Minda Nursing Home

Performance Report

12-16 King George Avenue   
NORTH BRIGHTON SA 5048  
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**Commission ID:** 6011

**Provider name:** Minda Incorporated

**Review Audit date:** 26 February 2020 to 28 February 2020

**Date of Performance Report:** 11 May 2020

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Non-compliant |
| Requirement 6(3)(c) | 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) | Non-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 Review Audit; the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Review Audit report received 3 April 2020
* the Assessment Contact – Site Report for the Assessment Contact conducted 10 to 11 February 2020.

# 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

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

The Assessment Team found the service not met in relation to Requirement (3)(f) in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with Requirement (3)(f) in this Standard and have provided reasons for my decision under this specific Requirement.

The Assessment Team found most sampled consumer representatives confirmed consumers are treated with dignity, respect and maintain identities of consumers. Specific comments from representatives include:

* A representative said when they have spoken with management and staff about their consumer, conversations have demonstrated a respectful manner and recognition of the consumer as an individual.
* Representatives indicated consumers’ culture and diversity is valued and respected.
* Representatives said consumers are supported to maintain relationships, including being supported to be prepared for outings and trips away.
* Representatives said they are informed of risks that occur and actions that taken to minimise risk.

The Assessment Team interviewed a sample of staff which indicated respect and an understanding of consumers’ personal circumstances and life journey. However, one staff member has been kind and respectful in all interaction with one consumer, see Standard 7 Requirement (3)(b) for further information. Staff were able to demonstrate a familiarity with consumers’ backgrounds, likes and dislikes and how this influences the delivery of care and services.

The Assessment Team reviewed a sample of consumers’ files and found care planning documents reflected what is important to consumers. Records also include details of consumers’ representatives and includes appointed and key decision makers.

The Assessment Team observed staff interacting with consumers respectfully and greeting consumers by using their names. Staff were observed explaining their actions and surroundings to consumers who have difficulty communication or who are living with a cognitive impairment.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
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) Non-compliant

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

The Assessment Team found the service was unable to demonstrate consumers’ personal information is kept confidential. The Assessment Team provided the following findings and evidence relevant to my decision:

* Consumers’ clinical information and care plans are not securely stored and accessibility to documents is not monitored.
* Management said they were currently investigating ongoing issues in relation to information going missing from consumer files.
* Management stated they have placed clinical files securely in a key-coded nurses’ station which only management and clinical staff can access. They also stated care plans are stored securely in locked cupboards in each wing of the service. A regular direct support worker has the responsibility of holding the key to these cupboards.
  + The Assessment Team observed processes to secure consumers’ personal information are not being effectively implemented:

Four staff (who were not management or clinical staff) were observed to enter the key-coded nurses’ station using the code.

On three separate occasions the key to the cupboard which contained care plans was left hanging on a hook next to the cupboard, visible to staff and others.

On one occasion staff were unable to locate a key to a cupboard containing care plans because a direct care worker had completed their shift and left without handing the key over.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The access code to the nurses’ station has been changed and an access code register has been implemented.
* Access to the area storing consumers’ clinical records has been restricted to the service’s staff.
* Consumer care plans will be stored in each house for ready access for staff at point of care delivery.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure consumers’ personal and sensitive information was stored in manner to protect the privacy and confidentiality of this information.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 1 Requirement (3)(f).

# 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

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

The Assessment Team found the service not met in relation to all Requirements in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with all Requirements in this Standard and have provided reasons for my decision under each specific Requirement.

The Assessment Team found that some consumer representatives interviewed feel like partners in the ongoing assessment and planning of consumers’ care and services. Three representatives said they have their consumers’ care needs discussed but have not viewed a care plan.

The Assessment Team found the service does not consistently ensure assessment and planning processes consider risks to consumers’ health and wellbeing or that care and services are reviewed when changes to consumers’ health, circumstances or preferences occur. The Assessment Team found consumers’ care plans do include information to guide staff in the provision of care, but care plans do not always contain sufficient information, are not always up-to-date or accessible to relevant staff.

The Assessment Team found appropriate assessments and care plans have not been completed for consumers requiring palliative care or these processes have not been completed in a timely manner.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found the service was unable to demonstrate consideration of risks to consumers’ health and wellbeing is consistently identified and planned for during assessment and care planning processes. The Assessment Team provided the following findings and evidence relevant to my decision:

* Management said five consumers who either have experienced a recent choking incident and/or had a diagnosis of aspiration pneumonia are not to have agency staff assist consumers to eat their meals because regular staff have better knowledge of consumers’ swallowing difficulties. However, this strategy to manage these consumers’ risk has not been documented in these consumers’ nutritional support plans.
* A consumer who returned from hospital with an indwelling urinary catheter did not have a continence assessment or care plan developed to guide staff in the effective management and care of the catheter.
  + The service uses a folder which contains information in relation to the management of consumers’ specialised nursing, including urinary catheter management. However, this folder did not contain any information about the care required for this consumer’s catheter.
* Registered nursing staff are completing twice daily checks for two consumers to ensure they are wearing identification bracelets because they have been identified as being at-risk of wandering outside the service and had previously had incidents where they had left the service unaccompanied. However, the service has not assessed this risk or documented associated strategies in care plans, including the use of identification bracelets.
* The Assessment Team identified in two consumers’ progress notes indications the consumers were experiencing new or increased pain. However, the service was unable to demonstrate a pain chart was completed as per the service’s pain assessment processes.
* The service uses two pain charting tools and staff are not consistency or accurately using the tools because they are scoring pain differently for the same occurrence of pain for individual consumers.
  + support staff to assess and manage pain. Management said they are in the process of developing a pain chart which would better

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* All consumers are under active review in relation assessment and planning, including the identification and assessment of risk associated with care and relevant treatment/management plans developed.
* The service has re-initiated the high-risk resident framework which includes weekly meetings with management to monitor and discuss strategies to support consumer care and services, including documenting management and monitoring strategies.
  + All relevant consumers have been added to the service’s high-risk register.
* Risk treatment plans will be located at the front of consumers’ care plans and highlighted on the daily handover sheet.
* Staff practices will be audited to ensure compliance with assessment and planning processes.
* A system review of the management of consumers’ specialised nursing care needs is planned to be undertaken to ensure staff have access to appropriate care plan documentation to support the delivery of this care.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure assessment and planning processes effectively considered or planned for risks to consumers’ health and wellbeing, to support the delivery of safe and effective care for consumers.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(a).

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

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

The Assessment Team found the service was unable to demonstrate assessment and planning processes identify and address consumers’ needs, goals and preferences, including the development of palliative care plans. The Assessment Team provided the following findings and evidence relevant to my decision:

* Three consumers who were assessed and considered as requiring palliative care did not have their care plans updated or a palliative care plan developed in accordance with the service’s policy and procedure.
  + One consumer was considered by the service to be palliating for several months and did not have their pain management needs adequately planned for or addressed during this period.
* The service does not have a process to monitor and document end of life care to support appropriate assessment and planning for individual consumers who require a palliative approach to care or who are in the terminal phase of life.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The service plans to implement palliative care procedures.
* All current consumers are being reassessed and care plans revised and updated accordingly.
* The assessment template has been amended to facilitate consumer engagement and establishment of consumer goals.
* A morning meeting held three times a week with clinical staff and management has commenced to facilitate a clinical update.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure assessment and planning processes effectively considered or planned for consumers’ end of life needs and preferences which has impacted on the delivery of appropriate and adequate end of life care.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(b).

