Millrace Hostel

Performance Report

422 Rouse Street   
TENTERFIELD NSW 2372  
Phone number: 02 6736 2622

**Commission ID:** 0307

**Provider name:** Tenterfield Care Centre Limited

**Site Audit date:** 25 May 2021 to 28 May 2021

**Date of Performance Report:** 10 August 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-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) | 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) | Non-compliant |
| Requirement 6(3)(b) | Non-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) | Non-compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Site report received 29 June 2021
* other intelligence and information received by the Commission regarding the service, including referrals received internally.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers considered that they were encouraged to do things for themselves, and staff understood their needs, preferences and what is important to them. Consumers felt they could make informed choices about their care and services and were supported to take risks to live the life they chose. Consumers advised staff assisted them to maintain relationships with friends and family members, both inside and outside the service. Consumers reported they were provided with information to help them in making choices about their care and daily activities; this included an organisation information pack on entry, detailing the services available to them as well as ongoing meal selections and service events.

Staff were able to explain the process for recording consumer preferences both when entering the service and on an ongoing basis, and staff described assessment processes and discussions held with the consumer/representative. Staff explained how they supported consumers to make informed choices about their care and services, which assisted to maintain consumers’ independence.

Consumer care planning documents reflected assessments and care plans that referred to supporting each consumer’s cultural safety; including the consumer’s life history, spiritual preferences, family and social networks and significant days and events. Care plans detailed decision making, individual choices and relationship preferences of consumers, and described risks the consumer wished to take, how they were supported to make these decisions and the strategies in place to support them.

While staff were observed to treat consumers respectfully while providing care and services, and when speaking to consumers; some consumers/representatives raised concerns that due to the actions of one staff member in relation to consumer care delivery and interaction, the consumers felt they were not treated with dignity or respect.

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

## Assessment of Standard 1 Requirements

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

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

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, information under this and other Quality Standards, including Standards 6 and 7.

Two named consumers and one consumer representative reported in various ways of a named care staff member who was verbally aggressive in their interactions with consumers, spoke rudely and in a disrespectful manner to them and other consumers, and who could be rough when providing care. The two consumers stated they felt either intimidated or scared by the care staff member’s attitude and that their quality of care was negatively impacted. While these concerns had been raised with staff and management on a number of occasions, both recently and in the past, the consumers and representative felt these issues had not been addressed or followed up appropriately. Two of the consumers/representatives had requested that the care staff member is not to provide them with care; this request has been actioned by the service. Seven staff from across the service expressed concern regarding the care staff member’s conduct, which included being rough and rushing consumers during care delivery and yelling or being rude to consumers; they said they had given written or verbal feedback to management but were unsure what actions management had taken to address the care staff member’s behaviour.

The Approved Provider in its written response to the Assessment Team’s findings stated the named care staff member had been subject to workplace bullying, harassment and had been falsely accused of allegations which originated from a workplace/staff dispute that had initially occurred in July 2020. The Approved Provider noted the outcomes of these allegations had been investigated by an external Human Resource firm (August 2020) who, the Approved Provider stated, had determined there was nil substance to these allegations. However, I note that in its response, the Approved Provider has not provided any supporting information to demonstrate how the service has acknowledged, reviewed, addressed or managed the more recent concerns raised and allegations made, in relation to the inappropriate behaviour of the care staff member, by the three consumers/representatives during the audit as reflected above.

In its response, he Approved Provider further referenced numerous complaints made anonymously to the Complaints Resolution Group (CRG), of the Aged Care Quality and Safety Commission (Commission) on 2 October 2020 and later (18 November 2020), which included allegations of inappropriate interactions with, and care delivery to consumers by the care staff member. The Approved Provider stated investigations conducted by certain parties including the Commission (CRG) deemed previous allegations involving the care staff member as false, and that during the process the Commission (CRG) interviewed the consumers named in the complaints and deemed the allegations as to have not occurred. However, I note that these two statements, that the allegations were false and had not occurred, were not documented in the Commission’s (CRG) correspondence, which was provided by the Approved Provider as part of their response. Information received independently by the Quality Assessment and Monitoring Group of the Commission from the CRG, on 18 November 2020 in relation to 12 anonymous complaints, reflected seven consumers/representatives were contacted by CRG and were found to not share the same concern of the complainant, at the time the complaint was made (November 2020), and the remaining five complaints contained limited detail and the service was to conduct their own investigation.

The Approved Provider has reported in its response, and through the provision of the service’s plan for continuous improvement, that due to the context of the complaints the matter has now been referred to an external Human Resource consulting firm for review and the staff member being investigated for the allegations has been stood down. Further staff training regarding dignity and respect was to be provided to staff. The service is to review disciplinary processes where there is ongoing performance issues with a staff member, especially where it impacts on consumers. Management of the care staff member is to be revisited and reviewed; the care staff member’s performance is to be monitored and they are to receive training in all areas across Standard 1 as well as complaints management. Management is to receive mentoring/training on performance management.

I acknowledge the Approved Provider’s response to the findings at the site audit and the actions they have taken and are planning on taking to address the deficiencies identified. However, in reviewing the information contained above it is my decision that at the time of the site audit, each consumer was not being treated with dignity and respect; I was particularly persuaded by the feedback brought forward by consumers/representatives regarding their experience in relation to the provision of care and services.

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Consumers/representatives were satisfied with the information that was provided to them about, and their involvement in, care planning processes. Consumers described what was important to them in terms of how their care was delivered and said the service understood their care needs, goals and preferences. Consumers/representatives described how they and the people important to them were involved in care assessment and planning on an ongoing basis. Consumers/representatives said staff talk to them about individual care and service provision for consumers and explain information when required.

Registered staff described processes for assessing consumer needs and these were evidenced in assessments and care planning documentation. Staff were able to discuss their approach to having discussions with consumers about end of life care and/or advanced care plans; this information was reviewed as consumers’ needs changed or their health deteriorated. Staff described processes for referral to allied health professionals and advised of the process for ensuring any changes made by external professionals is communicated to the staff by handover from registered staff. Registered staff said they meet with consumers/representatives to discuss any changes consumers may require and to ascertain if the care the consumers receive is meeting their needs, goals and preferences.

Reviewed consumers’ care planning documentation detailed the individual consumer’s current needs, goals and preferences, and reflected that consumers/representatives were involved in assessment and planning; this included other providers of care and services such as the medical officer, medical specialists and allied health professionals. A suite of evidence-based assessment tools and end of life pathways were available, and the Assessment Team observed care planning documents were readily available to staff delivering care, and staff were accessing consumers’ care plans and information electronically.

However, while the service had processes to direct assessment and care planning, the service was unable to demonstrate that initial and ongoing assessment and care planning, including consideration of risk to consumers was completed. Some consumers did not consider that they feel like partners in the ongoing assessment and planning processes. While care and service plans were reviewed, risks to consumers were not consistently identified, strategies implemented and/or reviewed for effectiveness, when circumstances change or when incidents impact on the needs, goals and preferences of consumers.

