Miranda Aged Care Facility

Performance Report

268 Port Hacking Road   
MIRANDA NSW 2228  
Phone number: 02 9525 3210

**Commission ID:** 2502

**Provider name:** Jesmond Aged Care Pty Ltd

**Site Audit date:** 20 October 2020 to 22 October 2020

**Date of Performance Report:** 23 December 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) | Non-compliant |
| Requirement 1(3)(d) | Non-compliant |
| Requirement 1(3)(e) | Non-compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Non-compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | 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 Site Audit 20-22 October 2020; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the Site Audit report of 17 November 2020, with continuous improvement plan and supporting documentation.

# 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

Overall, The Assessment Team reported consumers interviewed (and representatives on their behalf) considered the consumer is treated with dignity and respect and they provided information about staff understanding, valuing and supporting consumer culture, values and diversity and what is important to the consumer. The Assessment Team found consumers’ information and personal privacy is maintained.

However, some consumers interviewed (and representatives on their behalf) provided information about the consumer not being supported to exercise choice; lack information to enable them to make decisions and adequate support to maintain connections and relationships.

The Assessment Team reported management appeared to lack understanding about how to support consumers to take risks and to live their best life. The organisation’s policy/procedure about risk taking has not been consistently followed.

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

## Assessment of Standard 1 Requirements

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

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

The service was able to demonstrate that overall, consumers are treated with respect, their dignity maintained, and their identity and culture valued and supported.

Based on the information provided I find this requirement is compliant.

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

*Care and services are culturally safe.*

Overall the service was able to demonstrate care and services provided are culturally safe.

Based on the information provided I find this requirement is compliant.

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

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

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

#### The Assessment Team reported that some consumers and representatives said consumers are being supported to exercise choice and independence. However, others provided information that this not occurring. The Assessment Team identified feedback on this had been previously provided by consumers and representatives to both the organisation and service. The Assessment Team found the service was unable to demonstrate that sufficient or timely action was taken to address the matters raised.

The Assessment Team reported many consumer representatives said they were not given sufficient information about what is happening at the service or about their relative. This included concerns about being unable to visit their relative due to the service’s restricted visiting arrangements. In addition to this, some spoke of   
  
difficulties with the alternative arrangements for them to remain connected with their consumer. Such as issues with the arranged booking system for visits, including timely access. One consumer raised several communication and information issues relevant to their life at the service.

Service and organisational management responded to the Assessment Team’s findings advising the service had been in lockdown for much of 2020 due to COVID-19 requirements. There was a structure in place to manage visits. They believe this was clearly communicated to consumers and representatives and regularly updated as and when required. They said they did seek telephone feedback in July 2020 from consumer representatives on a number of issues including seeking their input into organisational strategic planning. The Assessment Team reported the records of these discussions show some consumer representatives provided feedback about difficulties with visiting arrangements and decision making.

In their response the approved provider outlined the actions they have taken to address the matters under this requirement, including how it had addressed the concerns of an individual consumer named in the report and held a consumer/representative meeting on 19 November 2020 to discuss the concerns raised. They will also commence a one-off project to review all consumer care plans/files/assessments to ensure they contain correct and current information. They have reviewed their electronic booking system and believe no visitors missed out on access. However, due to easing of restrictions they are adjusting frequency of visits.

I have considered the information provided. I acknowledge the actions taken by the approved provider to address the matters raised. However, I have taken into account the feedback provided by consumers and representatives and their concerns regarding being better supported to remain connected. In my view these were not addressed in a more timely or direct manner and therefore impacted on supporting consumer choice and independence. Although the approved provider has set up a structure to ensure this is addressed, I believe they need further time to demonstrate this is effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team reported that overall the service could not demonstrate an understanding of this requirement. In particular, how this might apply in practices other than clinical care. The organisation has a risk-taking policy and procedure   
  
which outlines a commitment to supporting consumers to take risk in accordance with their wishes, that they will document all risks and that strategies will be implemented to minimise risk. The policy and procedure includes that a risk register will be maintained of all known risks. The risk register they reviewed during this assessment performance site audit was not service or consumer specific. The Assessment Team also found that the organisation’s policy/procedure about risk taking was not being consistently and adequately followed.

In their response the approved provider said they addressed the consumer risk identified in the report. Following this all consumer risk profiles were reviewed, and assessments and risk plans updated as and where required. A risk assessment report (diversity action plan) has been established to identify consumers who undertake risk taking activities. This has been communicated to appropriate staff through hand-over.

I acknowledge the actions of the approved provider and the setting up of a service specific risk register. However, risk activities were not adequately identified prior to this. Although steps have since been taken to address this, during the performance assessment site audit the service was unable to demonstrate compliance under this requirement. It is my view the service needs further time to demonstrate the actions taken are effective and can be sustained. The service should continue to monitor this requirement to achieve this outcome.

Based on the information provided I find this requirement is non-compliant.

### Requirement 1(3)(e) Non-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.*

The Assessment Team reported that while some consumers and representatives said communication had improved, most consumers and representatives said they experienced difficulties accessing information. For some this was about information not being provided and for others this was about the information provided not being sufficient, including not being accurate or timely. This included issues regarding the answering of the service’s telephone particularly at weekends. The Assessment Team also identified an issue with the residential care agreements.

The approved provider acknowledge there are some communication issues requiring improvement. However, they strongly believe these did not impact on care outcomes. The service has upgraded its telephone service, and this is now connected to the call-bell system. They believe this has solved telephone call waiting times or   
telephone calls not being answered. Consumer agreements are being reviewed and will be updated to ensure they contain accurate information. The approved provider said they will continue to monitor this requirement to ensure changes implemented are effective.

Whereas I acknowledge the approved provider’s response and the actions taken to address the issues raised by the Assessment Team, it is my view the gaps identified impacted on consumer choice and information was not consistently accurate. The service requires more time to demonstrate changes it has made and is making are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

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

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

Most consumers and representatives interviewed provided information about the consumer’s personal privacy being respected.

Based on the information provided I find this requirement is compliant.

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

Overall consumers or representatives said they have been involved at some level in the process of assessment and care planning and have some knowledge of assessment and care planning processes at the service. The Assessment Team reported most sampled consumers or representatives considered that they feel like partners in the ongoing assessment and planning of their care and services. However, some did not.