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

*The organisation demonstrates that assessment and planning:*

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

The Assessment Team found the service was unable to demonstrate assessment and planning processes is based on ongoing partnership with consumers and/or their representatives. The Assessment Team provided the following findings and evidence relevant to my decision:

* Three representatives interviewed said they had not been consulted in relation to their consumer’s assessment and planning. They indicated the service had not discussed the care needs of consumers with them or viewed a care plan.
* Care plan documentation for a consumer does not demonstrate clinical staff consulted and planned for a consumer’s care following a significant decline in health, including palliation needs and preferences.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Consumers and their representatives will be formally advised to participate in assessment, care planning and review processes.
* Guidelines in relation to assessment, care planning and review processes will be updated to include consumer/representative involvement.
* The behaviour care plan template has been reviewed to ensure that each consumer has a behaviour care plan for each identified behaviour.
* A new auditor is to be appointed to monitor compliance between staff practices and procedures.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure assessment and planning processes are based on ongoing partnership with consumers and/or representatives, including supporting and encouraging active participation in these processes. In coming to my decision I have relied upon the representative feedback provided to the Assessment Team and find this feedback highly relevant due to all consumers residing the service having a diagnosis of either an intellectual disability or cognitive impairment at the time of the Review audit.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(c).

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

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

The Assessment Team found the service was unable to demonstrate assessment and planning processes are documented in care plans and are readily available to support staff to provide care. The Assessment Team provided the following findings and evidence relevant to my decision:

* Two consumers in the palliative phase of life did not have a care plan to reflect the consumers’ needs, goals and preferences.
* Care plan documentation is not always readily available for all staff, predominately agency staff, to support safe and effective delivery of care.
  + One agency staff member interviewed said they did not have access to care plans.
  + One agency staff member stated they did not have access to care plans for most of the shift because staff were unable to locate keys to the cupboard where they are stored.
* Nursing staff interviewed were unable to describe processes used to communicate the outcomes of care planning with representatives because they are new to their role and have not recently conducted care reviews.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* All current consumers are being reassessed and care plans revised and updated accordingly.
* The assessment template has been amended to facilitate consumer engagement and establish consumer goals.
* Care plans are located in a secure position in each house, however, are accessible to relevant staff.
* Recommenced a handover folder to alert staff to changes to consumers’ care needs, including mobility needs.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure the outcomes assessment and planning processes are documented in the care plan or care plans reflect consumers’ current needs, goals and preferences. Care plans were also not readily available to support care staff to deliver safe and effective care.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(d).

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

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

The Assessment Team found the service was unable to demonstrate care and services are reviewed regularly for effectiveness, when circumstances change or when incidents occur which impact upon consumers’ needs and preferences. The Assessment Team provided the following findings and evidence relevant to my decision:

* Three consumers care was not reviewed when changes to their pain was identified.
* Two consumers did not have their physical and mental health needs reviewed following an incident of sexual assault.
* Six consumers did not have their risk of choking reviewed following incidents.
* Nursing staff interviewed who are responsible for regular care review of consumers’ care were unable to describe how and when care plans are reviewed. They stated there is a care plan review schedule, however, many care reviews are not up-to-date.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* All current consumers are being reassessed and care plans revised and updated accordingly.
* The weekly high-risk management meeting has recommenced.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure care and services regularly for effectiveness, or when consumers’ care needs change following incidents, including significant incidents, or a change in health status.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(e).

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team found the service not met in relation to all Requirements in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with all Requirements in this Standard and have provided reasons for my decision under each specific Requirement.

The Assessment Team found some consumer representatives interviewed did not consider consumers receive personal or clinical care which is safe and correct for each consumer. Two representatives were not satisfied the service escalated or reviewed their consumers’ changes in health in a timely or effective manner and were not satisfied their consumer received the care they needed.

The Assessment Team found the service did not ensure each consumer received clinical or personal care in accordance with their needs or best practice. The Assessment Team found consumers’ health and wellbeing has been impacted by the lack of appropriate or timely care. Additionally, the service has not managed the risks associated with the care of each consumer or escalated changes or deterioration in consumers’ health status in a timely manner.

The service’s palliation and end-of-life care processes have not been effective in ensuring consumers’ comfort is maximised at the end of life, or that consumers’ preferences and wishes are effectively delivered during the palliation and terminal phase of life. Additionally, ineffective information management systems has impacted on the correct and effective communication of consumers’ current health status within and outside the service.

The Assessment Team found the service has not effectively implemented policies and procedures to guide staff practice in relation to the monitoring and minimisation of antibiotic prescription and use.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service was unable to demonstrate each consumer gets safe and effective personal or clinical care which is tailored to consumers’ needs, is best practice or optimises consumers’ health and wellbeing. I have also considered evidence presented by the Assessment Team who conducted an assessment contact on 10 and 11 February 2020. The Assessment Teams provided the following findings and evidence relevant to my decision:

* Staff interviewed stated issues with the service’s medication management system has caused them to administer medications without access to the prescribed order. This includes the administration of high-risk medications and drugs of dependence.
  + Management said there are hardcopy medication charts and spare medication tablets available to use when the system is having issues such as being off-line.
* Documentation shows two consumers’ catheter changes are not always attended in accordance with medical officer directives.
  + One consumer had their catheter changed on four occasions in an approximate three-month period but the catheter should have only been changed once in this period, in accordance with medical officer directives or three-monthly changes. Management and clinical staff were unable to provide a reason for two of the four changes and the Assessment Team found the consumer was commenced on antibiotics following the fourth change in three months.
  + One consumer’s catheter change periods are inconsistent in the consumer’s care plan and the catheter change record. Staff are not consistently adhering to either catheter change routine or documenting routine observations at each change in accordance with the service’s procedure.
* Documentation shows three consumers’ percutaneous endoscopic gastrostomy tubes (PEG) have not been monitored weekly for an approximately seven-week period, in accordance with the service’s procedure to ensure the PEG has sufficient fluid levels to maintain the positioning of the PEG.
* Observations and staff interviews demonstrate three consumers are not receiving pressure area care in accordance with their care plans.
  + Three consumers care plans directs they should receive pressure area care every two to three hours.

The Assessment Team observed these three consumers to be sitting in comfort chairs for three continuous hours. Staff interviewed confirmed the consumers had been sitting in the chairs two hours prior to the Assessment Team’s observations. The Assessment Team observed the consumers to not receive any pressure area care during their observation.

* Care staff interviewed said consumers will be in the comfort chairs for five or six hours each morning before being transferred back to bed and they will try to change the consumers’ positions, however, consumers are not provided pressure area care in accordance with their assessed needs.

One of these three consumers have pressure area injuries to both feet which are ongoing and not healing.

* Documentation shows four consumers are not receiving wound management or reviews in accordance with the service’s processes and wound care directives and/or best practice guidelines.
  + One consumer has not had their wound reviewed weekly in accordance with the service’s processes or had their wound dressing changed in accordance with the medical officer directive.
  + One consumer has not had their wound dressed in accordance with wound specialist recommendations.
  + One consumer had not had their wound dressing attended daily in accordance with the wound care regime. The wound management chart shows in an approximate six-week period, the consumer’s wound was only attended every two to three days on five occasions in this period. Additionally, there was no wound chart for one wound and wound reviews are not always occurring on a weekly basis.
  + One consumer has not had bruising monitored in accordance with the service’s process or the consumer’s daily directive. The bruised area is to be monitored daily, however, the wound treatment chart shows the area has only been monitored approximately every three days in a week period.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The registered nurse is conducting a daily morning briefing session with direct support workers.
* Staff allocations in each house have been reviewed to ensure consistency of staffing throughout the shift.
* Ninety percent of registered nursing staff have completed medication management competencies which includes the management of drugs of dependence. Additionally, staff are to be re-trained in relation to the electronic medication management system.
* A whiteboard has been established in the nurses’ station with details of consumers’ specialised nursing care needs and relevant due dates.
* Plan to develop specialised clinical champions to support complex care needs.
* A wound care chart audit has been conducted and a wound care folder has been developed for both areas, with a registered nurse allocated the responsibility of overseeing wound care management in their area.
* A top to toe skin assessment for all consumers has been completed.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure consumers received clinical or personal care in accordance with best practice, consumers’ needs or which optimised their health and wellbeing. I am specifically relying upon evidence indicating the service’s failed to administer medications and manage specialised nursing care needs in accordance with best practice guidelines, or provide care in accordance with plans of care.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(a).