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

## Assessment of Standard 2 Requirements

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

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

The service was unable to demonstrate that initial and ongoing assessment and care planning, including consideration of risk to consumers was consistently completed. The processes of assessment and care planning to inform safe and effective care and services was incomplete and did not identify the individual risk to consumers.

Assessment and care planning processes for consumers with compromised skin integrity, who exhibited episodes of challenging behaviours, with a history of recurrent infections, and/or had a diagnosis of insulin dependent diabetes were incomplete. The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings and reported on actions that have been completed, and that will be completed, to address the deficiencies identified. These included contracting the services of a national aged care peak body for 12 months to assist with the upskilling, mentoring, training and development of staff; risk management education scheduled for staff (August 2021), assessment and care planning reassessment processes have been commenced to ensure individual risks to consumers are identified and strategies implemented, and a post action audit scheduled to evaluate effectiveness.

For one named consumer requiring wound care management, wound assessment did not include measurement of the wound, frequency of dressing changes, and descriptions of wound characteristics to inform monitoring of healing. In its response, the Approved Provider reported on improvement actions completed, which incorporated improvement activities detailed above, and that further included; referral of the consumer to a wound specialist for further review (June 2021), wound education combining documentation requirements scheduled for staff, wound and skin management audits to be conducted, pain management education scheduled and a pain audit to be completed, and a review process commenced of consumer assessment and care plans to ensure assessment of risk is conducted.

Two named consumers with insulin dependent diabetes did not have diabetic care plans to direct staff on how to recognise and manage episodes of high or low blood sugar levels. The Approved Provider stated in its response this statement was incorrect and provided evidence both consumers have Diabetes Action Plans. The Approved Provider detailed further actions conducted, which included a diabetes management audit to be completed; clinical governance and roles and responsibilities education scheduled for staff (July and August 2021) respectively, blood glucose level (BGL) audit to be conducted daily and daily monitoring of BGLs by the Director of Nursing and registered nurses. Diabetes education is scheduled for staff (August 2021) and one of the named consumers with out-of-range BGLs is to be referred to the medical officer for further review.

For two named consumers with a history of infections, their care plans did not consistently detail strategies to manage or reduce the risk of the infections. The Approved Provider in its response described improvement actions that have been completed that incorporated improvement activities detailed above, and that further included; evidencing assessment and care plans have been reviewed with the two named consumers (on 29 June 2021) to include strategies to reduce the risk of developing known infections and education for staff regarding microbial stewardship (date not provided).

The care plans for two named consumers, who displayed episodes of verbal and physical challenging behaviours towards others, did not include identified triggers and individualised strategies to manage assessed risks and guide the provision of care by staff. In its response the Approved Provider reported on improvement actions that have been completed which incorporated improvement activities detailed above, and that further included; reassessment has commenced for the two named consumers to identify triggers and appropriate management strategies in relation to their behaviours, other consumers with frequent episodes of challenging behaviours to be reassessed, and behavioural management education scheduled for staff (August 2021).

The Assessment Team noted consumer assessment and care planning was not consistently completed due to registered staff lack of knowledge of the service’s electronic clinical management system. The Approved Provider in its response advised of actions that have been completed to address this, which included education scheduled for staff on the service’s electronic clinical management system (July and August 2021); the Director of Nursing to undertake quality monitoring of assessment and care planning and to review progress notes to ensure clinical follow up is completed, and clinical follow up education to be scheduled for staff.

While staff were knowledgeable of consumers likes, dislike and preferences, some consumers/representatives were not aware of the assessment and care planning processes at the service. In its response, the Approved Provider stated the process of assessment and care plan reviews is to be raised as a standing agenda item at consumer’s meeting, to highlight consumer engagement in this process and the availability of care plans to consumers at all times. Newsletters are to include information regarding the collaborative approach to care planning.

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified in assessment and care planning. However, it is my decision that at the time of the site audit, assessment and planning, including consideration of risks to the consumer’s health and well-being, did not consistently inform the delivery of safe and effective care and services and, therefore, this Requirement is Non-compliant.

### 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.*

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Requirements, including Requirement 2 (3)(a).

While care and service plans were reviewed by staff, risks to consumers were not consistently identified, and strategies implemented and/or reviewed for effectiveness, when circumstances changed or when incidents impacted on the needs, goals and preferences of consumers. The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings and reported on actions that have been completed, and that will be completed, to address the deficiencies identified. This included an audit to be conducted to ensure all care plans have been reviewed and updated post all incidents within the past four weeks, and to ensure all care plans and assessments are updated based on the audit findings. Review the service’s Documentation policy for clarity regarding assessment and care planning currency, and provide to registered nurses; provide training regarding person centred care documentation.

For one named consumer, staff had not considered the consumer’s underlying medical condition to be a contributing factor to their falls and the consumer’s care plan had not been reviewed post falls to eliminate any potential underlying contributing factors/risks. In its response the Approved Provider informed of improvement actions completed, which included reassessment conducted in consultation of the consumer to identify root cause analysis of their falls and ensure appropriated strategies implemented; root cause analysis training is scheduled to be provided for staff. A meeting has been scheduled with the physiotherapist to discuss expectations in post falls management review.

In relation to five named consumers who experienced unwitnessed falls, fall assessments and falls management strategies were not completed in line with the service’s policy; for three of these consumers evaluation of the effectiveness of the consumer’s fall management strategies had not been undertaken as part of post falls management, with the view to reducing the number of falls. The Approved Provider in its response advised of improvement actions conducted, which included falls risk assessments completed for the named consumers, falls management and post falls management education scheduled for staff (August 2021), review of service’s falls management policy and procedure with education on these to be provided to staff, and education provided to staff to access and review falls strategies via the electronic clinical management system. The service is to conduct a review of the call bell system and pendant use to ensure in good working order.

While staff were aware of their responsibility in relation to incident reporting, management and staff did not understand the Serious Incident Response Scheme (SIRS) legislative investigation and reporting requirements that became effective 1 April 2021. Scheduled care plan reviews or Resident of the Day review processes failed to identify the deficits in review and evaluation practices identified by the Assessment Team. The service did not consistently analyse clinical incident data to implement strategies to minimise the risk of incidents reoccurring for consumers and to improve staff practice where required. In its response the Approved provider stated improvement action have been completed that included further education scheduled for staff in relation to SIRS (July 2021) and staff knowledge post the SIRS education is to be evaluated. Clinical governance education scheduled for staff (July 2021) as well as assessment and care planning education. With the appointment of a national aged care peak body, mentoring and support is to be provided to staff. The service’s clinical indicator review template has been reviewed and updated to guide the user to identify strategies to minimise the risk of reoccurrence of incidents, and education is scheduled regarding incident follow up.

While I acknowledge the commitment of the Approved Provider to improve the review of care and services procedures, this process was not effective at the time of the site audit and will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this Requirement is Non-Compliant.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Consumers considered that they received personal care and clinical care that was safe and right for them and met their needs and preferences. Consumers/representatives were confident changes in the consumer’s care needs would be identified and addressed. Consumers/representatives were satisfied with the delivery of care, including referral processes. Consumers/representatives said they were satisfied with the service’s management of COVID-19 precautions and infection control practices. However, two named consumers reported concerns in relation to information about their needs and preferences not being adequately documented and communicated.

