requirement, because at the time of Site Audit, it had a documented clinical governance framework which encompassed the minimisation of the use of restraints, open disclosure and antimicrobial stewardship. I have previously disagreed with the Assessment Team’s non-compliant recommendations in Standard 3 and I find that other deficiencies in staff training and restrictive practices regulatory compliance have been assessed in earlier standards (namely Requirements 5 (3)(b) and 8(3)(c)). Finally, I note that the wording of this Requirement does not mention effectiveness of the clinical governance framework, only that the service must demonstrate they have one.

For the reasons detailed above, I find the service to be compliant with Standard 8 Requirement (3)(e).

# Areas for improvement

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

* Ensure free movement of consumers between indoor and outdoor areas of the service.
* Ensure all complaints and feedback are actioned and complainants are appropriately informed of outcomes.
* Ensure all forms of complaints and feedback are used to inform continuous improvement efforts.
* Ensure sufficient number and mix of staff are rostered and deployed to enable the delivery and management of safe and quality care and services.
* Ensure staff are supported to complete required training.
* Ensure governance systems can identify restrictive practices in place at the service level and that services are supported to ensure compliance with new regulatory requirements.
* Ensure governance systems address workforce issues relating to rostering and recruitment and steps are taken to support services to recruit and train staff.