Mercy Place Westcourt

Performance Report

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**Commission ID:** 5064

**Provider name:** Mercy Aged and Community Care Ltd

**Site Audit date:** 16 March 2021 to 19 March 2021

**Date of Performance Report:** 7 May 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-Compliant |
| **Standard 3 Personal care and clinical care** | **Non-Compliant** |
| Requirement 3(3)(a) | Non-Compliant |
| Requirement 3(3)(b) | Non-Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Non-Compliant |
| Requirement 3(3)(e) | Non-Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-Compliant |
| **Standard 4 Services and supports for daily living** | **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) | Non-Compliant |
| Requirement 8(3)(e) | Non-Compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 20 April 2021.
* other intelligence held by the Commission

# 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

Consumers and representatives said staff treated consumers with respect and were complimentary of their interactions and engagement with staff across all aspects of care and services. Staff were familiar with consumers’ backgrounds, lifestyle choices and daily preferences. Care planning documentation included information regarding consumers’ backgrounds and cultural practices.

Organisational policies and procedures and diversity and cultural resources outlined requirements for the delivery of culturally safe care. Cultural events were developed following discussions with consumers who may be from a culturally diverse background or affected by events including, but not limited to, the National Aborigines and Islanders Day Observance Committee celebrations.

Consumers and representatives acknowledged staff were aware of and supported consumers to exercise their lifestyle and cultural choices, preferences and decisions. Staff supported consumers to maintain relationships of choice and were guided by organisational policies, procedures and education in relation to supporting consumers with decision-making and maintaining relationships of importance.

Management confirmed risk assessments were completed in consultation with relevant health professionals, consumers and their representatives. Care information reflected information regarding consumers who preferred to take risks to live the best life they could.

Consumers were provided with a welcome pack on entry to the service which included information regarding the organisations and the services available to them.

Staff utilized different communication techniques for consumers with cognitive impairments or who were from Culturally and Linguistically Diverse backgrounds. Information for consumers including, but not limited to, activity calendars, monthly menus, advocacy organisations and other service information were observed on display during the site audit.

Consumer’s care information was securely stored in the service’s electronic care system and hardcopy files were kept in locked nurses’ stations. Staff addressed consumers by their preferred name and respected their personal privacy. Consumers advised, staff were respectful of their privacy and always knocked and announced themselves prior to entering their rooms. The organisation had guidelines in relation to the collection, use and disclosure of consumer’s personal information.

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

## Assessment of Standard 1 Requirements

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

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

### 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*

*make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Care and services were not regularly reviewed for effectiveness, and when circumstances changed, or incidents occurred that impacted the care needs of consumers. Care planning documentation was not consistently reviewed when the care needs of consumers changed and/or effective strategies implemented for in a timely manner. This has impacted negatively on consumers’ wound care and behaviour management needs.

Assessment and care planning documentation reflected the input from other providers of care including the Medical officer, allied health professionals and other medical specialists. Most consumers and representatives confirmed people important to them were involved in assessment and planning on an ongoing basis.

Most consumers and representatives said they were involved in care planning processes and did not have any concerns regarding the service’s communication processes. While most consumers were unable to confirm if they had received a copy of their care plan, no concerns were raised regarding the service denying consumers access to this information. Staff communicated the outcomes of assessment and planning through face to face or phone conversations.

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

## Assessment of Standard 2 Requirements

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

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

Care planning documentation was not regularly reviewed for effectiveness, when circumstances changed, or when incidents occurred which impacted on the care needs of consumers.

For one named consumer assessed as high risk for the development of pressure injuries, care information was not reviewed when changes in their skin integrity were identified. Pressure injury prevention strategies and wound care needs were not reviewed when wound deterioration was identified in January 2021.

In relation to episodes of physical aggression and wound management for two named consumers, strategies to manage or minimise their physical aggression or manage their compromised skin integrity were not consistently reviewed or recorded following incidents to inform management.

In the approved provider’s response, received on 20 April 2021, they acknowledged one of the four episodes of aggression for the named consumer were not recorded as an incident in the service’s incident management system however, no other information was provided in approved provider’s response in relation to the other three episodes identified by the Assessment Team during the site audit.

It is noted in the approved provider’s response documentation was submitted to the Commission to demonstrate a review of the named consumer’s care plan had occurred following incidents of aggression. However, I was unable to substantiate this as identifiable information was not included in the document provided.

Care information for a named consumer who experienced wandering behaviours and increased levels of agitation, did not reflect reassessment or review of behaviour management strategies had occurred. While staff had identified a specific trigger for the name consumer’s behaviours, the trigger and the effectiveness of strategies implemented to manage these behaviours were not reviewed for effectiveness or reviewed in the named consumer’s care plan. In addition, a risk assessment had been not been completed to address their preference to mobilise independently which was contrary to physiotherapist recommendations.

Assessment and care planning information for one named consumer who preferred food that was not in line with speech pathologist recommendations did not demonstrate a risk assessment had been completed. Registered staff were not consistently documenting when changes in consumers’ clinical needs and preferences were identified, monitoring actions or assessment information to indicate why medical or clinical reviews were indicated.