Consumers nearing the end of life received appropriate care; however, the service did not demonstrate each consumer got safe and effective personal or clinical care which was tailored to their needs and optimised their health and well-being. The service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Deficiencies were identified in the management and monitoring of risks associated with falls management, challenging behaviours, and management of consumers with diabetes. The service did not adequately demonstrate that deterioration or change of a consumer’s health status or condition was recognised and responded to appropriately. Registered staff were not onsite overnight (they were on call) and were not always immediately or readily available to assess consumers who might have experienced a deterioration during that time. Information about the consumer’s condition, needs and preferences were not consistently documented and communication regarding the consumer’s current or changed care needs did not always occur, within the organisation or with others where responsibility for care was shared.

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

### Assessment of Standard 3 Requirements

### 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/representatives were satisfied they received care that was safe and right for them, and that met their needs and preferences. However, reviewed consumers’ care documentation did not demonstrate consumers were receiving individualised care that was safe, effective and/or tailored to their specific needs and preferences. For a consumer identified as at risk of falling, documented management strategies were not consistently being implemented or monitored by staff. For a consumer identified with pain management needs, care documentation did not evidence that all pain management strategies had been implemented or monitored for effectiveness. Monitoring of blood glucose levels (BGLs) in relation to diabetic care was not consistently followed by staff in line with medical directives, and/or follow up actions or monitoring were not reported as actioned.

Care documentation did not evidence scheduled changes to urinary catheters, catheter bags, oxygen tubing, nasal cannulas and oxygen concentrator filters occurred as per medical directives to minimise the risk of infections. For two consumers who exhibited verbal and physical challenging behaviours, care documentation did not include individualised strategies to manage or minimise the risk associated with these behaviours to guide staff practice. Care documentation did not demonstrate whether wound care was effective, due to inconsistency in measurements of wounds, photographs and frequency of dressing changes; the status of the wound was not evident. For consumers requiring chemical and/or physical restraint, care documentation lacked information regarding restraint implementation, monitoring and review. Management had stated that lack of knowledge by staff in the use of the service’s electronic clinical management system resulted in care documentation not being completed; management could not provide evidence of directives being actioned by staff. Care staff reported they did not always discuss clinical issues at handover; they received a poor handover from the night carer and often found out about consumer incidents by chance.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, advised of improvement actions taken and to be implemented, which included training in the service’s electronic clinical management system to be provided to staff where care and services are delivered, as a priority. Consumers with a diagnosis of diabetes are to be reviewed to ensure they have a medical officer directive in place. Consumers with urinary catheters are to be reviewed and a schedule for changes is to be in place; a comprehensive schedule is also to be in place for the management of consumers requiring oxygen. The service’s wound policy is to be reviewed and provided to staff. Evaluation of the effectiveness of pain strategies is to be conducted. A review of all consumers on restraint is to be undertaken to ensure care plans are reflective of the management required by staff. A review of the handover process is to be completed and staff are to be educated on how handovers are to be conducted. Training is to be provided to staff on behaviour management, diabetes management, wound management, pain management, and catheter management and urinary infections. Cross training/rotation of clinical care staff across both organisation’s services to ensure consistent understanding of all elements of clinical care.

While I acknowledge the actions taken, and to be implemented by the Approved Provider, at the time of the site audit, consumers were not receiving care that optimised their health and well-being. Therefore, it is my decision 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.*

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Standards, including Standard 2.

High-impact, high-prevalence risks associated with the care of consumers who require specialised nursing care were not being effectively managed. For two named consumers who were identified at risk of falls and who had experience several falls, documented management strategies were not individualised to their care needs and post falls management, were not completed as required after each fall. Registered nurses did not have a shared understanding of the post falls clinical pathway process. The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, advised of improvement actions implemented that included all consumers with high prevalence risks are to be reviewed, and staff training is to be provided on high impact high prevalence risks, what these are and how to manage it. Staff are receive training in falls management including observations, assessment and documentation review to be conducted. Consumers with challenging behaviours are to be reviewed to ensure their care plans are reflective of the behaviour, triggers and management strategies.

Two named consumers with insulin dependent diabetes did not have diabetic care plans to direct staff on how to recognise and manage episodes of high or low blood sugar levels. The Approved Provider stated in its response said this statement was incorrect and provided evidence both consumers have Diabetes Action Plans.

Five consumers with verbal and physical challenging behaviours did not have behaviour care plans consistently completed, that identified triggers and effective strategies to manage the risk of their behaviours; including in relation to other consumers, in relation to agitation directed towards staff, or in relation to self-harm. Care documentation identified the consumers continued to display challenging behaviours. Management had stated behaviour care plans were not correctly completed as registered staff lacked knowledge of the service’s electronic clinical management system. In its response the Approved Provider advised an update of the electronic clinical management system has been scheduled to ensure information transfers through to the correct location.

The Assessment Team brought forward information under this requirement about clinical incidents being analysed and trended, but where no identification was made of potential or actual risks to consumers; I have considered this under Requirement 2(3)(e).

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified. However, it is my decision that at the time of the site audit, the service was not able to adequately demonstrate the management of high impact or high prevalence risks associated with the care of each consumer was effective. Therefore, 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.*

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, elsewhere under this Standard.

The service did not adequately demonstrate that deterioration or change in a consumer’s health status or condition was recognised and responded to appropriately. One consumer reported while they had informed care staff of falls overnight, these incidents were not escalated to the registered nurse or medical officer for further review. Care documentation did not reflect deterioration or change in the consumer’s function, capacity or condition was appropriately identified or responded to. For two consumers who experienced breathing difficulties, documentation reflected care staff did not escalate the consumers concerns to registered staff in a timely way (one of these consumers had requested to see the medical officer); review by the medical officer occurred 10 and 15 days after the consumers first raised their concerns.

For two consumers who experienced unwitnessed falls with injury to their head (that occurred either in the late afternoon or evening); care documentation identified that while care staff assisted the consumers following the fall, there was no evidence a registered nurse completed a physical assessment for the consumers, conducted falls risk assessments or completed physiotherapist referrals. One of these consumers had two further unwitnessed falls; however, post fall management was not completed as per the service’s clinical pathway. Staff had reported that while registered nurse are available on call for overnight care staff to refer to, post fall management after 4:00pm was not completed as there is no registered nurse on site. Registered nurses advised they are not always notified of consumers falls overnight.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, advised the service has registered nurse coverage 24 hours; the registered nurse is available to come onsite after hours when required. Currently the service is reviewing their staffing model and will consider 24 hour registered nurse onsite coverage. The on call registered nurse is less than 15minutes away from the service and New South Wales ambulance assists in consumer assessment processes. The Approved Provider advised on improvement actions completed and to be implemented, including a review of the service’s deteriorating consumer policy, which is to be provided to staff and the deteriorating consumer protocol is to be discussed at the staff meeting. Staff are to be educated on the importance of advising registered nurses of all consumer’s conversations or adverse findings. The availability of a registered nurse 24 hours for clinical issues, is to be evaluated and all staff are to attend handover.