The Assessment Team found initial assessment and care planning is not conducted in accordance with organisational expectation and to identify consumer needs, goals and preferences including in relation to risk. Care plans do not include all information about consumers’ needs and preferences. For consumers sampled there was limited information to support they or their representatives are partners in care or that specific goals are identified for the consumer and documented. Where critical incidents occur, investigation is not comprehensive and does not consider all possible causes.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team reported the organisation has policies and procedures to guide staff in relation to conducting assessments and developing care plans according to a schedule. The management team said that this schedule of assessments is completed following a consumer entry to the service, and this is then entered in on the electronic care and service records. It is noted the service has recently transitioned to electronic care and service records and the system went live on 15 September 2020.

However, information contained in care plans was not always consistent. The review of assessments and care plans identified that consumers have assessments and care plans that cover most care needs. However, they do not always address specific risks to the consumer’s health and well-being. For one consumer sampled, who had recently entered the service, comprehensive assessment had not occurred. Therefore, care planning was not sufficiently addressed to identify their needs and an interim care plan was not put in place in accordance with the admission checklist. It was identified the consumer had some complex care and high-risk needs including pain management.

The approved provider stated that, in relation to the consumer who recently entered the service, that this had been an oversight and that staff were aware of this consumer’s needs and were providing them accordingly. Their care plan has now been updated and completed. Registered nurse education has been provided to ensure this does not reoccur and that all consumers have an interim care plan developed in the first instance.

I acknowledge the approved provider’s response however, I am concerned about the delay in assessment of the consumer, particularly in relation to their pain.

Based on the information provided I find this requirement is non-compliant.

### 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 reported overall, current care needs were not seen to be adequately identified or addressed and incorporated into care plans with this deficit impacting on a range of care needs of the sampled consumers. Consumers’ personal goals and preferences are not specifically identified and therefore are not included in care plans. Some personal care goals were seen to be generic. One consumer sampled is currently receiving end of life care and their care plan was reviewed. However, no end of life management plan was commenced in accordance with the organisational policy.

The approved provider acknowledged the gaps identified in care planning and has commenced a care plan review and will specifically address the care plans of consumers identified in this report. They aim to have this completed by the end of November 2020. Intensive registered nurse education and training will be implemented on care plan review, including involvement of consumer/representatives in this process. Ongoing education will be provided on this in 2021 and the service will continue to monitor outcomes through auditing.

I acknowledge the actions taken by the approved provider to address the matters raised. However, I find assessment and care planning does not adequately address all areas of care and services. It does not address consumers’ individual goals and preferences. The service needs to demonstrate the changes it has implemented are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

### 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 reported the service demonstrated the involvement of other providers of other care and services in consumer care. However, the service could   
not consistently demonstrate that assessment and care planning actively includes consumer involvement, or involvement of a representative on their behalf.

Some consumers and representatives provided feedback to the Assessment Team that they have had input to the consumer’s assessment and planning. However, others could not recall this having occurred recently or said they did not know if the care plan was being implemented and spoke about not being updated regarding the consumer’s condition and the ongoing plan of care. The Assessment Team reported this was also reflected in the organisation’s own consumer/representative strategic planning consultation material and the complaints register.

The service’s plan for continuous improvement includes an entry that case conferences were scheduled to discuss updated consumer care plans and involve them in the care planning process. The approved provider, while acknowledging gaps in care planning and care plan review, is of the view that overall the report demonstrates that consumers and or representatives are involved or partners in consumer care.

Whereas I acknowledge there was consumer/representative feedback to support this; there was also feedback where others wanted more involvement or felt inadequately consulted with or partnered. This included information contained within the organisation’s strategic planning consultation process with consumers and representatives. It is my view the service has not been able to consistently demonstrate an effective ongoing partnership with consumers (and others where appropriate) in care planning, assessment and review. The service requires further time to show the changes made are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

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

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

The service has a process for the development of care plans across care areas. All consumers sampled had a care plan and evidence of some communication with consumers (or representatives on their behalf). Consumer (or representatives on their behalf) report mixed feedback in relation to this requirement however most confirmed the care plan is readily available to them.

Most consumer representatives interviewed said they had been given a copy of the consumer’s care plan. Service management said that during the annual case conference a hard copy of the care plan is offered to the consumer or their representative.

Based on the information provided this requirement is compliant.

### 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 reported the organisation has a suite of policies and procedures in relation to assessment and planning including one in relation to the review of care plans. Service staff report that care plans are reviewed regularly by the registered nurses,

However, the Assessment Team reviewed an identified incident which did not show effective review occurred. They reported a range of potential causal factors for the incident did not appear to have been considered in this process. They found the recommendations following the investigation into the incident were limited and strategies to minimise the risk of reoccurrence were not identified or sufficiently actioned to ensure effectiveness. Overall, across Standard Two, the Assessment Team reported gaps in care documentation that demonstrated the service’s care planning review was not consistently effective.

The approved provider strongly disagrees with this finding on the basis that its care plan review system is in place and scheduled. However, I am not satisfied this addresses the aspects of this requirement to demonstrate this is effective. I am satisfied that from information contained in the report, review of consumer care plans is not demonstrated as consistently applied when changes occur in a consumers’ condition or that the service has demonstrated its process for care plan review, overall, is effective.

Based on the information provided I find this requirement is non-compliant.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team interviewed consumers and representatives – reviewed consumer care plans and assessments and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined other relevant documents.

Consumers and representatives said overall, they were satisfied with the quality of care provided to consumers. However, the Assessment Team reviewed a significant number of care plans and reported that consumers were not consistently receiving clinical care that is always safe, or best practice and optimises consumer health and wellbeing.

The use of chemical restraint was not adequately identified and managed. Sharing of information has not always occurred within the service staff team and with others involved in the consumer’s care. While there are measures in place to minimise the risk of COVID-19 there are issues with service staff training and the wearing of personal protective equipment in some cases.

The service has taken action to address these matters and will continue to monitor that its care planning and assessment process appropriately supports the delivery of care and services to consumers.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found consumer (and representative) feedback was generally positive. However, their review of consumer care and service records indicates clinical care provided is not consistently best practice and does not always result in optimising their health and wellbeing. While the organisation has a range of policies and procedures to guide staff practice, staff have not complied with these. The use of chemical restraint is not identified and managed according to the organisational policy.