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

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

The Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. I have also considered evidence presented by the Assessment Team who conducted an assessment contact on 10 and 11 February 2020. The Assessment Teams provided the following findings and evidence relevant to my decision:

* Two representatives interviewed are not satisfied the service are effectively managing consumers’ pain.
* At the assessment contact the Assessment Team found while staff were providing pain management interventions for a consumer, these interventions were not always effective, and the consumer was in significant pain, on a daily basis, as evidenced by screaming.
  + Staff interviewed described the consumer’s pain as “terrible”, “horrendous”, “scream from the pain”, and “is worse when the nurses do his dressings”. Staff stated this has been ongoing for “months” and occurs “several times a day, most days”.
  + Progress notes in an approximate week period show staff do not review the effectiveness of ‘as required’ medication or follow-up with further pain management interventions when ‘as required’ medication has not been effective.

Progress notes show staff are not always considering pain as a trigger for agitation and progress notes in this period describe the consumer as ‘groaning, frightened, yelling, grimacing, confused, restless and anxious’.

* + At the Review audit, approximately two weeks after the assessment contact, the Assessment Team found this same consumer continued to not have their pain managed which impacted on the consumer’s comfort and well-being.

While the consumer had a palliative care review following the assessment contact, which resulted in an increase in ‘as required’ pain and sedation medication prior to dressings, the service was unable to locate pain charting to monitor the efficacy of these changes.

Staff have not consistently reviewed or escalated the consumer’s pain to the medical team when ‘as required’ medication was noted to only have a mild or moderate effect on four occasions following the pain medication changes.

Staff interviewed stated the consumer’s pain continues to be unmanaged and the consumer screams in pain at times.

Clinical staff stated when attending to the consumer’s dressing that despite giving the consumer pain relief, the consumer was “screaming during wound care”. The clinical staff member said they were almost crying because it was so hard listening to the consumer’s screams. Another clinical staff member indicated this consumer was the highest risk due to the consumer always being in pain and palliating.

* At the assessment contact the Assessment Team found a consumer had a fall which caused a fracture requiring surgical intervention. However, the consumer was not transferred to hospital for treatment of the fracture until six days after the fall.
  + Progress notes and pain charting show staff did not assess or manage the consumer’s pain following the fall but did indicate non-verbal signs of pain were observed. However, this did not trigger a review of pain or transfer to hospital.
  + Email conversations between management and staff the day following the fall indicate the consumer may have sustained an injury ‘something more serious than a bruise’ and indicated the possibility of a medical review. However, a medical review did not occur until two days later, with a further three-day delay in obtaining an x-ray as requested by the medical officer. The consumer was transferred to hospital for treatment and underwent a surgical procedure to rectify the injury sustained because of the fall.

Email correspondence indicates management were aware of the consumer’s challenging behaviours.

* + At the Review audit, the Assessment Team found the consumer’s pain continued to be unmanaged and not effectively monitored.

The service was unable to locate any pain charting for the consumer following the assessment contact. A progress note indicated the consumer had pain in relation to their fracture, however, no pain relief was provided.

Staff interviewed did not consider that the consumer’s responsive behaviours could potentially be related to pain. Staff statements include:

* The consumer will “often scream or yell, this is normal behaviour”.
* One staff member indicated triggers for behaviours could include hunger, attention or pain but said it is difficult to “work out”.
* Staff indicated behaviours occur “several times a day” but do not document them as they are “normal”.
* The service has not effectively reviewed or managed behaviours and wounds for a consumer who is self-harming causing injury to their body. This issue was identified by an Assessment Team during a Review audit in December 2018.
  + Incident reports and wound charts show the consumer continues to self-harm.
* At the assessment contact the Assessment Team found the service does not effectively record or manage consumers’ weight records and nutritional risks.
  + The Assessment Team identified seven consumers with significant weight changes which had not been identified, reviewed or effectively managed by the service in accordance with the service’s procedure.

A consumer lost almost 10 percent of their body weight in 11 months, but no review or nutritional risk assessments were completed.

A consumer lost 8.4kgs in a 12-month period but no review or nutritional risk assessments were completed.

A consumer lost 7.1kgs in a 12-month period but no review or nutritional risk assessments were completed.

A consumer lost 7.4kgs in a 12-month period but no review or nutritional risk assessments were completed.

A consumer gained 12kgs in 10-month period but not review was completed, even though a dietitian referral was completed.

A consumer was not referred to a dietitian in accordance with the service’s procedure, following a 12.9kg weight loss in a 14-month period.

* + At the Review audit, a further two consumers were identified as having incremental weight loss over several months, however, the consumers had not been referred for a dietitian review or had nutritional risk assessments completed in accordance with the service’s procedure.
  + Staff are not weighing all consumers monthly in accordance with the service’s processes
* A consumer had seven falls in an approximate three-month period, without the service implementing new or revised falls prevention strategies to minimise the consumers’ risk of falls.
* In an approximate one-month period the service transferred three consumers to hospital with significant episodes and/or a diagnosis related to a swallowing deficit. Additionally, there was one consumer with incidents in relation to swallowing difficulties. However, these consumers were not referred or reviewed by a speech pathologist to support their risks associated with eating in a timely manner:
  + Progress notes show a consumer had 21 episodes of coughing in an approximate two-and-a-half-month period. However, the service did not refer the consumer for a speech pathologist review. Immediately following this period, the consumer had a significant swallowing incident during meal service where the consumer had difficulty swallowing and maintaining their airway, resulting in a transfer to hospital for treatment.
  + A consumer returned to the service from hospital with a diagnosis of aspiration pneumonia. However, the consumer was not reviewed by a speech pathologist for 23 days following their return from hospital, at which point the speech pathologist downgraded the consumer’s diet consistency.
  + A consumer had a choking incident and was reviewed by their medical officer two days following the incident. The medical officer queried a diagnosis of aspiration pneumonia and the service updated the high risk register five days after the medical officer review to include the choking incident and with an action for a speech pathology review as soon as possible. The Review audit commenced nine days after this notation on the high-risk register, at which point the consumer had not been reviewed by a speech pathologist.
  + A consumer was transferred to hospital following a ‘non-responsive episode’. The hospital discharge summary shows the consumer was diagnosed with aspiration pneumonia. However, six days after the consumer returned from hospital, the service had their high-risk meeting but did not discuss the care of this consumer. Management said they “missed that one”.
  + The Assessment Team interviewed a staff member in relation to consumers choking risks who indicated communications issues in relation to staff checking care plans for directions for assisting consumers with meals and staff not taking the time to assist consumers with their meals impacting on safely assisting consumers with swallowing difficulties.
* The Assessment Team found the service did not implement effective behavioural management strategies following incidents of consumer-to-consumer physical and sexual assault.
  + A consumer physically assaulted another consumer, but the service did not implement effective behavioural management strategies to prevent a secondary incident.
  + A consumer was sexually assaulted by another consumer; however, the service did not implement strategies to mitigate a reoccurrence of a similar incident.
* Registered nursing staff are not completing twice daily checks for two consumers who have been identified as at-risk of wandering outside the service, to ensure they are wearing identification bracelets.
  + The first consumer’s charting shows in a two-month period, staff did not check the identification bracelet on 59 required occasions.
  + The second consumer’s charting shows in a two-month period, staff did not check the identification bracelet on 70 required occasions.
* Restraint authorisation for a consumer has not been reassessed since 2016, including consultation and consent from the consumer’s representative.
  + The consumer’s restraint authorisation dated 2016 indicates staff are to hold the consumer when attempting to scratch others. However, management said the consumer is no longer being restrained in this manner.