In their response, the approved provider acknowledged staff had not recorded conversations in relation to the named consumer who chose to consume food of their choice however, the approved provider refuted the need to complete a risk assessment for the named consumer who mobilised without the assistance of staff as recommended by the physiotherapist. Whilst I acknowledge the named consumer’s cognitive impairment inhibited their ability to follow the physiotherapists recommendations, no evidence was provided by the approved provider to indicate conversations had occurred with the named consumer’s representative regarding the risks associated with their mobility choices taking into consideration their history of falls.

While the Assessment Team received feedback from staff in relation to them not being required to complete incident documentation for skin tears, I am satisfied in information included in the approved provider’s response that a system is in place to record when this occurs.

The approved provider’s response states that actions are being taken to address the deficiencies identified by the Assessment Team. This includes additional monitoring of clinical and incident documentation, electronic mail correspondence to all staff advising of changes or providing updates with consumers care needs, additional education and staff recruitment,

Whilst I acknowledge the actions being taken by the approved provider, at the time of the site audit, consumers care and services were not reviewed regularly for effectiveness, and when circumstances changed or when incidents impacted on their needs, goals or preferences.

Therefore, my decision is this Requirement is Non-compliant.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Consumers were not satisfied the service delivered personal and clinical care that was in accordance with their needs, goals and preferences.

The service did not manage high impact or high prevalence risks associated with consumers’ care, specifically in relation to challenging and aggressive behaviour and falls management.

Staff reported they were unable to provide care and monitoring of consumer’s movements in a timely way. Staff did not have a shared understanding of their responsibilities in relation to antimicrobial stewardship.

Deterioration or changes of a consumer’s health status was not recognised or responded to in a timely way.

Incident documentation was not always completed following incidents of verbal and physical aggression. Care plans were not consistently reflective of the consumer’s individual and specific care needs and strategies for the management of consumers’ care needs were not consistently recorded.

Referrals to other providers of care and services when required or at the request of the consumer were not managed effectively.

The service was unable to demonstrate the minimisation of infection related risks through the preparedness for a potential COVID-19 outbreak.

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

### Assessment of Standard 3 Requirements

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

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

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

Consumers have not received safe and effective care that was tailored to their needs or optimised their health and well-being.

Consumers and representatives raised concerns in relation to consumer’s care needs and preferences not being addressed appropriately. Concerns raised by consumers included insufficient staffing levels which had impacted on consumers’ hygiene preferences, skin integrity, continence management and mobility and nutritional needs.

Care planning information confirmed four named consumers were not receiving wound care and personal care that was tailored to their needs and optimised their health and well-being. For example, in relation to one named consumer’s wound management for an advance pressure injury, the service failed to appropriately implement pressure injury prevention and management strategies, escalate and refer wound deterioration and provide enough clinical oversight to ensure wound care was provided in line with wound management directives.

The approved provider in its response, received 19 April 2021 states, an experienced registered nurse was consulted and reviewed the named consumer’s pressure injury following the site audit. While I acknowledge the detailed report provided in the approved provider’s response, evidence to demonstrate the origin of the author of the report or their qualifications were not provided to the Commission.

In the approved provider’s response, they acknowledged for one named consumer, their personal hygiene needs had not been provided in line with their preferences however, the approved provider refutes this was the result of insufficient staffing levels.

Management confirmed issues had been identified in relation to the service’s lack of clinical governance which included monitoring of staff practices and clinical documentation. Registered staff confirmed they had insufficient time to monitor care staff’s practices to ensure care delivered was tailored to consumers’ needs. Registered staff raised concerns regarding additional duties they were required to complete which included facilitating the visitor sign in process and answering the service’s telephone after 2.00 pm which distracted them from their clinical duties.

The approved provider in its response, acknowledged staffing shortages were experienced by the service due to the suboptimal allocation of staffing hours and unexplained absences. As a result, the service has undergone additional recruitment processes for casual staff, will review and has reallocated staffing hours to better meet the needs of the consumers at the service.

The approved provider, in their response, stated workload issues were impacted by a lack of teamwork amongst staff. To improve staff’s efficiency, the approved provider has advised that a re-set of staff’s expectations will be undertaken in line with the commencement of the new Service manager in April 2021. Staff will also be reminded to stagger their breaks to ensure continuous coverage is available for consumer care.

In relation to feedback received from Registered nurses in relation to overseeing care delivery, the approved provider acknowledged in their response, this was not acceptable practice and in addition to planned education, staff have been advised that failure to provide adequate care and support to consumers is not acceptable practice.

The service did not have a shared understanding of physical restraint in relation to key coded exits. Some consumers were observed to be unable to exit the service without the assistance of staff during the site audit. Consideration of physical restraint authorisations for these consumers had not been completed. Psychotropic medication documentation did not consistently include the required information to ensure usage was monitored effectively.