The Assessment Team’s review of a significant number of consumer care and service records showed deficits in care and service delivery indicating personal care instructions were incomplete or not being followed. The service could not demonstrate its consumers receive individualised care that is, best practice, safe, effective or tailored to their specific needs and preferences. This includes that recommendations by specialist services in relation to behaviour management not being implemented. Concerns were also identified in relation to the identification of consumers on chemical restraint and documentation of that in the care plan of the consumers sampled, and management of these consumers in accordance with the organisation’s policies and procedures.

In their response the approved provider said it is their view the service does provide best practice care. However, they have reviewed the care plans of the consumers reported on under this requirement to make sure the information is current and being followed and identified actions taken to address the issues identified. They will conduct ongoing training and education with relevant staff to ensure care planning, assessment and review is appropriately supporting the delivery of care and services.

I acknowledge the actions taken by the approved provider to address the matters raised under this requirement. However, it is my view the service was unable to demonstrate each of their consumers is receiving safe, effective care that is tailored to their needs and is best practice. The service will require further time to demonstrate the changes made are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team found care plans did not include information about all high impact and high prevalence risks, including identification of such risks for the consumers sampled. Negative outcomes were identified in relation to falls prevention and chemical restraint. The organisation has policies and procedures to direct staff however, they are not consistently followed in relation to chemical restraint, falls prevention and nutritional risk.

The care manager said the most significant clinical risks for consumers relate to falls, however the number of falls is reducing. They also self-reported skin tears as being a significant risk and that further manual handling training has been arranged to assist in minimising skin tears. They said the risk-based questions as asked by the Assessment Team are answered each week as part of their clinical management system.

In their response the approved provider said the psychotropic register has now been migrated into the electronic care planning system. This is to improve monitoring of psychotropic usage. Information from the register is then mapped into the individual consumer care plan ensuring records are up to date and correct procedures followed.

I have taken into consideration that the Assessment Team did identify that the service was not consistently identifying or recording high impact or high prevalence risk which had resulted in a poor outcome in care. However, I also acknowledge the service was able to self-report on areas of identified risk and were working towards addressing these through further staff training and education. I also acknowledge the approved provider’s response outlining actions to address monitoring of psychotropic medications and identification of the use of chemical restraint.

However, it is my view the service needs to demonstrate it can consistently manage high-impact and high prevalence risk. Therefore, the service requires further time to demonstrate the changes it has made are effective, including training and education, as well as needing to demonstrate that review of care plans and documents identifies such risks and provides staff with clear and consistent instructions and strategies to manage them.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team found overall, end of life care at the service is provided according to consumer needs and preferences. Staff gave examples of how they alter the care and provide support for consumers when nearing the end of their life. Although the assessment team identified a deficit in the end of life care management plan for one consumer sampled, the review of care and service records indicates end of life care is generally being provided in accordance with the consumer’s wishes.

The organisation has policies and procedures to guide staff providing end of life care. The policy also directs that the specialist palliative care end of life care pathway is used.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported service staff recognise and respond in a timely manner when there is a change in a consumers’ health, function and condition. The review of care and service records indicates timely escalation to the registered nurses and medical officers in response to when a consumer’s condition changes. For the consumers sampled, care and service records reflect the identification of, and response to, deterioration or changes in consumers’ function, capacity and condition. Staff interviewed said they report any changes in the consumer’s condition and accidents/incidents to the registered nurse who then assess the consumer and direct care. Staff said changes in consumers’ condition are discussed at shift handover.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported feedback from consumers and representatives indicated information is not always provided about the consumer, for example following incidents such as a fall. While there are systems in place for communicating information about the care of consumers, the Assessment Team found these were not always applied. An example was provided where significant information was not shared by service staff with other staff involved in a consumers’ care. The Assessment Team found care and service records were not adequately completed to support effective sharing of information about the consumer’s care. Other allied health professionals were seen to have provided direction to staff which was not effectively communicated or followed-up in a timely manner.

The approved provider acknowledged the gaps in documentation and they are confident that the implementation of an electronic system will ensure more timely and appropriate follow-up, as well as, increased accuracy in information supporting shared care requirements.

I have taken into account the findings of the Assessment Team based on review of care plans and records. Whereas I acknowledge the steps taken by the approved provider to address these matters, it is my view these still need to demonstrate they are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team reported consumers and representatives were satisfied with their access to medical and allied health services. Care and service records generally indicate appropriate and timely referral to other service providers. The service has access to onsite physiotherapy and occupational therapy services as well as visiting services including the palliative care team and Dementia Support Australia (DSA).

Staff were able to describe referral systems and processes. Consumer care plans reviewed showed evidence of timely referrals and interventions as directed by others including physiotherapist, occupational therapist, palliative care specialists, podiatrist and dietician.

Based on the information provided I find this requirement is compliant.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team reported staff demonstrated an understanding of how to minimise the spread of infection and strategies to decrease the unnecessary use of antibiotics. However, they found education records show not all service staff have completed required infection control and COVID-19 minimisation of transmission training.

The Assessment Team made several observations of service management and staff showing poor application of mask use. Although Infection data is collected monthly, the Assessment Team were unable to identify how this was trended to identify actions required to manage for example, urinary tract infections.

The approved provider acknowledged the Assessment Team findings under this requirement. However, they have taken action to address the matters and conducted mandatory COVID-19 preparedness training for all staff and provided documentation to show this has occurred. Further to this they note, the rate of infections within the service has dropped and they will continue to monitor, review and trend these clinical indicators.

I acknowledge the actions taken by the approved provider, However, in my view the Assessment Team findings in their report showed staff had not completed required COVID-19 training/education and this had not been identified by the service prior to the assessment contact site audit. The service should continue to monitor staff use of personal protective equipment to ensure this is appropriate.

Based on the information provided I find this requirement is non-compliant.

# 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

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

Overall consumers told the Assessment Team that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers said they are provided with a varied menu and meals that are of a suitable quality and quantity. Feedback, observations, a review of documentation and interviews with management confirmed equipment used to support consumer lifestyle is safe, suitable, clean and well maintained.

However, while consumers are supported to things of interest to them, consumers and their representatives said they have found challenges in maintaining relationships during visiting restrictions due to COVID-19 requirements.

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

## Assessment of Standard 4 Requirements

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

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

Overall the service was able to demonstrate each consumer gets safe and effective services to support them with daily living.