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified. However, it is my decision that at the time of the site audit, deterioration or change of a consumer’s health, function, capacity or condition was not recognised and responded to in a timely manner. Therefore, 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 was not consistently documented. Communication relating to the consumer’s current or changed care needs was not always occurring within the service, or with others where responsibility for care was shared; care documentation did not provide accurate information to guide staff practice.

For two consumers, care documentation did reflect their care needs around scheduled changes in clinical equipment. For four consumers, care documentation did not identify their changing needs in behaviour management, including triggers and strategies. Management had reported registered staff lacked knowledge of the service’s electronic clinical management system that resulted in shortcomings in consumer care planning and monitoring documentation. The service was unable to provide any documented evidence to verify medical officer’s directives were followed or care plan interventions were implemented.

Staff reported their concerns regarding inadequate communication of consumers care needs; care staff stated the night carer did not provide a thorough handover of what occurred overnight, and registered nurses informed of their concern that while consumer care concerns had been escalated to management, there had been a lack of follow up and/or action by management. Reviewed consumer care documentation demonstrated care staff did not consistently escalate changes in consumers’ condition, or when the consumer experienced a clinical incident, to the registered nurse, the medical officer or management.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, informed of improvement actions implemented and to be implemented, which included all consumers’ care plans are to be reviewed to ensure specified care needs are adequately detailed; as well as the high prevalence high impact risks.

While I acknowledge the actions taken, and to be implemented by the Approved Provider, at the time of the site audit information about the consumer’s condition, needs and preferences was not consistently documented and communicated within the organisation, and with others where responsibility for care was shared. Therefore, it is my decision this requirement is Non-Compliant.

### 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.*

# STANDARD 4 COMPLIANT Services and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Consumers considered that they got the services and supports for daily living that were important for their health and well-being and that enabled them to do the things they wanted to do. Consumers/representatives felt the lifestyle program supported the consumer’s lifestyle needs and staff assisted consumers to engage in additional independent activities of interest. Consumers described the ways in which they were supported to do things within and outside the service and how they kept in touch with people important to them. Consumers felt information about their daily living choices and preferences was effectively communicated and staff who provided daily support understood their needs and preferences. Consumers/representative were satisfied with the variety, quality and quantity of food currently being provided to consumers at the service.

Activities staff responsible for developing the activities calendar regularly sought feedback about activities from consumers/representatives via a variety of mechanisms. Staff provided examples of how consumers were supported to participate in the community and/or keep in touch with the people important to them, including during COVID-19 related visitor restrictions. Activities staff worked with external organisations in the area to supplement the lifestyle activities offered within the service; the service also offered multi-denominational church services, and pastoral carers visited to provide pastoral care to consumers. Staff described a variety of ways in which they shared information and were kept informed of the changing condition, needs and preferences for each consumer. Catering and care staff were aware of the dietary needs of consumers and the Hotel Service Manager attended the monthly consumer meeting and addressed any issues raised relating to the food.

Consumers’ care planning documentation included information about what was important to the consumers and the supports needed to help them do the things they wished to. Care plans contained information about the consumers emotional, spiritual and/or psychological well-being and how staff could support them. Consumers’ care documentation detailed information outlining activities of interest to the consumer and evidenced participation in those activities, as well as information about relationships the consumer wished to maintain. Information about individuals and external services who supported consumers to maintain their interests and participate in the community outside the service was also reflected. Care planning documentation detailed consumer dietary requirements and preferences and this information was available to guide staff practice.

Consumers were observed engaging in a variety of group and independent activities during the site audit, and interacting with each other, staff, family members and visitors. Reviewed monthly activity calendars demonstrated there were a variety of activities offered to meet the different needs and preferences of consumers. The kitchen was observed to be clean and tidy; staff observed food safety and work health and safety protocols. Equipment which supported consumers to engage in lifestyle activities were observed to be suitable, clean and well maintained.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Consumers considered that they felt they belonged in the service. Consumers reported in various ways they felt at home; the service was comfortable and supported their independence and interaction. Consumers/representatives advised they could decorate the consumers’ rooms with personal belongings as they chose. Consumers/representatives were satisfied that the service environment, furniture, fittings and equipment provided were kept clean, well maintained and suitable for the consumer to use.

Staff were aware of consumers’ needs and preferences and were observed to assist consumers to attend activities with directional guidance and physical assistance. Hospitality and environmental services staff described how maintenance and cleaning processes promoted a safe and comfortable environment for consumers and staff; this included maintenance of furniture, fittings and equipment. The Maintenance Service Manager advised on preventative maintenance processes that were monitored and maintained according to an annual schedule; approved external contractors attended regularly to scheduled preventative maintenance such as fire alert/prevention systems and pest control.

The service environment was observed to be welcoming, with signage that enabled consumers and visitors to navigate through the service as well as in the event of an emergency. Staff were observed welcoming and interacting with visitors to the service. Consumers were observed sitting or walking in the communal areas, visiting friends and family in private and communal spaces and attending various activities and events.

While the service environment was clean and well maintained, management was not able to demonstrate the service provided a consistently safe environment for all consumers. This was in relation to the potential of a fire risk due to the smoking habits of one consumer that smoked in none designated smoking areas without the assistance or supervision from staff. Three consumers further reported they felt unsafe in the care of one staff member due to the staff member’s inappropriate behaviours and interactions with consumers.

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.*

While the service environment was clean and well maintained, management was not able to demonstrate the service provided a consistently safe environment for all consumers. This was in relation to the potential of a fire risk due to the smoking habits of one consumer that smoked in none designated smoking areas without the assistance or supervision from staff; and three consumers reported they felt unsafe in the care of one staff member due to the staff member’s inappropriate behaviours and interactions with consumers.

The Assessment Team identified the strong smell of cigarette smoke in a named consumer’s room, observed smoking ash on the consumer’s person and smoking associated paraphernalia in the consumer’s room; a rusted tin was observed outside the consumer’s room which was being used to contain disposed cigarette butts. A risk assessment had been completed in relation to the consumer smoking and management strategies were implemented. However, staff and management had reported that while the consumer was directed to smoke at the designated smoking area and their cigarettes and lighter was retained by staff, the consumer was not always compliant, smoked outside their room, and the consumer purchased cigarettes independently and kept these in their room. Management implemented additional strategies during the audit that included the provision of a fire blanket outside the consumer’s room, screened the consumer’s room for further smoking items and arranged staff to escort the consumer to the designated smoking area.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessment Teams findings. The Approved provider informed of improvement actions conducted since the audit which included the consumer’s smoking risk assessment has been reviewed and updated, all lighters and matches have been removed from the consumers room in consultation with the consumer and their representative, additional supervision and direction is provided to the consumer to ensure smoking is only to occur in the smoking area, an enclosed ashtray has been provided and risk management education has been scheduled for staff.

The Assessment Team brought forward information under this requirement about three consumers who reported that they felt unsafe in the care of one staff member due to the staff member’s inappropriate behaviour and interactions with them; I have considered this under Requirement 1(3)(a).