The Assessment Team observed staff on three occasions holding a consumer’s hands or arms when they were attempting to scratch a staff member or another consumer.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The High-Risk Resident Framework will be re-initiated with regular meetings, recommendations and management strategies clearly documented in care plans to reflect care needs.
* Risk care plans will be clearly documented and accessible in the front of consumers’ care plans.
* Relevant assessments will be undertaken to ensure effective and individualised strategies are developed. All care plans will reflect consumers’ assessed needs and provide clear instructions.
* Staff practices will be audited to monitor compliance with relevant processes and procedures.
* A consumer’s care plan has been updated to indicate the consumer is not to be physically restrained during hygiene care.
* The restraint policy, procedure and related documentation is to be reviewed for accuracy and currency, with the restrictive practices register being updated.
* A register has been completed for identification of consumers who use regular and ‘as required’ psychotropic and benzodiazepam medications.
* Relevant consumers have had speech pathology reviews and relevant documentation has been checked for congruency and accuracy. Additionally, observation and review of staff practices in relation to assisting consumers with meals has been reviewed.
* Review of the policy and procedure for the management of nutrition and hydration, with consumer monthly weight data is now tabulated on an electronic record.
* Review of falls management protocol and completion of a full functional assessment for all consumers.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not always manage risks related to the care of each consumer. Specifically, the service did not appropriate respond to or manage risks associated with pain, nutrition and hydration, choking, restrictive practices and behavioural management. I find the organisation’s failure to recognise, manage and response to these risks has significantly impacted consumers’ health, safety and wellbeing.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(b).

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

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

The Assessment Team found the service was unable to demonstrate the needs of consumers nearing the end of life are recognised and addressed to maximise their comfort and preserve their dignity The Assessment Team provided the following findings and evidence relevant to my decision:

* The service does not have effective palliation processes, including monitoring signs and symptoms of discomfort and pain for consumers nearing the end of life.
* The service’s current palliative care plan does not include pain assessment and management. The service did not identify and address the needs of three palliating consumers at or nearing the end of life:
  + One consumer’s palliative care plan does not reflect the consumer’s pain levels or monitoring strategies. The consumer’s pain is not effectively assessed, managed or evaluated and staff report the consumer to be “screaming in pain”.

While the consumer had a palliative care review following an assessment contact which resulted in an increase in ‘as required’ pain and sedation medication prior to dressings, the service was unable to locate pain charting to monitor the efficacy of these changes.

Staff have not consistently reviewed or escalated the consumer’s pain to the medical team when as required medication was noted to have a mild or moderate effect on four occasions following the pain medication changes.

Staff interviewed stated the consumer’s pain continues to be unmanaged and the consumer screams in pain at times.

The consumer’s representative was not satisfied the service effectively managed the consumer’s pain and palliative needs.

* + One consumer receiving palliative care did not have a palliative care plan in place prior to their death.
  + One consumer receiving palliative care did not have a palliative care plan in place. At the time of the Review audit the consumer had been assessed as requiring palliative care ten days earlier.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The service plan to develop palliative care procedures with associated documents.
* All current consumers are being reassessed and care plans revised and updated accordingly.
* The assessment template has been amended to facilitate consumer engagement and establishment of consumer goals.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure consumers’ comfort was maximised at the end of life, specifically in relation to pain. Additionally, the service’s processes were inadequate to identify and monitor consumers’ needs, goals and preferences nearing the end of life to ensure their comfort is maximised and dignity preserved.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(c).

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

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

The Assessment Team found the service was unable to demonstrate they consistently ensure they identify deterioration or changes to consumers’ physical function and health or respond to these changes in a timely manner. The Assessment Team provided the following findings and evidence relevant to my decision:

* One consumer’s progress notes show the consumer was unwell over several months, had an increase in falls, was refusing meals and was displaying increased behaviours. However, the service did not adequately review the consumer’s care needs.
  + The consumer’s representative said they were concerned with the lack of escalation in relation to the declining health of the consumer. The representative said they had requested a medical review two weeks prior to the consumer being sent to hospital where they were diagnosed with a chest infection. The representative said the medical follow-up was insufficient and staff did not escalate the consumer’s change in health appropriately.
* One consumer’s health declined following an incident where another consumer pushed them over. The service did not identify changes to the consumer’s physical function for two days following the fall and did not transfer the consumer to hospital in a timely manner for review.
* Progress notes show a consumer had 21 episodes of coughing in an approximate two-and-a-half-month period. However, the service did not refer the consumer for a speech pathologist review. Immediately following this period, the consumer had a significant swallowing incident during meal service where the consumer had difficulty swallowing and maintaining their airway, resulting in a transfer to hospital for treatment.
* Management said they have performance managed several staff due to their inability to identify and escalate deterioration of consumers when needed.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The High-Risk Resident Framework will be re-initiated with regular meetings, recommendations and management strategies clearly documented in care plans to reflect care needs.
* All current consumers have been added to the service’s risk register.
* Management to ensure that actions from clinical meeting are attended to in a timely manner.
* Clinical care procedure to be reviewed to ensure consistency with the Quality Standards.
* Staff practices will be audited to monitor compliance with relevant processes and procedures.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not ensure deterioration or changes in consumers’ health were identified and acted upon in a timely manner. While staff are observation and documenting indicators relating to deterioration and changes in consumers’ health, these are not being identified, review and acted upon by clinical staff.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(d).

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

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

The Assessment Team found the service was unable to demonstrate it consistently provides information about consumers’ conditions, needs and preferences documented and available both within the organisation and when care is shared. The Assessment Team provided the following findings and evidence relevant to my decision:

* One consumer who was transferred to hospital did not have critical information in relation to changes in their health and wellbeing communicated accurately.
* Management said they have often found progress notes missing with page numbering not being in correct order.
* Management were unable to locate relevant assessment information such as pain charting.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* All current consumers are being reassessed and care plans revised and updated accordingly.
* The assessment template has been amended to facilitate consumer engagement and establish consumer goals.
* Care plans are located in a secure position in each house, however, are accessible to relevant staff.
* Recommenced a handover folder to alert staff to changes to consumers’ care needs, including mobility needs.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service’s ineffective information management systems impacted on the correct and effective communication of consumers’ current health status within and outside the service.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(e).

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

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

The Assessment Team found the service was unable to demonstrate it consistently refers consumers to relevant or appropriate health professionals and other organisations in a timely manner. The Assessment Team provided the following findings and evidence relevant to my decision:

* The service did not refer a consumer to a pain management specialist in a timely manner following an escalation of pain.
* The service did not refer two consumers for review and investigation at hospital for suspected fractures in a timely manner.
  + A consumer had a fall which resulted in a fracture, however, the consumer was not referred for review of the injured area until six days after the fall.
  + One consumer’s health declined following an incident where another consumer pushed them over. The service did not identify changes to the consumer’s physical function for two days following the fall and did not transfer the consumer to hospital in a timely manner for review.
* The service did not refer a consumer to their medical officer for review in timely manner when the consumer’s health deteriorated.
* Two consumers’ swallowing difficulties were not reviewed by a speech pathologist in a timely manner.
  + A consumer was not reviewed by a speech pathologist for 17 days following a choking incident.
  + Progress notes show a consumer had ongoing coughing during meals for over a three-month period. However, the consumer was not reviewed by a speech pathologist until a significant choking incident which initiated an emergency transfer to hospital.
* Eight consumers have had changes in their weight but have not been referred to dietitian for a review in a timely manner or in accordance with the service’s procedure.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* The service has developed a referral sheet, with unactioned referrals to be discussed at least weekly through the High-Risk Resident Meeting.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not always make referrals to other individuals, organisations or providers to assist in meeting consumers’ needs.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 3 Requirement (3)(f).

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found the service was unable to demonstrate practices which promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. The Assessment Team provided the following findings and evidence relevant to my decision:

* The service does not have a framework for antimicrobial stewardship to inform and guide staff in relation to minimisation of antibiotic use.
  + Two clinical staff interviewed were unable to describe antimicrobial stewardship and have not been provided training in relation to practices to support monitoring and review of the use of antimicrobials.
* The service was unable to provide any trending and evaluation of infection data for the preceding three months to the Review audit.
* The service did not demonstrate follow-up processes in relation to prescribing and use of antibiotics to treat consumers’ infections.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Revise infection control guidelines to ensure compliance with national infection control guidelines.
* Develop an antimicrobial stewardship framework.
* Introduce a process of completing an incident report when a consumer is identified with an infection.
* Management to conduct data analysis of infections.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not minimise infection related risk through not implementing practices to promote or monitor appropriate antibiotic prescribing and use to reduce the risk of increasing resistance to antibiotics.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 2 Requirement (3)(g).