Based on the information provided I find this requirement is compliant.

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

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

The service was able to demonstrate there are services and supports in place for daily living to promote consumer emotional, spiritual and psychological well-being.

Based on the information provided I find this requirement is compliant.

### 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.*

The Assessment Team reported most consumers and representatives were satisfied about the opportunities for consumers to do things of interest to them. In particular they provided positive feedback regarding the lifestyle team.

Staff provided examples of how they support consumers to participate in interests and to connect with others outside the service as much as possible. Care and service records support that most consumers’ needs are identified in relation to social and relationships and have identified their interests. However, both consumers and representatives said there were challenges in consumers remaining connected with family during visiting restrictions. In particular, regarding communication around the arrangements for visits; that staff were not responding to phone calls (and in particular on weekends) and that complaints regarding such matters were not consistently being followed up.

Service management told the Assessment Team that with COVID-19 restrictions in place, the service provided risk free visits, such as window visits and videoconferencing visits, as well as in person visits on compassionate grounds. They said they have followed up with consumers and representatives to establish how best to communicate requirements such as restrictive visiting practices. They also identified there have been issues with the service’s telephone system and they have worked to remedy this with additional wi-fi coverage installed.

The approved provider noted that restrictions on visiting during the COVID-19 pandemic were in response to state and federal government instruction and advice. They acknowledge the frustrations experienced by consumers and representatives over this period. In response to findings in the report they are surveying consumers and representatives to get feedback on how they perceived the restrictions and communication around them could have been more effectively communicated. They note that restrictions are now easing and there is now more capacity to recommence some activities and entertainments within the structure of COVID-19 safe practices.

I consider that the service was able to demonstrate compliance with this requirement.

Based on the information provided I find this requirement is compliant.

### 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 service demonstrated it has processes in place to communicate information about consumers’ condition, needs and preferences using the computerised care and service record in relation to services and supports for daily living. Care documentation generally provides sufficient information to support effective and safe care in relation to lifestyle supports and services. Staff are generally aware of consumers’ needs and preferences and could discuss these. Consumers and representatives said overall, staff are aware of their needs and preferences in relation to lifestyle supports and services.

Based on the information provided I find this requirement is compliant.

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

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

The service was able to demonstrate referrals to individuals and other organisations in relation to services and supports for daily living is in place.

Based on the information provided I find this requirement is compliant.

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

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

Most consumers and representatives told the Assessment Team consumers enjoy their meals; have enough to eat and there is variety in the menu. A contracted catering service commenced three weeks prior to the performance assessment; they have introduced a new menu with consumer input being sought, and they said the menu will change with each season. Information about consumer dietary needs and preferences is consistently documented and well understood.

The contracted catering service representatives explained in the three weeks since they have been providing the catering service, they have been out in the dining rooms during meal times speaking with consumers to get their feedback and they have received written feedback from some consumers.

The group property manager explained there is a plan to build a servery downstairs and to remodel the kitchen upstairs to turn it into a servery, and then meals will be served to consumers from a bain-marie. Documentation was shown to support that plans are underway, and work anticipated to be completed by February 2021.

Based on the information provided I find this requirement is compliant.

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

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

The service demonstrated equipment provided is safe, suitable, clean and well maintained.

Based on the information provided I find this requirement is compliant.

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team reported consumers and representatives informed them consumers feel welcome, safe and comfortable in the service environment, and that they feel furniture and equipment is well maintained. A lot of new equipment has been purchased for consumers in 2020.

The Assessment Team observed that there are elements of the service environment that are welcoming and there are communal spaces for socialisation and lounge areas for consumers to receive guests.

This consumer/representative feedback and observations show the service environment is generally safe, clean and well-maintained, and that consumers can access the outdoor areas. However, some gaps in the safety and maintenance of the service environment were identified. Some of these had been previously identified but not addressed. Gaps in safety, cleanliness, maintenance or suitability were identified in some areas for one or more consumers. The Assessment Team reported monitoring systems such as audits have not been demonstrated to be effective in identifying such gaps.

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

## Assessment of Standard 5 Requirements

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

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

The Assessment Team observed that there are elements of the service environment that are welcoming and there are communal spaces for socialisation and lounge areas for consumers to receive guests. However, the Assessment Team found the service environment does not reflect dementia enabling environmental principles, nor that management could demonstrate it had been adequately reviewed for this purpose.

However, the service provided information to show the environmental changes in progress and that are planned for the future refurbishment at the service. These include enabling consumers to move freely and access the outdoor areas.

The approved provider said a number of the changes identified by and discussed with the Assessment Team were improvements for consumers living with cognitive impairment in line with the dementia enabling principles and this was part of the planning for the service environment going forward. The service’s continuous improvement plan shows a nurse practitioner specialising in dementia environmental review was scheduled to conduct an audit of the service on 25 November 2020.

I am satisfied that the approved provider demonstrated compliance with this requirement.

Based on the information provided I find this requirement is compliant.

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

*The service environment:*

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

The Assessment Team observed, and consumer/representative feedback shows the service environment is generally safe, clean and well-maintained, and that consumers can access the outdoor areas and move freely in the environment. Consumers commented on the improvement in cleaning with the recent change in cleaning contractor. However, some gaps in safety and maintenance were identified. Errors were seen in the placement of emergency evacuation plans. There were also gaps in recording the monitoring and completing of reactive and responsive maintenance.

The group property manager advised the Assessment Team that the emergency evacuation plans were removed about seven weeks prior to the site audit and put back incorrectly by the painters at completion of painting work. Management said new plans in frames have now been put up in the right place. Identified areas of maintenance were planned to be attended to and management did not consider the damaged areas constituted a trip hazard. The continuous improvement plan did show issues such as the condition of flooring had been previously identified and there were plans for this flooring to be replaced.

In their response the approved provider said the issues raised were addressed almost immediately and they will continue to audit and monitor the environment to ensure maintenance records are complete.