While I acknowledge the actions undertaken and committed to by the approved provider, at the time of the site audit management was not able to demonstrate the service provided a consistently safe environment for all consumers. Therefore, it is my decision 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-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers/representatives advised they were not consistently encouraged and supported to give feedback and make complaints, that there had been a lack of response undertaken by the service regarding concerns raised, or that appropriate action was not taken. Consumers, their family members and representatives reported they were not aware of external complaints agencies and advocacy organisations and were not sure how to access them. Consumers/representatives were unable to provide examples of improvements made to the service as a result of their feedback or complaints.

Staff advised they were discouraged or instructed to not document complaints in consumer records, instead they were to verbally inform the clinical management of the complaint for investigation and follow up. Staff said consumers and representatives preferred to communicate verbally directly to management or staff regarding complaints. Staff did not demonstrate a consistent awareness of the advocacy and language services available for consumers. Staff stated they had not been provided with training or received information regarding external feedback channels, or how to use them; staff were unaware if consumers were aware of external feedback mechanisms. Care staff advised they were not informed of open consumer/representative complaints and would be unsure where to find the information.

Written material was observed to available to consumers/representatives about advocates and language services through the display of advocacy brochures and the Aged Care Quality and Complaints Commission posters. Feedback forms were available at the entrance of the service along with a locked box to submit them in. However, no other locked boxes were observed to be located throughout the service as the service’s policy required. The service could not demonstrate how it trended or analysed complaint/feedback data to identify service delivery gaps and improve quality of care for consumers. Management reported complaints and feedback are discussed by management with organisational governing body (the Board) via the monthly board report; however, management was not able explain how undocumented verbal complaints are trended and escalated for the Board to review.

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

## Assessment of Standard 6 Requirements

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

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

Consumers/representatives advised they did not feel comfortable, supported or encouraged to provide feedback or make complaints, regarding care delivery and staffing. Four consumers/representatives advised they had complained previously to management and felt their concerns were not taken seriously. Two named consumers expressed concern around providing complaints regarding care provided by, and interactions with, a care staff member. Three representatives explained they were not comfortable in raising complaints at the service due to concerns that their family member’s care would be negatively impacted. Staff advised they were discouraged or instructed to not document complaints in consumer records, instead they were to verbally inform clinical management of the complaint for investigation and follow up. One staff member reported of a complaint they submitted in July 2020 on behalf of a verbal complaint made by named consumer; however, this complaint had not been logged or addressed in the service’s complaint register.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings and informed of improvement actions undertaken and/or planned. These actions included education to be provided to consumers/representatives regarding the feedback process, consumers/representatives and staff are to be provided with reassurance and encouraged to provide feedback. The process for making a complaint/feedback is to be discussed and encouraged, as a standing agenda item at each consumer meeting. A review of staff and consumer handbooks is to be completed to ensure complaints are encouraged, through either internal or external processes.

The Assessment Team observed feedback forms to be available at the entrance of the service along with a locked box to submit them in. However, no other locked boxes were observed to be located within the service as the service’s policy required. The reviewed feedback register of the service for 2021, which contained all complaints from staff, consumers and representatives; contained one complaint lodged on 5 May 2021, which had not been addressed or followed up since lodgement. Management advised verbal complaints were to be investigated by the management; however, acknowledged that verbal complaints and investigations initiated were not always documented and therefore not always followed up.

In its response the Approved Provider informed of improvement actions conducted or to be implemented, which included additional feedback boxes have been placed around the service in areas of less exposure to provide privacy. A review of the feedback/complaints register is to be undertaken to ensure all complaints have been logged, actioned, and feedback given; all complaints are to be closed out when evaluation is satisfactory. Education and a memo were provided to staff to ensure complaints are captured, put in writing and communicated to management; complaints management to be discussed at staff meeting.

While I acknowledge the commitment of the Approved Provider to ensure consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints; this process was not effective at the time of the site audit and will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this Requirement is Non-Compliant.

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

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

Access to advocates, language services and methods of raising complaints were not consistently promoted by the service. The Assessment Team observed written information regarding advocates and language services displayed in the service; this included advocacy brochures and the Aged Care Quality and Complaints Commission posters. However, consumers/representatives reported they were not aware of external complaints agencies and advocacy organisations and were not sure how to access them. Staff did not demonstrate a consistent awareness of the advocacy and language services available. Staff advised they had not been provided training or received information regarding external feedback channels, or how to use them; staff were unaware whether consumers were aware of external feedback mechanisms. Management were not able to state whether staff had received training regarding external feedback mechanisms; however, advised these mechanisms are included in consumer handbooks for consumers and representatives.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, reported there are numerous external complaint posters around the facility. However, external complaint processes will be discussed at the next consumer and representative meeting (July 2021). The Approved Provider advised of further improvement actions to be implemented, which included the process for making a complaint/feedback is to be discussed and encouraged, as a standing agenda item at each consumer meeting; this is to incorporate external advocacy services as well as the Aged Care Quality and Safety Commission. Staff are to be made aware of and be required to read the complaints policy, and training is to be provided to staff on external complaints mechanisms. Complaints management is to be included on the service’s training schedule.

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified. However, it is my decision that at the time of the site audit, consumers were not made aware of or how to access advocates, language services and other methods for raising and resolving complaints. Therefore, this Requirement is Non-compliant.

### 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.*

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standard 1.

The service did not demonstrate appropriate action or open disclosure processes were utilised when an adverse incident impacted the lives of consumers and/or that appropriate action was undertaken in response to all complaints. For one named representative, who received an email acknowledging receipt of a complaint they made in May 2021 regarding a breakdown in communication that had negatively impact their visit with an ill consumer; they informed the Assessment Team they had received no further correspondence.

Two consumers/representatives provided feedback of the lack of response undertaken by the service regarding concerns they raised in relation to the behaviour of a named care staff member. One complainant had been making verbal complaints for over 12 months to management regarding the care staff member’s inappropriate, rough and rude interactions with consumers, but had received no response. While the other complainant’s similar concern, which was raised in April 2021, had been addressed (it was agreed the consumer was no longer to receive care from the care staff member), the complainant had not been provided with an apology regarding their experience. This consumers complaint/incident had not been officially documented, reviewed and managed in line with the service’s complaint or open disclosure policies; nor had this incident being recognised by management as a potential reportable instance of elder abuse in line with the Serious Incident Response Scheme (SIRS) legislation.

Seven staff across the service expressed dissatisfaction with management’s response and processes in managing and responding to written, emailed and verbal complaints regarding the care staff member’s verbally abusive and inappropriate behaviour towards consumers during care delivery. Staff reported in a variety of ways that numerous complaints had been made, complaints were not written down, and no action had been taken in relation to these complaints. The Assessment Team identified the service’s feedback register had contained no logged or documented complaints or concerns that were raised verbally. Management reported they had documented on complaints followed up in a personal diary; however, these complaints were not documented or reported in the service’s complaints register and were not reflected in Board reports.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessment Teams findings. The Approved Provider reported on improvement actions to be implemented, which included a review of the service’s complaints, feedback, open disclosure and discrimination policies; clinical management is to ensure these policies are followed at all times. Complaint documentation is to be managed and maintained in line with policy. Clinical management is to ensure all complaints are logged in the feedback register, actioned as per policy, evaluated when completed and all parties are satisfied with the outcomes; feedback is to be given to all complainants and the feedback register is to be current. Clinical management is to attend training on open disclosure.