Deficiencies were identified in relation to the lack of consultation with consumer’s representatives when chemical restraint was commenced or changes in medication regimes had occurred. Restraint assessment records were inconsistently completed. Clinical incident data had not consistently captured clinical incidents.

In relation to the services psychotropic medication register and chemical restraint, the approved provider in their response advised, actions for improvement had been developed including, a review of the register and further education is planned for staff regarding its use, the required actions for those consumers administered medication as chemical restraint and the management of changes in medication prescribed. The approved provider acknowledged, in relation to one named consumer, staff did not manage the increase in chemical restraint medication in accordance with organisational guidelines.

The approved provider advised in their response, due to COVID-19 and border closures, staff from the organisation’s interstate office were unable to supervise the planned implementation of the service’s electronic medication management system in March 2020. The new medication system is planned to be implemented mid 2021 and will improve data and medication monitoring processes.

While I acknowledge the actions taken by the approved provider, at the time of the site audit, consumers were not receiving clinical and personal care that was tailored to their needs or optimised their health and well-being.

Therefore, my decision is this Requirement is Non-compliant

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

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

The service did not demonstrate effective identification and management of high-impact or high prevalence risks associated with the care of consumers.

Some consumers raised concerns about other consumers residing at the service wandering into their rooms uninvited and displaying verbal and physical aggression.

Staff were not consistently managing, reporting or reviewing consumers’ episodes of verbal and physical aggression and/or falls in a timely manner. Registered staff raised concerns in relation to staffing which has impacted on their abilities to oversee clinical care and monitoring of consumers’ needs including behaviours and falls.

The service’s incident management system was not effective and does not enable the accurate reporting and analysis of monthly clinical incident data. Incident forms are not always correct or reviewed in a timely way.

Staff had a shared understanding of consumers’ care needs and strategies to manage of high impact risks for two named consumers however, not all strategies used by staff were recorded.

Three named consumers had experienced increased periods of agitation, wandering behaviours and/or unwitnessed falls, these incidents had not informed ongoing assessment and care planning. Strategies that contributed to falls and behaviours or actions taken to minimise increased behaviours including wandering, delusions and agitation and falls were not consistently included in care planning information following incidents.

For one named consumer, concerns were identified regarding the ongoing management of their wandering, delusional and verbally disruptive behaviours. Concerns raised were in relation to the risk these behaviours created for other consumers. Additional concerns identified for this named consumer were in relation to the accurate completion of incident documentation and review of risk assessment information following falls.

The approved provider in its response acknowledges for this named consumer, care plan information was inaccurate and has since been updated. However, the approved provider refutes the named consumer posing a risk to the safety of other consumers. The approved provider states in their response, risk assessments had been completed when this named consumer had experienced falls. While I acknowledge the information, the approved provider has provided to demonstrate risk assessments had been completed, insufficient details were included in this information to demonstrate it was pertinent to this named consumer.

Care information for one named consumer who experienced increased episodes of physical aggression towards staff did not demonstrate the service had consistently managed, reported or reviewed episodes in a timely manner.

The approved provider in its response refutes that these increased episodes of physical aggression towards staff placed consumers at risk and states no episodes of physical or verbal aggression had occurred between this named consumer and other consumers. Several incidents were not recorded in incident documentation. While no incidents involving physical aggression had occurred between this named consumer and other consumers, I am concerned that deficiencies identified with the service’s incident reporting processes and inconsistent review processes is not effectively managing the named consumer’s behaviours.

The approved provider in its response included actions for improvement to address the deficiencies including additional clinical documentation education.

While I acknowledge the actions taken by the approved provider, at the time of the site audit, the service was unable to demonstrate the effective management of high impact risks associated with the care of each consumer.

Therefore, my decision is this Requirement is Non-compliant

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

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

### Requirement 3(3)(d) 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 service was unable to demonstrate a deterioration or change of a consumer’s health physical or cognitive function was recognised and responded to in a timely way.

Registered staff were not consistently documenting when changes in consumers’ clinical conditions were identified or information to demonstrate why Medical officer or allied health reviews were indicated. For three named consumers, changes including clinical function, increased behaviours, swallowing deficiencies, the development of swelling and oral health had not been consistently recorded in care information or follow up actions completed. Care staff did not consistently document in progress notes when changes in consumer’s care needs were identified in progress notes.

The approved provider refutes statements brought forward in the Assessment Team’s report in relation to care staff not consistently recording information in consumer’s progress notes. The approved provider acknowledges in their response, this did not traditionally occur prior to the approved providers’ ownership of the organisation however, all staff have since received training in service’s electronic clinical care system including documentation processes.

Management advised they were alerted to clinical incidents through progress note reviews however, care staff were not consistently documenting when changes were identified in consumer’s cognitive or physical condition in clinical care information.

The approved provider in their response states that management and senior Registered nurses are alerted to clinical incidents via an automated email from the incident system for all high-risk incidents. The approved provider advised in their response, the organisation implemented an organisation-wide improvement in March 2020 to ensure progress note reviews for the previous 24-hour period occur. The approved provider states in their response, to monitor this improvement, audits of progress notes will be completed by the Quality officer.