# 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

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

The Assessment Team found the service not met in relation to Requirements (3)(a) and (d) in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Compliant with Requirements (3)(a) and (d) in this Standard and have provided reasons for my decision under the specific Requirements.

The Assessment Team found most representatives for sampled consumers are satisfied consumers get the services and supports for daily living which are important for consumers’ health and wellbeing and enable consumers to do the things they would like to do. Specific representative feedback includes:

* Representatives confirmed consumers are supported to keep in touch with people who are important to them.
* Representatives said consumers like the meals provided by the service and have observed them enjoying the meals.

The Assessment Team interviewed staff who advised activities provided to consumers are flexible and based on what consumers would like to do. Staff were also able to explain how they know when a consumer is feeling low and associated strategies to manage these feelings. Staff also indicated processes they use to work with other organisations to supplement the lifestyle activities offered within the service. Staff said they have access to relevant equipment to use to support consumers’ needs.

The Assessment Team found care plans included information about emotional, spiritual and psychological wellbeing. They also included information about how consumers participate in the community and maintain chosen relationships. Care planning documents reflected the dietary needs and preferences of consumers.

The Assessment Team found consumers are provided with appropriate furniture, adaptive equipment and mobility equipment to enable them to participate in activities of interest to them.

The Assessment Team observed consumers enjoying their meals and staff adhering to food safety protocols when handling food. The Assessment Team observed meals served were in accordance with consumers’ dietary preferences and needs.

## 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.*

The Assessment Team found this Requirement not met based on a consumer being forced to attend activities by a staff member without their consent or permission. I have differed from the Assessment Team’s findings and have found the service Compliant with this Requirement.

I have considered the evidence presented by the Assessment Team in this Requirement is more relevant to Standard 7 Requirement (3)(b), in that the staff member’s actions are not demonstrative of kind, caring and respectful behaviours towards the consumer. See Standard 7 Requirement (3)(b) for further reasoning for my finding.

I find the evidence presented by the Assessment Team demonstrates one staff member has not treated the consumer as an individual with their own needs and preferences and the impact to the consumer’s wellbeing has not been considered by a staff member who is employed to support and maintain the consumer’s wellbeing. The staff member is aware that the consumer does not wish to attend activities as part of their daily. These actions are not demonstrative of kind, care and respectful behaviours towards consumers.

In coming to my decision in relation to this Requirement, I have also considered the Assessment Team’s evidence which indicates consumers’ care plans contain information about what is important to each consumer. Additionally, staff interviewed could explain what was important to consumers and how they support consumers to do the things they like to do, in accordance with consumers’ care plans.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Compliant in relation to Standard 4 Requirement (3)(a).

### 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.*

The Assessment Team found this Requirement not met based on the service not having an effective system to manage information that keeps suitable controls to maintain privacy and manage information and records of the consumer. I have differed from the Assessment Team’s findings and have found the service Compliant with this Requirement.

I have considered the evidence presented by the Assessment Team in this Requirement is more relevant to Standard 3 Requirement (3)(e) and Standard 8 Requirement (3)(c), in that the evidence relates to the storage and confidentiality of consumers’ personal information, insufficient information management systems and the impacts to the personal and clinical care needs of consumers. For further reasoning for my findings of Non-compliance in these Requirements, please see the relevant Requirement in this report.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Compliant in relation to Standard 4 Requirement (3)(d).

### 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 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team observed the service environment to be divided into six houses, with each house having an individual kitchenette, dining and activity tables and access to outdoor areas. The Assessment Team observed consumers walking with and without assistance from staff or assistive devices, from their house to the main building.

The Assessment Team observed the environment to be safe, clean and well-maintained and consumers were accessing indoor and outdoor areas. They found furniture, fittings and equipment to be safe, clean, well maintained and suitable for consumers.

The Assessment Team interviewed a sample of staff who said maintenance staff attend to maintenance tasks in a prompt manner.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

The Assessment Team found the service not met in relation to Requirements (3)(b) and (d) in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with Requirements (3)(b) and (d) in this Standard and have provided reasons for my decision under the specific Requirements.

The Assessment Team found some consumer representatives considered they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken.

The Assessment Team viewed feedback and complaints documentation which showed consumers and representatives are encouraged and supported to provide feedback and make complaints. However, the service did not demonstrate that consumers and representatives are made ware of external complaints avenues or advocacy services.

The Assessment Team viewed the service’s complaints management summary log which demonstrated complaints are documented and addressed in accordance with the organisation’s complaints policy and procedure, including the use of open disclosure processes. However, the service was unable to demonstrate how feedback and complaints are reviewed and used to improve the quality of care and services.

## Assessment of Standard 6 Requirements

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

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

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

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

The Assessment Team found the service was unable to demonstrate consumers are made aware of external complaints avenues and advocacy services. The Assessment Team provided the following findings and evidence relevant to my decision:

* One representative interviewed said they were only aware of verbal complaint feedback processes.
* Management said they do not currently have a formal process to provide written information about internal or external complaint avenues or advocacy services.
  + Management said the only information available is found at the reception desk. The Assessment Team observed no information about external advocacy services.
* Management said they are currently reviewing admission processes, including the provision of information to consumers about feedback and complaints processes. However, consumers are not currently provided with information about advocacy and complaints avenues.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Feedback information packs to be distributed to all consumers and/or their representatives.
* A consumer survey has been completed and results will be evaluated and actioned.
* Posters in relation to mandatory reporting and external complaint processes to be downloaded from the internet.
* External complaint process information to be placed above all suggestion/feedback boxes.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did support consumers and/or representatives to be aware of various complaints mechanisms, specifically external, and available advocacy services to support them to raise complaints.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 6 Requirement (3)(b).

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

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

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

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

The Assessment Team found the service was unable to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. The Assessment Team provided the following findings and evidence relevant to my decision:

* The organisation did not demonstrate how complaints are used to identify trends or inform continuous improvement activities.
  + A memorandum approximately two months prior to the Review audit outlined organisational learnings and actions in relation to three external anonymous complaints. These complaints related to reportable incidents, escalation of incident, staffing model and changes to consumers’ conditions.

The Assessment Team identified the service had not recorded the above learnings and actions on the plan for continuous improvement and similar issues and deficiencies in care and processes were identified by the Assessment Team at the Review audit. The service had not identified these areas for opportunities for improvement.

* + The service did not identify a trend in complaints from a representative about staff identifying and escalating changes to a consumer’s health status. The consumer’s progress notes show a deterioration in the consumer’s health which culminated in an admission to hospital.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* A consumer survey has been completed and results will be evaluated and actioned.
* A review of the agenda for the Risk Improvement Safety and Quality Meeting has occurred to include feedback and complaint results and continuous improvement opportunities.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not effectively use external complaints information to make improvements to the safety and quality of care and services which has negatively impacted on consumers.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 6 Requirement (3)(d).

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Assessment Team found the service not met in relation to all Requirements in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with all Requirements in this Standard and have provided reasons for my decision under each specific Requirement.

The Assessment Team found most sampled representatives indicated consumers receive quality care and service when they need them and from people who are knowledgeable, capable and caring. However, the service was unable to demonstrate a sufficient or effective workforce to ensure consumers’ personal care and clinical care needs are met. Additionally, the service’s staff do not always interact with consumers in a kind, caring and respectful manner.

The Assessment Team found the service’s workforce did not have the skills and knowledge required for their roles to provide appropriate and adequate care and services. Additionally, staff training has not been effective in providing staff with appropriate skills and knowledge and training sessions have not been sufficient to meet the needs of a significant number of new staff.

The Assessment Team found the service was unable to demonstrate monitoring and review of staff performance is undertaken regularly or in response to insufficient performance or substandard clinical practice.