While I acknowledge the commitment of the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

The service could not demonstrate improvements made to quality of care and services was initiated and implemented through the review of feedback and complaints. Consumers/representatives were unable to provide examples of improvements made to the service as a result of their feedback or complaints. While consumers/representatives and staff reported making complaints over the past 12 months, the service’s complaint register contained one representative complaint for 2021 (5 May 2021). Management could not demonstrate it trended or analysed complaint/feedback data to identity service delivery gaps and improve quality of care for consumers. While complaints were discussed at Board meetings and Heads of Department meetings, details about the complaint or outcomes from discussions are not documented. The service could not demonstrate what improvements or gaps had been raised by management or the Board, based on consumer/representative feedback.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessment Teams findings. The Approved Provider informed of actions that are to be actioned to address the identified deficiencies, which included consumers are to be updated at all consumer meetings on any improvements that have been made through the feedback mechanisms, and staff are to be advised of all open complaints to manage the complaint, where appropriate. Staff are to be advised and encouraged to follow formal complaint procedures and all verbal complaints are to be documented in formal process and presented to the Board. All meetings where complaints are discussed need to be minuted, with planned actions and outcomes. All complaints are to be trended and analysed, and where appropriate placed on the service’s plan for continuous improvement.

I acknowledge the commitment of the Approved Provider to ensure future feedback and complaints are reviewed and used to improve the quality of care and services; however, this process was not effective at the time of the site audit and will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this Requirement is Non-Compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Most consumers felt they got quality care and services when they needed them and from people who were knowledgeable, capable and caring. However, some consumers/representatives were dissatisfied with the adequacy in numbers of trained staff to provide care and/or services in the afternoon and evening shifts. While consumers/representatives felt most staff were kind and caring while undertaking their duties, and respectful of consumer’s identity and personal preferences, they identified one care staff member who had impacted their well-being and care delivery negatively. Consumers/representatives felt staff were well trained and had the skill and capability to perform their role.

All service staff were recruited in accordance with organisational standards and screened to ensure they are qualified to perform their roles. However, staff reported there were insufficient staff rostered to deliver care and services, especially in the afternoon and on the night shift. Staff expressed concern regarding a care staff member’s inappropriate manner of care delivery and/or interaction with consumers. Care staff advised they had not completed elements of care delivery training; nor had they been provided with any information and/or education regarding the newly legislated Serious Incident Response Scheme (SIRS). While staff demonstrated how they access information and were knowledgeable of their duties and scope of practice on shift; staff had an inconsistent understanding regarding the use of the service’s electronic clinical management system.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful way. Reviewed personnel files demonstrated staff and management had completed performance appraisal forms, and documented staff performance and areas of improvement. However, management were unsure how to access a copy of the service’s online training records, and the Assessment Team was unable to verify the education provided to staff and their relevant completion rates. The monitoring and review of one care staff member had not been consistent following allegations of inappropriate behaviour and interactions with consumers, while providing care.

The Quality Standard is assessed as Non-compliant as four 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 could not demonstrate how its workforce is planned to enable the delivery and management of safe and quality care and services. Consumers/representatives reported dissatisfaction with the adequacy of numbers of trained staff to provide care and services during the afternoon and evening shifts; this impacted negatively on the timely delivery of care and services for consumers and wait times for visitors wanting to gain access to the service. Staff, which included care, clinical and kitchen staff, reported there was insufficient staff rostered to deliver care and services in a timely way; this included timely provision of meals. Staff said this specifically occurred in the afternoon, when two care staff were rostered at the service and on the night shift when one care staff was rostered; staff were concerned in their ability respond to multiple consumers’ request for assistance and to follow up when clinical incidents occurred after 4:30pm when the registered nurse shift ended. While a registered nurse was on call overnight (4.30pm to 6.00am) the Assessment Team identified a variability in the registered nurses response times evidenced by post-fall observations of consumers, not been consistently conducted in a timely way.

While the service had a dedicated staff roster and undertook ongoing recruitment, management could not demonstrate how the roster or staff allocation was reviewed to reflect consumer care needs, and/or consumer feedback, to ensure there were adequate staff to provide care for consumers based on their acuity and requirements overnight. While management advised they investigated call bells over 10 minutes, they could not demonstrate what investigations had taken place or what actions had been implemented to address specific instances. The Assessment Team observed that the meal service across all days of the audit was provided later than scheduled (between 20 to 45 minutes late); consumers had expressed their dissatisfaction with the timing of the food service at consumers meeting in May 2021 saying this was an ongoing issue.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider provided information on improvement actions to be taken, which included a review of the service’s base roster is to be completed (August 2021) with the intention to increase staffing numbers to include additional overnight care staff, additional registered staff to provide on call cover and additional catering hours to ensure meal delivery can be managed on time; the service will recruit into these roles/increased hours. A review of the call bell policy will be done to ensure time frames are acceptable for call bell response times; staff will be provided with the call bell policy to read. Staff will also receive training on call bell response times.

Following complaints made in relation to the verbally aggressive behaviour of a care staff member, two named consumer had requested that the care staff member not provide them with care; which was agreed to by management. However, while management informed the Assessment Team during the audit that the care staff member will no longer be working by themselves (27 May 2021), the Assessment Team had identified the care staff member had been rostered for night duty on three occasion following this date, where the care staff member would work alone and unsupervised by either a registered staff member or accompanied by another care staff member. Management was further aware that the care staff member went home out of the service for lunch and dinner whilst on shift; management acknowledged the staff member was not monitored to ensure they returned within the allocated break-time, or that they would be readily available in the event of an emergency occurring. In its response the Approved Provider noted a review of working shifts for the care staff member will be undertaken, changing their night shifts to day shifts only where there is supervision as well as allowing all consumers’ options of who delivers care. Further performance management is to be conducted with the care staff member who leaves the facility unattended to go on a break.

While I acknowledge the commitment of the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1 and 6.

The service was not able to demonstrate workforce interactions with consumers were consistently kind, caring and respectful. While consumers/representatives reported most staff were kind, caring and respectful, three named consumers/representatives provided feedback about one care staff member whose interactions with consumers had been inappropriate. The consumers/representatives provided detailed information about the care staff member’s poor demeanour and attitude, yelling at consumers and being rough during care; this had been an ongoing issue which had resulted in two of the consumers refusing care delivery from the care staff member. While consumers/representatives had reported this behaviour to management, no further action had been taken to address these allegations. Seven staff across the service had expressed concern regarding the care staff member, who demonstrated behaviour that was unkind, rude and dismissive to consumers during care delivery.

In its written response, and through the provision of the service’s plan for continuous improvement, the Approved Provider informed of improvement actions taken and to be implemented. The approved Provider reported that due to the context of the complaint, the matter has been referred to an external Human Resources consulting firm for review, and a review of service’s disciplinary processes is to be conducted, especially where it impacts on consumers. Management of the care staff member is to be revisited and reviewed; the care staff member’s performance is to be monitored and they are to receive training in all areas across Standard 1 as well as complaints management. Management is to receive mentoring and training on performance management and further training is to be provided to staff in regard to dignity and respect and elder abuse.