Improvements planned to address the deficiencies brought forward by the Assessment Team recorded in the approved provider’s response includes, planned education, audits and feedback for individual staff members who have not recorded enough information or completed clinical and incident documentation in a timely manner.

While I acknowledge the actions being taken by the approved provider, at the time of the site audit, the service was unable to demonstrate effective clinical monitoring processes were in place and changes in consumer’s clinical conditions were identified and responded to in a timely manner.

Therefore, my decision is this Requirement is Non-compliant.

### 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.*

Information about the consumer’s condition, needs and preferences is not consistently documented and communicated within the organisation and with others who provide care and services to the consumer.

Assessment and care planning processes are not effective and do not consistently inform care and service delivery. Care plans are not consistently updated to reflect the individual needs and preferences of consumers, or include interventions required for the management of consumers’ specific care needs. Consumer’s care needs were not monitored in line with care plan directives.

Care documentation did not evidence that the care needs of three named consumers including insomnia, increased agitation, hearing loss, compromised skin integrity, changes in mobility preferences and hypoglycaemia, had been adequately addressed and strategies recorded to inform care delivery.

The approved provider in its response advises that refresher education has been scheduled for all clinical staff regarding care planning processes.

Care staff said they did not receive a verbal handover. Management advised the clinical management team had commenced a verbal handover process daily Monday to Friday however, due to time constraints this had been discontinued.

The approved provider in its response states handover processes occur between care staff via the service’s electronic clinical care system. The approved provider advised in its response that a review of this system will be undertaken by personnel from the organisation’s national leadership to determine if further education or an alternate process is required.

Registered staff raised concerns in relation to care staff not carrying mobile communication devices which has impacted on their abilities to locate and inform care staff of changes in consumers’ care needs in a timely manner.

The approved provider in its response, states care staff are required to carry portable pagers during care delivery. The approved provider has advised in their response, that staff have been reminded of this requirement when working.

While I acknowledge the actions being taken by the approved provider, at the time of the site audit, the service was unable to demonstrate information about the consumer’s condition were documented or communicated effectively within the organisation.

Therefore, my decision is this Requirement is Non-compliant.

### Requirement 3(3)(f) Non-Compliant

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

Care information demonstrated the service had referral processes in place and Medical officers and allied health specialists including the dietician, physiotherapist, speech pathologist and podiatrist visited the service regularly.

Referrals to individuals and other providers of care were generally occurring however, for three named consumers with varying issues relating to psychotropic medications, increased nutritional requirements and requiring additional equipment, the Assessment Team identified concerns with the service’s actioning of referrals.

Staff were aware of the service’s referral processes and confirmed Medical officers and other providers of care visited the service regularly and when requested.

The Assessment Team raised concerns with the service’s failure to action requests from one named consumer to see their Medical officer on multiple occasions. The approved provider in its response acknowledges staff may not have recorded when the Medical officer was contacted however, evidence provided to the Commission in their response, demonstrates the named consumer was reviewed by the Medical officer on each occasion.

The Assessment Team brought forward concerns during the site audit in relation to the completion of a referral to the dietician for one named consumer. The approved provider in its response refutes the Assessment Team’s findings in relation to this and provided evidence to demonstrate this occurred.

Care information for two named consumers indicated they had not been referred to the physiotherapist for a review of their equipment needs.

Management advised in response to the Assessment Team’s findings during the site audit, the service had ordered the equipment for two named consumers and a referral to the physiotherapist had been completed.

The approved provider in its response acknowledged there was a communication breakdown between the organisation and the service in relation to the supply of equipment for one named consumer however, information responding to the Assessment Teams findings for the other named consumer whose representative requested equipment was not included in their response.

The approved provider stated in its response additional education will be provided to staff to ensure concerns and requests of consumers are recorded and communication and referral processes are improved.

While I acknowledge the concerns raised by the Assessment Team and their recommendation, I am satisfied the service was able to demonstrate referrals to individuals, other organisations and providers of other care and services occurred during the site audit.

Therefore, my decision is this Requirement is Compliant.

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

*Minimisation of infection related risks through implementing:*

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

The organisation did not have an effective infection control program that included planning and preparedness for an outbreak of COVID-19 and the service’s infection prevention and control lead had not completed mandatory training.

The approved provider in its response states the infection prevention and control lead was provided with multiple opportunities to complete their training prior to their appointment to a management role. However, evidence provided to the Commission to support this response was of low probative value.

Registered staff did not have a shared understanding of antimicrobial stewardship. While staff confirmed they had completed mandatory training which included infection control principles and handwashing, registered staff confirmed they had not received education regarding antimicrobial stewardship.

Care information did not demonstrate for one named consumer that discussions had occurred regarding the suitability of prophylactic antibiotic medication for urinary tract infections.