## Assessment of Standard 7 Requirements

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

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

The Assessment Team found the service was unable to demonstrate the workforce is planned to ensure the delivery and management of safe and quality care and services. The Assessment Team provided the following findings and evidence relevant to my decision:

* One representative interviewed said there is a lack of staff and their consumer has to wait for up to 45 minutes for assistance with their nutrition, resulting in the consumer feeling hungry.
* Staff interviewed said there are not enough rostered staff to provide consumers with the care and assistance they require.
  + One staff member indicated it is hard to manage consumers’ responsive behaviours because there are not enough staff.
  + Four staff interviewed indicated there are not enough staff at meal times to support and assist consumers to eat their meals.

One staff member said consumers have to wait for assistance with their meals due to several consumers needing assisting with their meals. They also said one consumer has falls while trying to take themselves to the toilet because staff are not available to assist them. The Assessment Team notes this consumer has a history of several recent falls.

One staff member said staff become stressed because there are not enough staff to meet consumers’ needs.

One staff member said there are several consumers requiring assistance with their meals during dinner time but there are not enough staff to support and assist and consumers.

One staff member said there are four consumers in their area that eat their meals unassisted because there are not enough staff to provide support. Two of these consumers are high choking risks.

* + Staff said they have provided feedback to management. However, they have not received any additional staffing hours.
  + The Assessment Team observed staff assisting consumers to bed during the Review audit. Staff indicated that due to staffing they need to assist some consumers to bed to manage the responsive behaviours of one consumer.
  + The service has had several changes to key personnel in recent months and high use of agency staff.

Management advised the organisation had identified a review of the workforce was required due to staff shortages and over-reliance on casual and agency staff. This resulted in the organisation commencing recruitment of staff.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Rosters have been reviewed and revised to create clear shift patterns and ties, identifying remaining staffing gaps and increased registered nurse supervision of care and service delivery.
* Direct support worker recruitment plan has been established to identify target numbers required to fill key gaps and reduce casual and agency staff usage.
* Agency staff are to be allocated with the service’s regular staff.
* Active recruitment of an additional three registered nurses.
* A coaching psychologist has been appointed to interview clinical and care staff to identify barriers to current practice expectations, support staff performance expectations and self-reflection and professional development needs.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service’s workforce was insufficient to ensure the effective and safe delivery and management of care and services, specifically to support consumers with eating their meals, and managing behavioural and toileting needs.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 7 Requirement (3)(a).

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

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

The Assessment Team found this Requirement met based on most representatives interviewed generally indicating staff are kind, caring and respectful, including that staff understand the needs and preferences of individuals. The Assessment Team also observed staff interactions with consumers to be kind, caring and helpful.

However, my finding differs from the Assessment Team and I found this Requirement Non-compliant. In coming to my decision, I have relied on evidence presented by the Assessment Team in Standard 4 Requirement (3)(a) and (g):

* A representative stated their consumer is forced to attend activities by a staff member even though they have indicated they do not want to attend and is taken to activities without the consumer’s permission or consent. The representative indicated this has occurred on a few occasions but had not reported this management.
  + The Assessment Team interviewed the relevant staff member who confirmed the consumer does not like to attend activities and will refuse to join in. However, even with this knowledge of the consumer’s preferences, this staff member takes the consumer to activities without permission.
* The Assessment Team observed staff to be playing with building blocks or scrolling through their mobile phones rather than interacting with consumers who were sitting next to them. One consumer requested a staff member to play a certain genre of music, however, the staff member ignored the request until they realised the Assessment Team was observing them.
* On the first day of the Review Audit the Assessment Team observed staff not interacting with consumers who were in communal areas.

The approved provider’s response to this evidence indicates consumers and representatives have been invited to participate in a consumer survey to provide an opportunity to design services and supports. Additionally, several staff training sessions have been planned to support staff to deliver care and services safely and correctly.

I find the evidence presented by the Assessment Team demonstrates that day-to-day staff interactions with the consumer forced to attend activities has not treated the consumer as an individual with their own needs and preferences and the impact to the consumer’s wellbeing has not considered by a staff member who is employed to support and maintain the consumer’s wellbeing. These actions are not demonstrative of kind, care and respectful behaviours towards consumers. Additionally, the Assessment Team observed staff neglecting interactions with consumers or responding to requests and I find this omission to interact or respond to requests does not reflect kind, caring or respectful interactions with consumers.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 7 Requirement (3)(b).

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

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

The Assessment Team found the service was unable to demonstrate the workforce is competent and staff have the knowledge to perform their roles in accordance with best practice or consumers’ needs. The Assessment Team provided the following findings and evidence relevant to my decision:

* One representative is not satisfied staff managed a consumer’s pain effectively.
* Evidence and outcomes for consumers in relation to Standard 3 Personal care and clinical care demonstrates staff do not always have the appropriate skills and knowledge to provide safe and quality care.
  + Care staff do not identify consumers at risk of choking and have not escalated episodes of coughing during meal assistance.
  + Clinical staff do not identify consumers at risk of aspiration or make relevant referrals and escalations.
  + Management said they had identified staff are not always competent to assist and manage consumers at risk of choking but have not yet provided training.
  + Staff interviewed indicated they do not always understand signs and symptoms which may indicate a consumer is in pain. Clinical staff do not always identify or manage consumers’ pain effectively.
  + Clinical staff are not always managing consumers’ urinary catheters in accordance with best practice.
  + Clinical staff demonstrated medication management practices which are inconsistent with best practice medication management guidelines.
  + Clinical staff do not always effectively monitor consumers following incidents or changes in health, resulting in delayed assessment and care impacting on the health and wellbeing of consumers.
* Monitoring processes for competency of agency staff were only completed the week prior to the Review audit.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* A training plan has been developed to ensure the workforce has the appropriate skills to deliver safe and quality care.
* A psychologist has been engaged to support the transfer of skills and knowledge into practice.
* Competency of staff to be assessed via questionnaire and/or observation.
* Registered nursing staff will conduct ‘buzz’ meeting on required topics.
* Direct support worker induction and probationary period to include competency monitoring and assessment.
* New staff competency tools are to be developed.
* Increased supervision and observation by registered nursing staff will be facilitated by changes to staff allocation and increased registered nurse presence.
* A new quality program to be re-established with a new Quality and Training registered nurse, Practice Improvement specialists and Nurse Educators.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service’s workforce did not have the skills and knowledge required for their roles to provide care and services. The service has not effectively monitored clinical care outcomes for consumers to ensure staff providing care have the skills and are delivering care to meet consumers’ needs.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 7 Requirement (3)(c).

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

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

The Assessment Team found the service was unable to demonstrate effective recruitment or staff training processes to ensure safe and quality delivery of care and services to consumers. The Assessment Team provided the following findings and evidence relevant to my decision:

* The organisation developed a workforce corrective action plan, including recruitment, to ensure continuity of care and services by competent and quality staff. However, the plan has not been completely implemented and it has also not been effective:
  + Management advised they identified insufficient clinical coverage to provide clinical guidance, support and supervision. However, while some new clinical staff have been recruited, this process is ongoing and clinical outcomes for consumer are not yet adequate.
  + Management advised they identified staffing shortages and over reliance on casual and agency staff, particularly care staff. While the service has transitioned some casual direct support workers to permanent employees and employed new staff, recruitment is ongoing and care outcomes for consumers are not yet adequate.
* Staff are not up-to-date with mandatory training:
  + Seventeen of 77 staff had not completed mandatory training by their due date.
* The Board identified in August 2019 training requirements were required to be reviewed and adjusted. However, this has not been completed.
* Management did not consistently identify staff training needs and/or implement training to ensure staff provide safe and effective care and services to consumers.
  + While several training sessions have been provided to staff at the end of 2019, management said 90 percent of staff have changed since then and most staff would not have completed the training.
  + While three consumers were transferred to hospital in an approximately one-month period in relation to significant swallowing deficits, the service did not implement any additional training for staff in relation to consumer swallowing.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* A training plan has been developed to ensure the workforce has the appropriate skills to deliver safe and quality care.
* A psychologist has been engaged to support the transfer of skills and knowledge into practice.
* All staff to participate in corporate induction and essential training prior to commencement.
* An audit to be conducted in relation to mandatory training completion by staff.
* The induction pack and duty list for agency staff to be reviewed. All agency staff will be required to sign a declaration on completion of induction that information has been understood.
* Agency staff are to be allocated work with the service’s regular staff.
* Site recruiting and induction process to be reviewed to reflect critical requirements for staff aligned with the service’s values and consumer profile.
* Monitor the effectiveness of the implementation of ‘buddy’ shifts.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service’s workforce was not supported to ensure their day-to-day practice protected against risk and improve the care outcomes for consumers. Ongoing support, training and professional development has not been provided to staff to support them to carry out their role and responsibilities. Training needs have not been adequate identified or met.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 7 Requirement (3)(d).