I acknowledge the actions taken and planned by the Approved Provider to address the deficiencies identified. However, it is my decision that at the time of the site audit, workforce interactions with consumers were not consistently kind, caring and respectful. Therefore, this Requirement is Non-compliant.

### 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.*

Management was not able to demonstrate the workforce is trained and equipped to deliver the outcomes required by these Standards. Consumers/representatives stated staff were well trained and had the skill and capability to perform their role. While staff advised they received reminders to complete their mandatory training, staff were unaware on any additional training provided by the service. Staff stated they had not completed training regarding falls management, clinical deterioration and behaviour management; nor had they been provided with any information and/or education regarding the newly legislated Serious Incident Response Scheme (SIRS), which commenced 1 April 2021.

Management had acknowledged that actions around the management and monitoring of staff training had been inconsistent; they advised the staff member recently appointed to the role worked one day a week at the service. As management were not able to access the service’s online training records, the Assessment Team were unable to verify the education courses provided to staff or their relevant completion rates. Staff had an inconsistent understanding regarding the use of the service’s electronic care management system; during the audit, management arranged for additional training for staff with the care software service provider. Management advised the service had experienced ongoing difficulty in recruiting clinical management (an Assistant Director of Nursing), to be based at the service and to provide clinical oversight.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider advised of improvement actions to be implemented, which included the review and development of the services training schedule to include issues raised by the Assessment Team during the audit. A review of all staff training records is to be undertaken to determine staff training needs in the required areas. The allocation of one staff member to maintain training records and investigate how training records can be obtained as required. The Approved Provider has contracted the service of a national aged care peak body to deliver identified training needs on site and remotely. All staff are also to receive training in the use of the service’s electronic clinical management system, as well as training in SRS and comprehensive training in Dignity and Respect.

While I acknowledge the commitment of the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

In coming to a decision on compliance for this Requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this and other Quality Standards, including Standards 1 and 6.

While the service undertook regular formal performance reviews for most of its staff, the lack of ongoing monitoring and review of one named care staff member’s performance, following allegations of verbal aggression and inappropriate care delivery to consumers; reflected the service was not adequately able to demonstrate that the performance of each member of its workforce is monitored and reviewed.

Management stated all staff were required to attend annual performance reviews, which could be expedited due to an increase in incidents or issues with performance. Staff were aware of the service’s performance appraisal process, which involved scheduling a time with service management for review and completion of a self-assessment. Newly employed staff explained the staggered performance review process during their probationary period. Reviewed personnel files demonstrated staff and management had completed performance appraisal forms, documented staff performance and areas of improvement. However, in relation to the allegations of inappropriate behaviour and interactions made by consumers and staff in relation to one care staff member, clinical management were unable to demonstrate how the service addressed these ongoing allegations or monitored and reviewed the care staff member’s performance. Clinical management had acknowledged that the care staff member was not monitored when they were rostered to work alone on the night shift.

The Approved Provider in its written response reported the care staff member had been subject to workplace bullying, harassment and had been falsely accused of allegations which originated from a workplace/staff dispute that had initially occurred in June 2020. The Approved Provider noted the outcomes of these allegations had been investigated by an external Human Resource firm who, the Approved Provider stated, had determined there was nil substance to these allegations. As part of its response the Approved Provider provided information regarding a Recommendations Brief following preliminary Assessment of Workplace Complaint (undertaken 3 August 2020), demonstrating investigations/discussions had been commenced in relation to this workplace dispute. However, I note that in its response the Approved Provider has not provided any supporting information to demonstrate how the service investigated, addressed and/or managed the care staff member’s performance; following the more recent concerns raised, and allegations made of inappropriate behaviour and care delivery provided of the care staff member, by the consumers/representatives during the audit.

Through the provision of the service’s plan for continuous improvement, the Approved Provider reported on improvement actions the service is to implement, which included the commencement of further monitoring and management of the care staff member; which is to incorporate a review of the roster and removal of the care staff member off the night shift. Training is to be provided to the care staff member on topics such as dignity and respect, elder abuse and SIRS, together with the relevant policies, and performance management processes for the staff member are to be reviewed.

While I acknowledge the actions implemented by the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

# 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

Consumers/representatives confirmed they engaged with management and staff during consumer meetings and surveys regarding their experience at the service. However, consumers/representatives advised of their concerns regarding how the organisation was run; consumers/representatives felt management of the facility was inconsistent as it was shared across the service and the organisation’s other collocated aged care service/site. Consumers/representatives said they did not feel supported or encouraged to provide feedback or make complaints.

The organisational governing body (the Board) met regularly to review ongoing operations and identified risks from an organisational and consumer perspective. There were organisation wide-governance systems and a business growth strategy to monitor service operations and structure improvements to improve business sustainability. All operations were reviewed by the organisation’s quality team to support and align activities with regulatory requirements, to deliver safe and quality care.

However, due to gaps in the reporting of clinical incidents, mandatory reporting and complaints, the Board was being provided with incomplete data for consideration when promoting a culture of safe, inclusive and quality care. The service’s governance system was ineffective in addressing concerns around workforce governance, regulatory compliance and feedback/complaints. The service’s risk management practices had not identified or responded to allegations of elder abuse, nor did it reflect aspects of Serious Incident Response Scheme (SIRS) legislation. The service could not demonstrate it had an effective clinical governance framework, which was effective in identifying and responding to clinical incidents to mitigate consumer impact; and how it practiced open disclosure as part of care delivery.

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

## Assessment of Standard 8

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

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

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

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

Management provided monthly reports to the Board detailing results in relation to incidents, clinical indicators, complaints from external agencies, human resources and staff training; anti-psychotropic medication use and chemical restraint management, and mandatory reporting. However, reports provided were incorrect and/or incomplete, specifically in relation to complaints made about staff behaviour and reportable incidents which have occurred, but that were not reported or documented. The service had drafted an incident policy to reflect SIRS legislation. However, the service could not demonstrate how they had amended their incident management system; in relation to defining roles and responsibilities of staff, informing staff, consumer, families and representatives regarding the changes, and providing education on the incident management system to consumers, staff, management and the Board in line with legislation. While the service had provided mandatory training to staff on elder abuse, it could not demonstrate how it had informed staff on the new reportable incidents requirements, which encompassed wider scope/description of what constituted abuse, including psychological abuse.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider informed of improvement actions commenced and to be implemented, which included the engagement of the services of a national aged care peak body to assist with the review of the clinical governance framework. Work in progress encompasses a review of the clinical monitoring systems and framework, review of the service’s policies and procedures, mentoring and support to be provided by the national aged care peak body and clinical governance education is to be scheduled with the Board. Education scheduled for staff to include clinical governance, root cause analysis, open disclosure, and roles and responsibilities of registered nurses.