The approved provider in its response acknowledges that registered nurses can discuss the use of antibiotics with the Medical officer however, it states that it is the decision of the Medical officer to prescribe antibiotics and the type prescribed.

The service’s outbreak management plan did not include information that was individualised to the service to provide guidance for staff in the event of a COVID-19 outbreak. While information regarding where contact details, rosters, consumer’s Medicare numbers were stored, instructions for staff in relation to how they accessed this information was not recorded.

Floor plans of the service did not reflect rooms and zones where the donning and doffing of personal protective equipment was required and how many staff were allocated to each area.

The service did not have access to signage to communicate lockdown or service closures or identify potential areas where consumers are located who may be COVID-19 positive.

The approved provider in its response refutes the Assessment Teams concerns with the appropriateness of the service’s outbreak management plan. However, evidence to demonstrate the required information had been recorded in the service’s outbreak management was not provided.

The Assessment Team did not observe the availability of disinfectant wipes throughout the service in areas where shared equipment including computers and telephones, were utilised. The approved provider in its response states additional disinfectant wipes have been put in place following the site audit.

While I acknowledge the actions being taken by the approved provider, at the time of the site audit, the service was unable to demonstrate an effective infection control program that included planning and preparedness for an outbreak of COVID-19 was in place.

Therefore, my decision is this Requirement is Non-compliant

# STANDARD 4 COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers said they were supported to do things they enjoyed which were important for their health and well-being. Care information confirmed consumers’ interests, goals and preferences were identified and supported. Activities were developed and implemented to ensure all consumers were provided with the opportunity to participate.

Consumers were observed interacting with each other, staff, family members and visitors and engaging in a variety of activities during the site audit. Consumers were provided with emotional and spiritual support which was reflected in care planning documentation. Pastoral care team services visited the service periodically and staff implemented strategies to enhance consumers emotional well-being. Consumers said they liked the food offered at the service, they have enough to eat and are generally supported by management when issues were raised.

Consumers living within the service come from diverse backgrounds, who like to access the outside and venture into town with support from the service as they please.

Weekly activity schedules were provided to consumers and daily activities were posted on noticeboards. Consumers were observed engaging in a variety of activities during the sites audit.

Pastoral care services visited the service and care plans included information to promote consumer’s emotional, spiritual and psychological well-being.

Staff described how they supported consumers to maintain relationships of choice and participate in the community.

Information regarding consumers’ condition, needs and preferences were communicated through care plans, handover processes, progress notes, electronic alerts and staff communication books. Care information demonstrated the involvement of others in the provision of lifestyle supports including external services and representatives.

Consumer’s dietary needs and preferences were discussed and recorded in care planning information and updated in accordance with speech pathologists and dietician’s recommendations.

Menus were seasonal and rotated every four weeks. Catering staff were aware of consumers’ individual needs and preferences. Food focus groups were held to provide consumers and representatives with opportunities to provide feedback in relation to meals.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s services 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 service environment did not enable all consumers to move freely outdoors. The service did not have a shared understanding of consumers who were physically restrained during the site audit. The comfort and safety of consumers was impacted by consumers with wandering behaviours.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

Consumers were unable to access all areas of the service. Not all consumers had been provided with the code to access all areas of the service. Most registered staff did not have a shared understanding of physical restraint and documentation was not provided to confirm consumers had been consulted, assessed or provided with codes to leave the service. While some consumers were observed to be using the key code independently others were observed to be assisted by staff. Most consumers confirmed they did not know the code to exit the service and required staff assistance to do so.

The approved provider’s response contains planned improvements including a review of consumers who have been identified as disruptive, additional staff education and the deactivation of keypad security.

Some consumers said they did not feel safe living at the service as a result of other consumer’s challenging and wandering behaviours. Care documentation confirmed some consumers had raised concerns regarding their safety and were impacted by other consumers challenging behaviours. Staff were not aware of consumers who had been negatively impacted and had not implemented strategies to effectively manage consumers behaviours appropriately.

The approved provider in its response states that personnel from the organisation’s national leadership team will review the service’s management of consumers with disruptive behaviours.

A named consumers’ preference to smoke was not managed appropriately. While a smoking risk assessment had been completed for the named consumer, an environmental risk assessment had not been completed or the safety of other consumers considered.

While I acknowledge the actions being taken by the approved provider, at the time of the site audit, the service environment was not safe or enabled consumers to move freely, both indoors and outdoors.

Therefore, my decision is this Requirement is Non-compliant.

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The organisation has a complaints management system including policies and procedures in relation to the management of feedback and complaints and open disclosure.

However, appropriate and timely action was not consistently taken in response to consumer feedback or complaints. An open-disclosure process was not consistently applied following incidents which harmed or had potential to cause harm to consumers.

Some consumers and representatives said they were dissatisfied with the way their complaints had been managed and they had experienced delays in the service addressing their concerns.

Feedback and complaints were not consistently recorded, reviewed and used to improve the quality of care and services for consumers receiving aged care services.