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

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

The Assessment Team found the service was unable to demonstrate monitoring and review of staff performance is undertaken regularly or in response insufficient performance or substandard clinical practice. The Assessment Team provided the following findings and evidence relevant to my decision:

* The organisation requires management to conduct annual performance reviews with staff. The Assessment Team viewed the service’s plan for continuous improvement which showed annual performance reviews are not completed within recommended timeframes. Management did not provide evidence in relation to completed performance reviews.
* The service did not always implement monitoring or effective performance management strategies following allegations of substandard clinical practice incidents to mitigate potential risks to consumers in relation to the provision of clinical care or in accordance with the organisation’s incident management procedures.
  + One clinical staff member was alleged to have failed to render appropriate clinical care or escalate review of a consumer’s health following an incident where the consumer fell and had sustained a fracture. While an investigation into the allegation was commenced, the staff member continued to work unsupervised and without monitoring processes to ensure the safety of consumers during the investigative period. During this period the staff member was involved in allegations of two medication incidents and had not rendered appropriate assistance while a consumer was having a seizure.

Management said they had only gained sufficient information to suspend the staff member following the four alleged incidents, at which point the staff member’s employment was suspended and employment ultimately terminated.

* + One clinical staff member was alleged to have failed to escalate and report a consumer incident in accordance with the service’s processes. While the incident was significant, the service did not implement monitoring processes of the staff member’s practice and they continued to work unsupervised during the investigation period.

Management said during the investigation they were attempting to ascertain if the clinical staff member took reasonable steps following the incident and said the staff member provided reasons why the incident was not escalated. At the completion of the investigation a determination was made to terminate the staff member’s employment.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Conduct audit of performance appraisal status for all current staff.
* In consultation with the coaching psychologist, review performance appraisal processes and individual staff performance of registered nurses.
* Training plan to be implemented and updated according to identified staff training needs.
* Reported incidents to be escalated to People and Culture division.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the service did not demonstrate regular review and evaluation of staff performance to assess each staff member’s performance in their role to identify, plan for and support any training. Additionally, appropriate review or implementation of monitoring processes of staff following allegations of substandard practice was not implemented to ensure the safety and wellbeing of consumers.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 7 Requirement (3)(e).

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team found the service not met in relation to Requirements (3)(b), (c), (d) and (e) in this Standard. Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with Requirements (3)(b), (c), (d) and (e) in this Standard and have provided reasons for my decision under the specific Requirements.

The Assessment Team found the organisation demonstrated consumer input in relation to care and services provided by the service. However, was unable to demonstrate the governing body understands their responsibility to ensure performance of the service against the Aged Care Quality Standards.

The organisation did not adequately demonstrate effective governance systems, specifically in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints. Additionally, the service did not adequately demonstrate it has established effective clinical governance systems, including but not limited to antimicrobial stewardship and minimising the use of restraint.

The organisation did not demonstrate effective risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and support consumers to live the best life they can.

## Assessment of Standard 8 Requirements

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

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

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

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

The Assessment Team found the organisation was unable to demonstrate the governing body understands their responsibility to ensure performance of the organisation in relation to the Quality Standards. Additionally, the governing body has not set timely priorities to review or implement effective governance processes in relation to risks associated with the care of consumers, clinical care and the organisation’s workforce framework. The Assessment Team provided the following findings and evidence relevant to my decision:

* Improvements identified by the governing body have either not yet been implemented, have not been implemented or are not effective.
  + In August 2019 the Board identified the need to establish a Clinical Governance Committee as a matter of urgency, however no timeframe for implementation was established.

The Clinical Governance Committee was not established until November 2019, three months after the Board identified an urgent need to establish the Committee. It took the Board a further month to endorse the Committee’s terms of reference.

* The Assessment Team viewed the organisation’s governance reform master project plan dated November 2019 and identifies recommendations, key initiatives/actions and due dates. The plan was discussed at Board meetings in November 2019 and February 2020, however, initiatives have either not been implemented or are not effective.
  + A key action was to develop immediate plans to address known high risks in clinical care and safety. An example was management of choking and aspiration risks action plan which was distributed to the service in January and February 2020. However, the organisation did not demonstrate this has been effective, as evidenced by the service’s failure to effectively manage choking and aspiration risk consumers identified in this report.
  + Key metrics and reporting processes do not separate data or differentiate between disability or aged care consumers.
  + The development and implementation of risk-based clinical governance audits reported through the Clinical Governance Committee to the Board have not yet been developed.
  + Establishment of a workforce plan and workforce management strategy was due March 2020, however, while the initiative has commenced systemic deficiencies are still occurring in relation to human resource processes.
* Management were unable to demonstrate reporting and monitoring processes for the Clinical Governance Committee effectively monitor performance of the service or identify risk because information in relation to key clinical risks including incident data does not differentiate between disability and aged care consumers.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* Implementation of a Quality, Safety and Wellbeing Framework and the Clinical and Service Governance Committee of the Board to ensure safe and quality care and services are provided to consumers.
* Finalise development of the revised Operational Quality Safety and Wellbeing Governance Framework.
* Board members have or are scheduled to complete training in relation to organisational governance.
* Clinical high-risk action plan developed in response to independent review of clinical risk.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the organisation’s governing body did not ensure the promotion of a culture of safe, inclusive and quality care and services. While the Board had identified the need for effective monitoring and oversight of clinical care and performance, actions implemented were not timely and have not supported the service to comply with the Quality Standards.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 8 Requirement (3)(b).

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

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

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

The Assessment Team found the organisation was unable to demonstrate effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints. The Assessment Team provided the following findings and evidence relevant to my decision:

* In relation to information management:
  + The organisation does not have effective processes to ensure consumers’ care and services documentation is stored safely and confidentially, manage staff access to information and were unable to locate documentation when required and/or requested.

The Assessment Team observed consumers’ personal and sensitive information to not be stored securely during the Review audit and staff accessing areas where this information is stored who do not have authorisation to enter these areas.

Management said various consumer documentation such as progress notes, pain charts, assessment and care plans, have gone missing since late 2019, hence the move of this documentation to a secure area. However, the Assessment Team observed unauthorised staff accessing this area.

The service was not able to provide the Assessment Team with requested documents, especially documents relating to the provision and monitoring of consumers’ clinical care needs.

* + Clinical staff do not consistently use best practice in relation to clinical documentation.

The Assessment Team viewed progress notes which were able to be altered and not written in chronological order.

Management are aware of these issues and plan to implement an electronic system.

* + Staff do not have access to appropriate information or system to provide safe and quality care and services.

Policies and procedure are not always reviewed or implemented effectively or in a timely manner.

Staff interviewed said they are unable to always access the electronic medication management system and this impacts on their ability to implement best practice processes in relation to medication management.

* In relation to continuous improvement:
  + While the organisation has identified some improvements and have documented them on the plan for continuous improvement, the improvements were either related to compliance or have not always been implemented in accordance with the organisation’s timeframe or due date. Additionally, improvements have not been effective to ensure safe and quality care and services for consumers.
* In relation to financial governance:
  + The organisation’s current financial management, reporting and monitoring systems have not identified financial governance risks in relation to care and services, relevant to the aged care division of the business.
* In relation to workforce governance:
  + The organisation’s workforce corrective action plan, including a review of the service’s staffing model, recruitment of additional staff and provision of training, has not been effectively implemented as evidenced by the service’s performance in relation to Standard 7 Human resources.
* In relation to regulatory compliance:
  + The organisation’s policy and procedure in relation to compulsory reporting of alleged or suspected consumer assaults is not specific to aged care and training in relation to roles and responsibilities of compulsory reporting has not been effective.