I acknowledge the actions commenced and to be implemented by the Approved Provider to address the deficiencies identified. However, it is my decision that at the time of the site audit, the organisation’s governing body was not supported or provided with accurate information to assist them in promoting a culture of safe, inclusive and quality care and services. Therefore, this Requirement is Non-compliant.

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

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

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

While the organisation was able to demonstrate effective information management, continuous improvement and financial governance processes; systems and process relating to management of regulatory compliance, workforce governance and feedback and complaints were not ineffective. Management were unable to demonstrate how the organisation tracks changes to aged care law and communicates these to staff. While the service’s policies had been updated to reflect incident management in line with SIRS legislated requirements (on 19 March 2021), the service was unable to demonstrate the change to the incident report processes had been implemented, that they had notified all consumers/representatives and staff, and that staff had received training in relation to the new requirements as well as their roles and responsibilities. With the allegations of potential elder abuse made by two named consumers regarding the behaviour of a care staff member, management did not follow legislative requirements, or the service’s elder abuse policy, and implement appropriate actions; including immediately ensuring the safety of the consumer, documenting further actions they were to take and undertaking mandatory reporting within 24 hours.

Workforce governance had not ensured there was enough staff to ensure the delivery of safe and quality care and services. Workforce interactions with consumers was not consistently kind, caring and respectful of each consumer’s identity, culture and diversity; due to the inappropriate behaviour of one care staff member. Training of the workforce was inconsistent; staff were not provided with training reflective of consumer needs and changes to legislation regarding SIRS. The monitoring and review of performance for one care staff member had not been consistent following allegations of inappropriate behaviour while the care staff member provided consumer care. Consumers/representatives did not feel supported and encouraged to provide feedback and make complaints, or that management consistently responded to their feedback. Consumers/representatives were unable to provide examples of changes to the service based on their feedback. Consumer's feedback/complaints were not consistently documented or trended to initiate continuous improvement processes While the service had an open disclosure policy and procedure, management could not demonstrates how it had been used in response to adverse incidents.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider provided improvement actions commenced and to be implemented, which included the engagement of the services of a national aged care peak body to assist with the review of the clinical governance framework. Work in progress encompasses a review of the clinical monitoring systems and framework, review of the service’s policies and procedures, mentoring and support to be provided by the national aged care peak body and clinical governance education is to be scheduled with the Board. Education scheduled for staff to include clinical governance, root cause analysis, open disclosure, and roles and responsibilities of registered nurses.

I have taken into consideration the Assessment Teams report, the Approved Providers response and my findings in relation to Standard 1, Standard 2, Standard 3, Standard 5, Standard 6, Standard 7 and Standard 8; which demonstrate that these governance systems were not effective at the time of the site audit. While I acknowledge the commitment of the Approved Provider to address the deficiencies identified, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

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

While the service could demonstrate it had a risk management framework, it had not been effective in identifying ongoing issues pertaining to allegations of elder abuse nor it did not support two named consumers to live the best life they could.

The organisation had policies describing how the abuse and neglect of consumers was identified and responded to. However, the organisation was not able to demonstrate an understanding of the changed definition/legislation in relation to consumer abuse and neglect, and SIRS reporting requirements. A monthly facility report was provided monthly to the Board that included clinical incidents, mandatory reports and clinical indicators. However, management were unable to demonstrate how the organisation analysed clinical incident results to determine gaps in clinical care, or strategies and directives to address these. The Assessment Team had identified two instances of unreported allegations of elder abuse made by two named consumers. Investigations and outcomes of these allegations were found to remain the personal diary of management and did not feature as incidents; documented on incident forms, recorded in the mandatory reporting register or as part of the monthly Board report.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider advised the service had recently engaged the services of an external Human Resources company to provide human resource support with staff performance issues raised in complaints. A national aged care peak body has also been engaged to assist with the review of the risk management framework of the organisation and to provide mentoring and support. The allegations of elder abuse made by two named consumers are under recent investigation.

I acknowledge the improvements actions commenced and to be implemented by the Approved Provider to address the deficiencies identified; however, these improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

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

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

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

Management and staff could demonstrate how they supported antimicrobial stewardship and minimising the use of restraint as part of care delivery. However, the lack of effective clinical monitoring and analysis in response to clinical incidents and an inconsistent open disclosure process, demonstrated the service did not have an effective clinical governance framework that monitored clinical care delivery.

The Assessment Team found deficiencies in consumer post-fall management and diabetic management, and response to clinical incidents had not been effectively identified, monitored or reviewed to implement corrective changes to address care delivery gaps. The service was unable to demonstrate open disclosure policy requirements were followed in response to clinical incidents and allegations of abuse; staff did not demonstrate an understanding of open disclosure. There were inconsistent review processes and a lack of analysis regarding call bell reports, clinical incidents, mandatory reporting and complaints, which reflected the service’s clinical governance framework was ineffective; this included the lack of corrective actions taken following increases in clinical incidents such as unwitnessed falls.

The Approved Provider in its written response, and through the provision of the service’s plan for continuous improvement, did not disagree with the Assessments Team’s findings. The Approved Provider informed of improvement actions commenced and to be implemented, which included the engagement of the services of a national aged care peak body by the organisation to assist with the review of the clinical governance framework. Work in progress encompasses a review of the clinical monitoring systems and framework, review of the service’s policies and procedures, mentoring and support to be provided by the national aged care peak body and clinical governance education is to be scheduled with the Board. Education scheduled for staff to include clinical governance, root cause analysis, open disclosure, and roles and responsibilities of registered nurses.

While I acknowledge the actions implemented by the Approved Provider to address the deficiencies identified by the Assessment Team at the time of the site audit, improvements will require time to be implemented and evaluated for effectiveness. Therefore, it is my decision this requirement is Non-Compliant.

# Areas for improvement

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

* Each consumer is to be treated with dignity and respect, their identity and culture valued.
* Assessment and planning is to include consideration of risks to consumers.
* Care and services are to be reviewed regularly for effectiveness.
* Each consumer is to get safe and effective personal and clinical care that optimises their health and well-being.
* Effective management of high impact or high prevalence risks.
* Deterioration or change of a consumer’s health or condition is recognised and responded to in a timely manner.
* Information about the consumer’s condition, needs and preferences is to be documented.
* The service environment is to be safe.
* Consumers and others are to be encouraged and supported to provide feedback and make complaints.
* Consumers are to be made aware of advocates, language services and other ways for raising complaints.
* Appropriate action is to be taken in response to complaints and an open disclosure process is used.
* Feedback and complaints are reviewed and used to improve the quality of care and services.
* The workforce is planned to enable the delivery and management of safe and quality care and services
* Workforce interactions with consumers are kind, caring and respectful.
* The workforce is trained, equipped and supported to deliver the outcomes required by these standards.
* Regular monitoring and review of the performance of each workforce member is undertaken.
* The organisation’s governing body promotes a culture of safe and quality care and services and is accountable for their delivery.
* Effective organisation wide governance systems are to be established that include management of regulatory compliance, workforce governance and feedback and complaints.
* An effective risk management that includes managing high impact or high prevalence risks and that identifies and responds to abuse and neglect of consumers.
* A clinical governance framework that includes open disclosure.