Staff did not have a shared understanding of the principles of open disclosure.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

The service was unable to demonstrate that appropriate action is taken in response to complaints and an open disclosure process was used when things went wrong.

Some consumers and representatives raised concerns with the service’s management of complaints which were not actioned or resolved in a timely manner. They said management and staff do not always provide an apology, communicate when issues were identified or involve them in the resolution process.

Consumers provided examples of complaints that had been poorly managed, and these complaints related to concerns with clinical and personal equipment. Further to this, representatives expressed frustration with the lack of actions from the service and had either given up making complaints or had resorted to lodging their concerns with external complaints services.

The approved provider’s response acknowledged the service had not been recording all complaints in the feedback register. The approved provider’s response included actions for improvement which focused on education for staff, the development of home specific complaints e-mail inboxes, adding an additional item to the standard agenda used for resident and relative meetings to discuss complaints information and updating the electronic incident and feedback system.

While staff had a shared understanding of complaints processes, complaints documentation did not evidence complaints had been actioned or discussed with consumers and representatives in a timely manner. Staff did not demonstrate a shared understanding of open disclosure and management were unable to provide examples where open disclosure was applied. Training records confirmed not all staff had completed complaints and open disclosure education modules.

The service’s Quality officer advised they did not have time to oversee quality improvement activities due to time constraints. The approved provider in its response states an organisation wide improvement was identified early this year and involves changing the Quality officer’s reporting lines to ensure enough hours are allocated for the role.

While I acknowledge the approved provider’s response and note the service had documented open disclosure processes in place, I am not satisfied that appropriate action has been taken in response to consumers’ complaints or that the principles of open disclosure have been applied. The approved provider has not included information in their response to evidence this had occurred.

Therefore, my decision is this Requirement is Non-compliant

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

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

Feedback and complaints were not consistently used to improve the quality of care and services. Consumers and representatives raised concerns regarding the service implementing improvement which were not sustained or satisfactory.

Management were unable to confirm if improvement actions commenced at the service in response to feedback or were communicated to consumers. Management acknowledged their limited understanding of matters relating to continuous improvement during the site audit. Improvement activities were not consistently evaluated for effectiveness.

The approved provider in their response acknowledged the service’s improvement register was not up-to-date and have implemented improvements to address the deficiencies including, changing the reporting responsibilities of the organisation’s Quality Officers in the service. This change will enable the organisation to ensure that allocated hours are used for that purpose, new quality officers have the required characteristics for their role and are accountable for their performance.

While complaints, feedback and improvement activities were discussed each month at local quality meetings, information recorded in the service’s action plans did not include the required information including, sources, completion dates, results or an evaluation of the improvement.

The approved provider’s response refutes information brought forward by the Assessment Team in relation to the cessation of resident and relatives’ meetings. The approved provider states in their response, meetings were ceased between March 2020 and February 2021 following the advice of the service’s infectious disease physician due to various requirements associated with the COVID-19 pandemic.

The approved provider’s response refutes statements made by management during the site audit relating to continuous improvement activities being delegated to the service’s Quality officer. While the approved provider states in their response, that staff’s individual roles in quality and continual improvement were reflected in position descriptions, I was unable to substantiate the origin of the information provided or the source it had been extracted from.

While I acknowledge the approved provider’s response, I am satisfied that feedback and complaints were not used to improve care and service delivery to consumers, continuous improvement records were not maintained, and management had limited understanding of matters relating to continuous improvement.

Therefore, my decision is this Requirement is Non-compliant

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Most consumers and representatives raised concerns regarding the insufficiency of staff which has resulted in frequent delays in care delivery. The delivery of care was not consistently completed in accordance with care and service plans. Seven consumers or their representatives raised concerns with staffing levels and advised the service had insufficient staff to ensure personal and clinical care is delivered in a timely way or in accordance with their preference.

Call bell response for a specified period during March 2021 exceeded the service’s benchmark times. The Assessment Team observed delays for assistance during meal service during the site audit.

The workforce was not supported at a service and organisational level to effectively perform their roles. Staff expressed concerns regarding their inability to adequately monitor, supervise or support consumers with their mobility needs or consumers who exhibit complex behaviours.

The service was unable to demonstrate the workforce was adequately recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-Compliant

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

The service did not demonstrate the workforce was planned to enable the delivery and management of safe and quality care and services.

Most consumers advised there were insufficient staff which resulted in their care needs not being met in a timely manner or in accordance with their care and service plans.

Most staff confirmed they do not have enough time to undertake their allocated tasks and responsibilities. Staff reported not being able to meet the care needs of consumers and delays were experienced answering consumers call bells. Staff raised concerns with undertaking tasks outside of their normal duties.

The service has not recruited a lifestyle assistant to assist in the provision of meaningful activities.

Registered staff raised concerns regarding additional duties they were required to complete which included facilitating the visitor sign in process and answering the service’s telephone after 2.00 pm which distracted them from their clinical duties.