The Assessment Team identified two allegations of physical assault of consumers had not been reported in accordance with legislative requirements

The Assessment Team identified two suspicions of physical assault had been recorded on the reportable incident log but had not been reported in accordance with legislative requirements.

* In relation to feedback and complaints:
  + The organisation did not demonstrate how feedback and complaints are used to improve results for consumers.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* An enhanced document management system is under development, supported by document audits as part of the Quality Management System.
* A training plan has been developed which includes training staff in relation to documentation management.
* A revised Quality Management System is being implemented, along with a new leadership and quality team.
* Compliance and continuous improvement is a standing agenda item on the Board Clinical and Service Governance Committee agenda.
* Weekly meetings with advisors and quality and safeguarding team have been established.
* A Board Management Committee has been established to monitor progress of improvement and provide assurance to the Board.
* Several measures in relation to recruitment and training of staff have been commenced.
* The policy and procedure in relation to compulsory reporting of alleged or suspicions of consumer assault has been revised to be consistent with relevant legislation.
* The complaints management policy is being reviewed.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the organisation’s governance processes were not effective to ensure accountability and action at all levels of the organisation. Several key governance areas were ineffective impacting on outcomes for consumers.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 8 Requirement (3)(c).

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

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

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

The Assessment Team found the organisation was unable to demonstrate the organisation’s risk management framework has not been effectively implemented. The Assessment Team provided the following findings and evidence relevant to my decision:

* In relation to high impact or high prevalence risks associated with the care of consumers the service were unable to demonstrate policies and procedures to support effective management of high risk areas of care, such as pain. Additionally, the service has not identified risks to consumers through incidents or used this information to improve the service’s performance.
* In relation to identifying and responding to abuse and neglect of consumers, the service has not always reviewed incidents of consumer assault to implement strategies to minimise the risk of another incident occurring. This includes the service not implementing strategies in response to four alleged incidents of sexual assault between two consumers and ongoing incidents of physical aggression between consumers.
* The service uses a high risk register and holds weekly meetings to discuss consumers’ care needs and potential risks for consumers who have been identified as high risk. The Assessment Team identified one consumer who recently had a significant clinical event requiring hospitalisation had not been included on the register.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* A morning meeting with clinical staff and management has commenced to facilitate a clinical update at least three times per week.
* The High Risk Resident Framework will be re-initiated with regular meetings, recommendations and management strategies clearly documented and care plans to reflect care needs.
* The policy and procedure in relation to compulsory reporting of alleged or suspicions of consumer assault has been revised to be consistent with relevant legislation.
* A training plan has been developed which includes training staff relevant to this Requirement.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the organisation did not have effective systems and processes to assist them to identify and assess risk to the health, safety and wellbeing of consumers, including the incident management system.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 8 Requirement (3)(d).

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

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

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

The Assessment Team found the organisation was unable to demonstrate the organisation’s clinical governance system has been effective to ensure consumers are provided safe and quality clinical care, including antimicrobial stewardship, and minimising the use of restraint. The Assessment Team provided the following findings and evidence relevant to my decision:

* The service’s failure to meet all Requirements in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care demonstrates the service’s clinical governance framework is ineffective.
* The organisation has not yet implemented policies and procedures in relation to antimicrobial stewardship.
* The organisation has implemented restraint authorisation forms, however, was unable to demonstrate evidence of assessment and alternatives trialled prior to the use of chemical and physical restraint.

The approved provider submitted a response to the Assessment Team’s report and have indicated a commitment to rectifying the deficiencies identified by the Assessment Team. The approved provider has developed an action plan and are directing attention and resources to ensure action items are achieved within their proposed timeframes. Specifically, in relation to this Requirement, the following actions have or will be actioned to address the deficiencies identified by the Assessment Team:

* A new Clinical and Governance Framework has been implemented. This Committee is responsible for ensuring clinical indicators are monitored, analysed and trended, with escalations to the Board as required.
* Implement the clinical high risk action plan.
* Develop internal auditing and monitoring systems
* Progress the draft antimicrobial stewardship framework, including reporting structure.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I acknowledge the approved provider’s commitment to rectifying the deficiencies identified in this Requirement and the actions and improvements stated as being implemented. However, I find at the time of the Review audit, the organisation did not have effective systems and processes to ensure the delivery of safe, quality clinical care and for continuously improving services, including in relation to antimicrobial stewardship and minimising the use of restraint.

For the reasons detailed above, I find Minda Incorporated, in relation to Minda Nursing Home, is Non-compliant in relation to Standard 8 Requirement (3)(e).

# Areas for improvement

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

* **Standard 1 Requirement (3)(f):**
  + Ensure consumers’ private and sensitive information is stored security and can only be accessed by authorised and relevant individuals.
* **All Requirements in Standard 2:**
  + Ensure assessment and planning processes encompasses processes for staff to consider risks to consumers’ health and wellbeing.
  + Ensure assessment processes include processes for staff to identifying consumers’ needs and wishes in relation to palliation and terminal phases of life.
  + Ensure assessment and planning processes include consultation and ongoing communication with consumers and/or representatives.
  + Ensure consumer care plans are updated and reflective of consumers’ needs.
  + Ensure care plans are accessible to relevant staff to assist in the effective delivery of care and services.
  + Ensure care plans are reviewed following changes in consumers’ health or after incidents, including conducting relevant reassessments.
* **All Requirements in Standard 3:** 
  + Ensure consumers are provided personal care and clinical care which is best practice and in accordance with consumers’ needs, including but not limited to appropriate medication administration practices, management of consumers’ specialised nursing care needs and appropriate skin and wound management care.
  + Ensure the risks associated with consumers’ personal and clinical care are identified, assessed and managed, including but not limited to pain management, falls managements, nutrition and weight loss management, choking management, and the use of restraint.
  + Ensure consumers’ condition is monitored and regularly evaluated during the terminal phase of life, including pain and comfort levels.
  + Ensure staff are supported to understand signs and symptoms of deterioration in health status and implementation of appropriate review and monitoring.
  + Ensure consumers’ assessment information is effectively documented to support accurate evaluation and review of consumers’ health needs and status.
  + Ensure consumers are referred to appropriate health specialists in accordance with consumers’ changing needs and requirements.
  + Ensure staff are monitoring the use of antibiotics and evaluating the outcomes and efficacy of the medication. Ensure this information is used to inform the effective and appropriate prescribing of antibiotics.
* **Standard 6 Requirements (3)(b) and (d):**
  + Ensure consumers and/or representatives are provided information about external complaints avenues and advocacy services in a clear and timely manner.
  + Ensure feedback information is analysed to identify opportunities to improve care and services.
* **All Requirements in Standard 7:**
  + Ensure appropriate and adequate staffing levels and skill mix are used in accordance with consumers’ needs and acuity.
  + Ensure recruitment processes are effective to ensure staff have the appropriate skills and knowledge required to undertake their role.
  + Ensure staff interactions with consumers are monitored to maintain kind, caring and respectful interactions at all times.
  + Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
  + Ensure staff are provided training in accordance with the approved provider’s training plan and to address the deficiencies identified in six of eight Quality Standards.
  + Ensure regular staff performance review processes are conducted and staff are effectively monitored following incidents of alleged inadequate provision of care.
* **Standard 8 Requirements (3)(b), (c), (d) and (e):**
  + Ensure the Board effectively monitors the timelines of implementation of action to address deficiencies related to the Non-compliance with the Quality Standards, including ensuring regular reporting from management.
  + Ensure review of the organisation’s governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.
  + Ensure risk management systems are effective at identifying incidents and practices which requires senior personnel to review and assess risk to consumers.
  + Ensure the organisation implements an antimicrobial stewardship framework.
  + Ensure restraint policies and procedures are reviewed and consumers’ care is relevantly reviewed.