Although I acknowledge the actions taken by the approved provider to address the matters raised under this requirement, it is my view the service has not adequately demonstrated the auditing processes in place were sufficient to monitor and consistently identify issues requiring remedy in its environment. I have also taken into consideration maintenance and cleaning matters reported under Standard 5 Requirement (3)(c) as evidence that the service could not demonstrate the overall effectiveness of its maintenance program. The service will require further time to demonstrate the changes it has made are effective and its auditing system consistent in monitoring, addressing and identifying gaps in maintenance, its evacuation system and plans and the condition of the environment.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team said that overall, furniture, fittings and equipment were observed and found to be safe, clean, well-maintained and suitable for the consumer. A lot of new equipment was seen to have been purchased for consumers in 2020. However, the Assessment Team identified some gaps in the safety, maintenance, use and cleanliness of equipment. For example, one consumer was seen to be unable to reach their call bell, and another did not have a floor-line bed. One consumer’s electric wheelchair was seen to be dirty, and a process was not demonstrated for cleaning this. The kitchen cool room door seal was known to be extensively damaged but had not been repaired. Lifter audits and essential fire safety measures service reports identified problems with equipment. Issues were also   
  
  
raised concerning the service’s call bell and telephone system not functioning adequately.

Service management advised the Assessment Team the kitchen cool room door seal was replaced three months prior to this visit, but they will ensure it is reviewed by the contractor who installed it and replaced again. It was acknowledged two lifters (out of the eight in use) should have been put out of service and replaced.

The service’s plan for continuous improvement includes actions to replace the call bell and telephone systems and this was due to occur by the end of 2020.

In their response the approved provider notes there were no adverse comments by consumers or representatives under this requirement. The services continuous improvement plan shows an electronic preventative and reactive maintenance program is being tested. The service has also set up an asset register for all equipment.

I acknowledge the actions taken by service management to address the issues raised. However, I am of a view that the service was unable to demonstrate equipment used by consumers was safe, clean and well maintained.

Based on the information provided I find this requirement is non-compliant.

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

Most consumers interviewed (and representatives on their behalf) considered that they are encouraged and supported to give feedback and make complaints. The consumer representatives sampled who had made a complaint, overall considered their complaint/s was addressed. This feedback and other information gathered shows consumers are encouraged and supported to give feedback and make complaints, and they have access to advocacy and languages services to raise and resolve complaints.

However, it was not demonstrated how the organisation’s system for addressing complaints has been implemented at the service. There was a lack of documentation to show how complaints have been addressed and open disclosure has been implemented. For one complainant there is information showing information given to them in response to their complaint was incorrect. A review of the complaint records does not show if and how complaints are being used to improve the quality of care and services.

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

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found consumers/representatives and others are encouraged to provide feedback and make complaints. Staff described what to do if a consumer or representative gives feedback or makes a complaint. The organisation has a policy and procedure about feedback and complaints, which reflects best practice. A new website for the organisation is under construction and once built will have a section for feedback and a dedicated email address directed to the organisation’s governance department will be promoted.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported consumers and representatives informed them they know where to find information about, or were directly aware of, advocacy and language services. The organisation’s complaint policy and procedures includes details for contacting advocates and language services.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team found overall feedback from consumers or representatives who had made a complaint; was that their complaint/s had been addressed, and the organisation has a system for actioning complaints and implementing open disclosure.

However, the Assessment Team found the service’s complaint records do not consistently show complaints are acknowledged, investigated and actioned or that actions are evaluated for effectiveness or that complaints are resolved. The organisation has a policy and procedure about open disclosure, which provides management and staff with guidance about open disclosure including to give an explanation and to apologise when things go wrong. However, the Assessment Team found staff, including key staff were unable to describe the key principles of open disclosure and how these applied in practice. Although it was identified the former service manager had left suddenly just prior to the site audit and they had managed complaints at the service.

The Assessment Team was advised that the service’s complaints records were reviewed prior to the performance assessment commencing and identified gaps. They outlined their plan to contact each of the complainants to understand from their perspective where the complaint is up to and then move forward in resolving any open complaints. Although this had not yet occurred. Staff were to undergo further training in complaints management in November 2020.

In their response the approved provider said they believe it was a documentation issue. However, they have taken steps to follow-up with complainants who had expressed their dissatisfaction with the previous complaints process. The service’s continuous improvement plan show extensive training has been delivered to staff on complaints management over November 2020, including on open disclosure.

Although I acknowledge the approved provider and service consultant’s actions, I am not satisfied their response has demonstrated that the ongoing management of complaints, including resolution, at the service was effective. In my view, the service requires further time to demonstrate appropriate action is taken in response to complaints and that staff responsible for managing complaints understand how an open disclosure process is used and can demonstrate this in practice.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment Team reported consumers, representatives, management and staff interviewed provided limited information about feedback and complaints being used to improve the quality of care and services. A review of the complaint records did not show complaints were being used to improve the quality of care and services.

The organisation’s and service’s management and the staff provided information about improvements made generally at the service. There was a lack of information provided about improvements relating to consumer feedback and complaints. During later discussions with approved provider representatives they explained that the improvements relating to the service environment and food service (outsourced catering provider) came from consumer feedback.

A complaint register has been commenced and assists in identifying complaint trends at the service. A complaints committee has been formed and complaint trends are monitored monthly. A new system (eQstats) will be introduced to log complaints and will give organisational management representatives visibility of complaints information and trends. Training has been provided to staff in complaints management and consumers and representatives are being more actively involved in the complaints process.

The approved provider in their response said re-occurring type complaints such as about staff at the service not answering incoming telephone calls has now been addressed.

Although I acknowledge the actions taken by the approved provider and the service, I am not satisfied it has addressed how the service demonstrates a review of consumer or representative feedback or how complaints are used to improve the quality of care and services. It is my view the service needs to demonstrate that consumers or representatives can describe how they are involved in finding solutions to issues or how matters they have raised lead to improvements they can describe so that they have confidence that issues they raise are valued and lead to improvements.

Based on the information provided I find this requirement is non-compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

To understand the consumer’s experience and how the organisation understands and applies the individual requirements within this Standard, the Assessment Team spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Most consumers and representatives said overall, consumers get quality care and services when they need them from people who are knowledgeable, capable and caring. Consumers identified they have seen improvements at the service particularly that the staff are more caring. Feedback and the review of documentation showed overall that the workforce is planned, and the workforce deployed enables the delivery and management of safe and quality care and services; and that workforce interactions with consumers are kind, caring and respectful of each consumer.