Care staff raised concerns regarding staffing levels which has resulted in call bell delays, increased falls, limited social engagement with consumers and consumers hygiene preferences not being met

Management confirmed consumers, representatives and staff have raised concerns regarding insufficient staffing levels. Complaints register information indicated several complaints were received from consumers and representatives in relation to staffing inadequacies and the impact on care delivery. Call bell delays were in excess of the service’s expectations.

The approved provider in its response refutes the findings of the Assessment Team and states that staffing reductions in July and September 2020 occurred in response to a decrease in consumer occupancy during this period.

The approved provider does acknowledge the Service manager did not allocate staffing hours in the most optimal manner and the service had experienced an increase in unplanned leave.

In relation to staffing sufficiency, the approved provider’s response stated the service has recruited more staff for their casual bank.

While I acknowledge the approved provider’s response, at the time of the site audit, the service was not planned to ensure the delivery and management of safe and quality care.

Therefore, my decision is this Requirement is Non-compliant

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

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

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

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

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

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

Some representatives said they did not feel confident that the Acting service manager was supported to make significant changes at the service.

Staff advised they did not have time to undertake education in addition to mandatory training requirements. Staff did not feel supported or equipped to undertake their duties effectively to ensure the delivery of safe care and services.

The Acting service manager advised they were not provided with adequate support, including education and orientation from the organisation when appointed to their position in January 2021. While the Acting service manager occupied this role, recruitment for their previous role as a Care manager had not been completed. As a result, the Acting service manager assumed responsibilities for both roles which was not in line with position description information.

The Acting service manager was appointed as the service’s infection prevention and control lead however, time and support were not provided by the organisation to undertake the required training. The Acting service manager advised they were not invited to the Service manager meetings each fortnight.

The Quality officer and the Acting service manager were not equipped and supported to monitor the service’s continuous improvement processes.

The approved provider in their response, refutes information in the site audit report in relation to the lack of support provided by the organisation to staff. In their response, the approved provider states, efforts were made to backfill the Care manager position, but they were unsuccessful, however additional staffing was provided.

The approved provider in its response refutes that training was not provided to the Acting service manager prior to their appointment to the role.

The approved provider in its response has acknowledged the Acting service manager did not attend Service manager meetings each fortnight since they were appointed to the role however, meeting minutes were provided. In its response, the approved provider that a process has now been developed to ensure all Acting service managers are included in the invitation list and all Care managers will continue to receive copies of the meeting minutes via electronic mail correspondence.

The approved provider in its response refutes information in the site audit report in relation to staff being supported, trained and equipped to deliver the outcomes required by these Standards. Whilst I note this, the approved provider’s response has included information which is of low probative value and does not demonstrate actions included had occurred.

I have considered information in the site audit report and the approved provider’s response. I am concerned a person in a senior management position has not been trained, equipped and supported to deliver the outcomes required by these standards*.*

Therefore, my decision is this Requirement is Non-compliant

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

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The organisation was unable to demonstrate it applied and understood all requirements of this standard.

The organisation did not have effective organisation wide governance systems in relation to information management, continuous improvement, workforce accountabilities, regulatory compliance and feedback and complaints.

The organisation was unable to demonstrate it had effective risk management systems and processes, including but not limited to, the management of high impact and high prevalence risks associated with the care of consumers and supporting consumers to live the best life they can.

Processes to monitor the implementation of the organisation’s clinical governance framework were ineffective.

While consumers felt engaged in the development, delivery and evaluation of care services and the organisation’s governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery, the organisation’s governance systems were ineffective and impacted on care delivery to consumers.

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

## Assessment of Standard 8 Requirements

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

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

### Requirement 8(3)(b) 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 organisation does not have effective governance systems in relation to information management, continuous improvement, workforce governance, or feedback and complaints.

Information was inaccurate and incomplete in relation to incident recording, assessment, care planning, and feedback and complaints data. Information about consumers. This does not support effective information management.

Continuous improvement documentation is not reflective of organisation wide improvement and compliance activities. Actions to reflect improvement activities have been undertaken or intended to be undertaken by the service are not reflected in continuous improvement documents and action plans. Information to demonstrate the source, completion date, outcome and evaluation of the improvement was not consistently recorded.

In relation to financial governance, management raised concerns regarding the responsiveness of the organisation to requests for budgetary changes to support the needs of consumers. While delays in requests for equipment were identified during the site audit, I am satisfied this the result of the service’s ineffective communication systems and not the result of budgetary deficiencies.

While policies and procedures relating to human resource management were in place, the workforce was not planned to enable the delivery and management of safe quality care and services. The service did not demonstrate sufficient staff were allocated to meet consumers’ needs and preferences. Staff advised they did not feel equipped or supported to effectively perform their roles.

The organisations legal and compliance department monitors overarching regulatory compliance and maintains up to date information about relevant legislation which is communicated to staff. While policies and procedures are in place for restrictive practices, staff did not have a shared understanding of what constitutes physical restraint.

Management described how the organisation maintains up to date information about relevant legislation and how this is communicated to staff. Staff have received education in relation to the Serious Incident Response Scheme however, management had not been advised of when a review of overarching frameworks, policies and procedures would occur. Staff did not have a shared understanding of what constitutes physical restraint and restraint authorisations for consumers subject to restraint were not accurately or consistently completed. The organisation had not completed discussions with the infection prevention and control lead within period specified by the Department of Health.

The approved provider in its response refutes information regarding the organisation providing training opportunities relevant to their role. Improvements are planned to discuss with the vendor of the service’s electronic clinical care system the possibility of improving restraint assessment information.

The organisation does not have an effective feedback and complaints system. The service does not maintain accurate records of feedback, complaints or continuous improvement activities. Consumers remained dissatisfied with the management of their complaints. Information contained in the complaints register was incomplete and not consistently actioned.

The organisation was unable to demonstrate effective governance systems in relation to information management, continuous improvement, workforce governance and the effective management of high impact or high prevalence risks. However, I have determined deficiencies brought forward by the Assessment Team in relation to financial governance was not in response to budgetary changes being denied but more so related to a breakdown in the service’s communication processes.

The approved provider in its response has planned improvements to address the significant non-compliance identified during the site audit and improve organisation wide governance systems. Improvements included in the approved provider’s response include the implementation of electronic medication management systems and improvements to the service’s current electronic care and incident systems and changing the reporting lines for Quality officers to oversee continuous improvement activities.

While I acknowledge the approved provider’s response, the organisation did not demonstrate effective governance systems were in place in relation to information management, continuous improvement, workforce governance or feedback and complaints.

Therefore, my decision is this Requirement is Non-compliant.

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

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

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

The service was unable to demonstrate that effective risk management systems were in place in relation to high impact and high prevalence risks including, falls, complex behaviours and pressure injuries.

Care planning documentation confirmed strategies used to minimise or prevent falls and pressure injuries and to reduce and monitor the use of restraints were not consistently applied. Restraint authorisations were not consistently signed by consumers representatives and staff did not have a shared understanding of physical restraint.

In relation to the management of consumers who exhibit complex behaviours including wandering and the impact these behaviours have had on the safety and wellbeing of other consumers residing at the service.

While the organisation has a documented risk management framework for the management of high-impact and high prevalence risks associated with the care of consumers, management advised they did not have the capacity to govern staff’s compliance with these processes or review and investigate all recorded incidents.

Care documentation and incident reports for consumers who had experienced falls and physical behaviour incidents confirmed management had not reviewed or investigated the incidents.

The approved provider in its response states the organisation is planning to improve their electronic incident management systems to ensure all high impact or high prevalence risks are recorded.

While I acknowledge the approved provider’s response, the organisation did not demonstrate effective risk management systems and practices and consumers had not been supported to live the best life they could, as evidenced through extensive Non-compliance in all seven Quality Standards and this is not reflective of effective risk management systems.

Therefore, my decision is this Requirement is Non-compliant.

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

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

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

Registered staff’s understanding of antimicrobial stewardship was varied. The organisation had a designated consultant responsible for services antimicrobial stewardship processes. The use of antibiotics is discussed at local medication advisory committee meetings and is monitored through annual national audits. While staff did not demonstrate a shared understanding in relation to antimicrobial stewardship, they could explain how they discouraged the unnecessary use of antibiotics and what preventative strategies they would implement.

Staff did not have a shared understanding of the legislative requirements for the application of physical restraint or the principles of open disclosure. The approved provider in its response states education is planned for staff in relation to physical restraint.

The service was unable to demonstrate management provided enough oversight in relation to staff’s compliance with organisational policies and frameworks for safe and effective care delivery. Registered staff confirmed they were unable to monitor staff practice due to time constraints.

The organisation could not demonstrate that the principles of open disclosure have been applied appropriately. The service’s electronic incident management system is not effective and does not indicate when open disclosure has been used.

The approved provider in its response states improvements to the organisation’s electronic incident and clinical care system are planned to ensure staff have considered when open disclosure processes are required.

While I accept that the approved provider has a clinical governance framework, I am not satisfied that processes to monitor the deployment of the framework at the service level are effective. Monitoring processes had not identified deficits identified by the Assessment Team during the site audit in care delivery and responding to adverse events.

Therefore, my decision is this Requirement is Non-compliant.

# Areas for improvement

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

* 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.
* Requirement 3(3)(a) – Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that optimises their health and well-being.
* Requirement 3(3)(b)- Effective management of high impact or high prevalence risks associated with the care of each consumer.
* 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.
* 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.
* Requirement 3(3)(g) - Minimisation of infection related risks through implementing:
1. standard and transmission based precautions to prevent and control infection; and
2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.
* Requirement 5(3)(b) – Ensure the service environment is
1. Safe, clean, well maintained and comfortable
2. Enables consumers to move freely both indoors and outdoors
* Requirement 6 3(c) – Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d)- Feedback and complaints are reviewed and used to improve the quality of care and services.
* 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.
* Requirement 7(3)(d) -The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* 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
* 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.
* 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.