However, the Assessment Team identified issues under this Standard including that: some training and competencies deemed mandatory for staff have not been completed; some of the training provided was not seen as effective in giving staff the knowledge and/or skills they need to perform their role; overall, training for staff has had limited attendance and staff performance reviews have not been occurring.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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.*

Most consumers and representatives said there are enough staff to meet the needs of consumers and that overall, call bells are answered quickly. Other information gathered shows overall the workforce deployed enables delivery and management of safe and quality care and services.

Based on the information provided I find this requirement is compliant.

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

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

The Assessment Team reported consumers and representatives provided consistent feedback that staff are kind, caring and respectful to consumers. The Assessment Team observed this to be the case during the site audit.

### 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.*

Consumers and representatives interviewed provided information about staff knowing how to perform their roles, and it was demonstrated a system is in place to support staff to have the knowledge to effectively perform their roles. However, some competencies deemed mandatory for staff have not been completed. It was not demonstrated that one staff member sampled has the qualifications and knowledge to effectively perform their role.

A review of two most recent staff meeting minutes shows in relation to manual handling that: staff were reminded to pay more attention and be gentle during personal care provision in the context of consumer skin tears and bruises. And staff were advised of "recent incidents of poor manual handling. Unacceptable, risk to residents, selves. This is performance management issue".

In response, the approved provider submitted an updated continuous improvement plan showing the staff education matrix has been reviewed and updated. Manual   
handling training was scheduled for 15 November 2020. A new mandatory education delivery has been scheduled to occur between 11-13 November 2020, with all staff required to attend. The continuous improvement plan shows a position review has now occurred for a staff member who the Assessment Team identified had been unable to demonstrate they had the skills or qualification required for their role.

Although I acknowledge the actions taken to address the matters raised, I am satisfied the Assessment Team identified a gap in education and mandatory education. The organisation has responded swiftly to this, but the service requires further time to demonstrate that this education has been effective and includes all staff completing education as required.

Based on the information provided I find this requirement is non-compliant.

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

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

Consumers and representatives informed the Assessment Team they did not consider staff needed more training in any areas, and a system was seen in place to support staff recruitment and training. However, as reported by the Assessment Team under the requirement above, it was not demonstrated that all staff have completed all mandatory training or other training relevant to their role such as care planning and assessment.

The Assessment Team’s findings in relation to Standards 2 and 3 reflect gaps in staff knowledge and skill relating to the identification of chemical restraint, managing critical incidents and understanding of the risks associated with falls. The records show there has been some training for staff, however attendance was limited.

In their response the approved provider submitted the continuous improvement plan. This showed staff had been sent a memo to remind them of their requirement to complete mandatory training and ensure their competencies are up to date. The approved provider outlined the system in place to ensure orientation, mandatory training requirements are addressed and met. This includes a training matrix.

I am satisfied the Assessment Team demonstrated the service was unable to show its workforce was trained and supported to deliver the outcomes required by these Standards. Although I acknowledge the actions taken by the organisation to address this. It is my view the service needs to demonstrate the changes made and training and education provided will be effective in meeting this requirement.

Based on the information provided I find this requirement is non-compliant.

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

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

The Assessment team reported there is a plan to commence regular assessment, monitoring and review of the performance of each member of the workforce, but this has not been occurring. A staff performance review schedule was presented, which shows that all staff have been scheduled to have a performance review in November or December 2020. A staff performance review template was also presented, and review of the content shows that the reviews, when undertaken, will be linked to staff competencies.

There is an organisational policy and procedure and a staff handbook which reflect staff performance review is to be undertaken initially after the staff member’s first three to six months of employment and then second yearly. The organisation’s and service’s management representatives acknowledged performance assessments had not been occurring but will be commenced and were due to occur in November and December 2020. However, the Assessment Team identified a staff member’s performance was inadequate requiring them to undergo a performance review in June 2020. However, findings from this review about the staff member’s poor performance were not seen to be in place or addressed.

The service’s plan for continuous improvement includes review is required by human resources of staff performance appraisals. Action includes a new head of people and culture commencing employment on 26 October 2020, and the schedule of staff performance reviews to be completed by the end of the year.

The approved provider in their response stated the performance appraisal system has been reviewed and updated. Workforce planning will provide a framework for ongoing recruitment in line with consumer needs and operational requirements.

I acknowledge that the service has implemented a schedule to complete performance appraisals by the end of 2020. I acknowledge the approved provider has stated there are systems in place to assess, monitor and review staff practices, from orientation to professional development. However, I accept the findings of the Assessment Team that this is an improvement in progress. The service requires further time to demonstrate the systems it is putting into place are effective and will be consistently applied in managing each member of the workforce’s appraisal.

Based on the information provided I find this requirement is non-compliant.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

To understand how the organisation understands and applies the requirements within this Standard, the Assessment Team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services (as assessed through other Standards).

Some consumers interviewed (and representatives on their behalf) said they have seen improvements since the approved provider has been involved and that management of the service has been approachable. The sampled consumers (and representatives on their behalf) recalled being asked for input and feedback via surveys.

It was demonstrated that consumers and their representatives have recently been engaged in the development of the organisation’s new strategic plan and in plans for refurbishment, and they have been engaged in some evaluation of consumer care and services.

A strategic plan is being put in place. A new organisational strategic plan 2021-2025 promoting a culture of safe, inclusive and quality care and services has been developed and is to be communicated to stakeholders and implemented. There has not been and is not yet comprehensive and systematic reporting to the Board about service performance against the Quality Standards and results/outcomes for consumers. A new reporting template is available and there is a plan to commence using this. Information provided by Board members and a senior executive is there are frameworks and systems/processes for Board accountability relating to a culture   
of safe, inclusive and quality care and services, although in some instances these were not shown to be entirely effective or documentation requested was not provided to enable the Assessment Team to validate this.

While the need for improvement in organisation wide governance has been recognised and is being actioned with progress made, implementation remains underway. Effective organisation wide governance at this service was demonstrated in relation to financial and workforce governance, but was not demonstrated in relation to information management, continuous improvement, regulatory compliance, or feedback and complaints.

While a risk management framework exists, effective risk management systems and practices were not demonstrated in general or specifically in relation to managing high-impact or high-prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; or supporting consumers to live the best life they can.

An effective clinical governance framework was demonstrated in relation to antimicrobial stewardship and in relation to physical restraint minimisation. However, an effective clinical governance framework was not demonstrated in relation to chemical restraint minimisation or open disclosure; and it was not demonstrated there are comprehensive monitoring and review mechanisms for ongoing clinical oversight.

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

## Assessment of Standard 8 Requirements

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

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

It was demonstrated that consumers and their representatives have recently been engaged in the development of the organisation’s new strategic plan and in plans for refurbishment, and they have been engaged in some evaluation of consumer care and services.

Some consumers interviewed (and representatives on their behalf) said they have seen improvements since the approved provider has been involved and that   
  
  
management of the service has been approachable. Consumers and representatives recalled being asked for input and feedback via surveys.

The organisation has a policy and procedure about governance-consumer engagement. This includes there are regular resident meetings, feedback mechanisms and consumers are involved in development and update of care plans. Although this has not yet fully formed, I am satisfied progress in this area is occurring.

Based on the balance of information provided I find this requirement is compliant.

### 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 reported the organisation does not have a strategic plan and while one is being developed (2021-25) it is not yet in place. The new organisational plan promotes a culture of safe, inclusive and quality care and services. However, it is in development and was yet to be communicated to stakeholders and implemented. A strategic priority is organisational and clinical governance and being accreditation ready in line with the eight Standards and with continuous improvement in place. Information in the strategic plan about next steps is that implementation plans are to be developed with measurable key performance indicators. One of the pillars the strategic plan is built on is consumer inclusion.

Interviews with a member of the Board and approved provider identified there has not been and is not yet comprehensive and systematic reporting to the Board about service performance against the Quality Standards and results/outcomes for consumers. A new reporting template is available and there is a plan to commence using this. Executive weekly meeting summaries were provided for the last four meetings. However, these did not demonstrate information about results or outcomes for consumers is being regularly and consistently collated, analysed, trended and then reported on and relevant information systematically presented to the Board.

Information was provided about a new clinical governance framework consistent with best practice being introduced; self-assessment of performance against the Quality Standards being undertaken, which the Board has had input into; and the monitoring and review of the risk register which is done in consultation with the Board.

The approved provider representatives/Board members and the general manager operations were able to provide examples of changes made in the last six months   
  
(driven by the Board) as a result of consumer feedback. This included the review of the catering service and its replacement. They also identified the Board were informed and kept updated regarding a critical incident which occurred at the service on 3 September 2020 and resulted in a critical incident investigation. However, the Assessment Team reported a review of this incident did not show a comprehensive investigation had taken place. Nor reflect the steps taken to prevent similar incidents occurring for consumers.

The approved provider in their response acknowledged the work in progress in developing the strategic plan and this was launched on 3 November 2020.

I acknowledge the work being undertaken by the organisation in governance. However, I am satisfied that the findings of the Assessment Team demonstrate that the organisation’s governance system under this requirement is not yet sufficiently formed. In particular, the organisation was unable to demonstrate how it understands and meets its responsibilities in being accountable for the delivery of care and services. It is my view, it needs time for the new framework to be in place that results in comprehensive and systematic reporting to the Board about service performance against the Quality Standards and showing results/outcomes for consumers.

Based on the information provided I find this requirement is non-compliant.

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

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

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

The assessment Team reported the approved provider has recognised and is actioning improvements under this requirement. They note although progress is being made in organisation wide governance it is still in the process of being implemented. Effective organisation wide governance at this service was demonstrated in relation to financial and in general, workforce governance, but was not demonstrated in relation to information management, continuous improvement, regulatory compliance, or feedback and complaints.

The general manager operations explained to the Assessment Team that the Board has recognised the investment which needed to be made to organisational governance and have committed to this. They also explained the organisational structure review, which took place and the new executive level positions created (such as governance, people and culture, property). Approved provider representatives/Board members said the general manager operations coming on board is one of their biggest achievements as they have been instrumental in driving change, including setting up the new governance framework and organisational structure. They all explained these are the reasons why they have been able to effect change quickly, for example, the new computerised care records system was implemented across the group’s services within a short timeframe.

However, the Assessment Team identified a range of deficits regarding the effectiveness of information management. These included: gaps in consumer assessment and care planning and in effective communication within the care team; meetings showed a lack of systematic reporting against standard agenda items; It was not evident that quality audit or comprehensive clinical indicator data is systematically presented and discussed at meetings. The Assessment Team also found gaps in information management relating to communication with consumer representatives.

The Assessment Team identified the organisation has a continuous improvement framework. This does show some effective changes at the service level such as improvements in aspects of communication, meal services and a reduction in the use of physical restraints. However, the Assessment Team found concerns and complaints raised by consumers were not necessarily resulting in improvements. Although the organisation informed the Assessment Team they had quality indicators and audits which demonstrate continuous improvement, these were not provided to show this. The Assessment Team also identified the service’s self-assessment for this performance assessment site audit was not reflective of where the service was up to in achieving compliance against the Standards.

In relation to regulatory compliance matters, information about the schedule of specified care and services was not always up to date. The Assessment Team also reviewed documentation around the service’s consolidated records and found a number of incidents which did not follow mandatory reporting requirements.

Deficits were identified regarding the oversight and trending of complaints at the service and that deficits in this process were only picked up by the organisation just prior to this performance assessment – site audit.

In their response the approved provider said there is an effective, comprehensive, organisation wide governance system. This is under review to ensure it supports individual service needs under this framework and has effective reporting systems. The organisation has commenced processes to comprehensively address the issues raised under this Standard and this requirement. They are establishing a senior executive support team to provide their services with strategic assistance including in maintaining regulatory compliance. A continuous improvement plan was submitted identifying actions being taken and in progress. These include the service moving In October 2020 from a paper-based system, re-establishing moving on audits. Building staff skills and competency. The organisation will launch a web site in November 2020 to provide a further means of communicating and providing information to consumers, representatives, staff and other services.

I acknowledge the comprehensive response from the approved provider in addressing the matters raised under this requirement. However, I am satisfied the Assessment Team findings and the approved provider’s response show that this is a work in progress and still requires further time to demonstrate its effectiveness. I find the organisation and service need further time to demonstrate these changes are effective, can be sustained and do address the gaps identified in this report.

Based on the information provided I find this requirement is non-compliant.

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

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

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

The Assessment Team reported that while a risk management framework exists, effective risk management systems and practices were not demonstrated in general or specifically in relation to managing high-impact or high-prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; or supporting consumers to live the best life they can.

The Assessment Team reported the organisation has governance-risk management policy and procedures, which references and generally reflects the Australian Standard for risk management. This includes a commitment to effective risk management, and guidance for management and staff about risk identification,   
assessment, elimination/control and monitoring/evaluation. The policy and procedure includes that the Board will identify and categorise the major risks faced and create a proactive risk management plan. It includes management provides a report to the Board each month or quarter including about the risk register, all incidents, and improvements made as a result of incidents, near misses and identified risks.

In their response the approved provider wrote, the organisation’s leadership team will have a governance manager involved in monitoring and maintaining the service’s risk register. All staff completed mandatory education on mandatory reporting and reporting abuse. This includes members of the board and the operations manager. All incidents will form part of the Board’s report. Risk assessments in consumer care plans and files will be reviewed at least three monthly and schedule is in place to monitor this.

I acknowledge the range of actions taken by the approved provider to address the issues raised under this requirement. However, I have taken into account these changes are recent and ongoing and will require further review and development. It is my view the organisation and service require further time to show the changes made have been effective in addressing the issues raised under this requirement.

Based on the information provided I find this requirement is non-compliant.

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

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

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

The Assessment Team reported the organisation has a governance-clinical framework and procedure and it reflects best practice, including domains (or pillars) of clinical governance and guidance for management and staff about how to implement these. However, as the Assessment Team found that these were not effectively implemented across the service.

The Assessment Team also reported they were satisfied with how the organisation and service have implemented antimicrobial stewardship which reflects best practice. They identified whereas minimising the use of restraint has been effective in reducing physical restraint (from 22 to nil consumers), they found gaps in restraint minimisation relating to chemical restraint.

In relation to an open disclosure policy the organisation has a policy and procedure, which reflects best practice. However, key staff at the service were unable to demonstrate understanding of this relevant to their role; and the service’s complaint records and some feedback from consumer representatives does not show that open disclosure is consistently implemented in relation to complaints or consumer incidents.

The approved provider in their response stated the service now has a nominated privacy officer. Staff have undergone training in open disclosure. The clinical governance framework will be fully implemented by the end of December 2020.

I am satisfied that based on the Assessment Team findings that the service was unable to demonstrate it was fully compliant with this requirement. Although I acknowledge the changes put in place by the approved provider, the service requires further time to demonstrate they address the issues raised, are effective and can be sustained.

Based on the information provided I find this requirement is non-compliant.

# Areas for improvement

## Standard 1 Requirements

### Requirement 1(3)(c)

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

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

### Demonstrate consumers (and where required- their representatives are supported to make choice and decisions about the way in which their care and services are delivered and that this is effectively communicated with them.

### Requirement 1(3)(d)

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

* Demonstrate that each consumer is supported to take risks to enable them to live the best life they can, and the actions taken to achieve this are effective and can be sustained.
* Monitor and review the effectiveness of this support.

### Requirement 1(3)(e)

*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.*

* Demonstrate that information provided to each consumer supports their choice and decision making and is accurate, timely and effectively communicated.

## Standard 2 Requirements

### Requirement 2(3)(a)

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

* Demonstrate that assessment and planning ensures any consideration of risk supports the delivery of safe and effective care and services and supports consumers’ health and well-being.
* Monitor and review the effectiveness of these assessment and planning processes.

### Requirement 2(3)(b)

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

* Ensure that assessment and planning identifies and addresses consumer goals and preferences, reflect current needs and that it includes end of life planning as and when required.

### Requirement 2(3)(c)

*The organisation demonstrates that assessment and planning:*

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

*services, that are involved in the care of the consumer.*

* Demonstrate that assessment and planning, and review, is based on ongoing partnership with consumers and other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

### Requirement 2(3)(e)

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

* Demonstrate that care and services are effectively reviewed, particularly when circumstances change or when incidents impact on consumer needs, goals and preferences.
* Review and monitor the effectiveness of the systems and processes to support the review of care and services.

### Standard 3 Requirements

### Requirement 3(3)(a)

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

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

* Demonstrate that consumers get safe and effective care and services that are tailored to their needs, are best practice and optimises their health and well-being, including but not limited to behaviour management, identification and management of chemical restraint, and ensuring personal care instructions are complete and being followed.

### Requirement 3(3)(b)

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

* Demonstrate consistent management of high-impact and high prevalence risk, including but not limited to chemical restraint, falls prevention and nutritional risk.
* Demonstrate that review of care plans and documents identifies such risks and provides staff with clear and consistent instructions and strategies to manage them.

### Requirement 3(3)(e)

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

* Ensure that gaps or deficiencies in documentation is addressed and that information is effectively shared.

### Requirement 3(3)(g)

*Minimisation of infection related risks through implementing:*

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

* Demonstrate that all staff have completed required COVID-19 training/education
* Monitor the usage of personal protective equipment to ensure this is appropriate.

## Standard 5 Requirements

### Requirement 5(3)(b)

*The service environment:*

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

* Demonstrate that the service’s auditing system is effective in monitoring, addressing and identifying gaps in maintenance, evacuation systems and plans and the condition of the service environment.

### Requirement 5(3)(c)

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

* Demonstrate equipment used by consumers is safe, clean and well maintained and that the maintenance program is effective.

## Standard 6 Requirements

### Requirement 6(3)(c)

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

* Demonstrate that appropriate action is taken in response to complaints and that staff responsible for managing complaints understand how an open disclosure process is used and can demonstrate this in practice.

### Requirement 6(3)(d)

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

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

## Standard 7 Requirements

### Requirement 7(3)(c)

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

* Ensure that required mandatory education is implemented and completed and is effective in ensuring workforce competency.

### Requirement 7(3)(d)

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

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

### Requirement 7(3)(e)

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

* Ensure the ongoing performance appraisal of each member of the workforce.

## Standard 8 Requirements

### Requirement 8(3)(b)

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

* Demonstrate how the organisation meets its responsibilities to promote a culture of safe, inclusive and quality care and services and in being accountable for the delivery of care and services.

### Requirement 8(3)(c)

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

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

* Demonstrate effective organisation wide governance systems and that can be sustained in relation to the matters identified.

### Requirement 8(3)(d)

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

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

* Demonstrate effective risk management systems and practices in relation to the matters identified

### Requirement 8(3)(e)

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

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

* Demonstrate that the clinical governance system is effectively implemented and supports safe and effective care practices in relation to the matters identified.