Newmarch House

Performance Report

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**Commission ID:** 0974

**Provider name:** Anglican Community Services

**Review Audit date:** 30 June 2020 to 3 July 2020

**Date of Performance Report:** 14 August 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

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Non-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) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Non-compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Non-compliant |
| Requirement 4(3)(e) | Non-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) | Non-compliant |
| Requirement 6(3)(b) | Non-compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Review Audit and Assessment Contact of 16 June 2020; the Review Audit and Assessment Contact report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Review Audit report received on 11 August 2020.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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 the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

While most sampled consumers consider that they are usually treated with dignity and respect, can maintain their identity, make informed choices about their care and services, consumers and representative said the recent COVID-19 outbreak (11 April to 15 June 2020) has significantly impacted on their ability to live the life they choose.

For example:

While consumers and representatives repeatedly spoke with appreciation and regard for the service’s regular staff, issues were raised with agency staff including not being familiar with consumers’ needs including their culture and diversity as well as areas of importance to the consumer.

Although most consumers said they are treated with respect, staff availability and knowledge has negatively impacted on consumer dignity.

Care and services are generally culturally safe.

Although regular staff understand and respect consumer dignity, diversity and culture the heavy reliance on agency staff, staff knowledge and staff availability has negatively impacted on consumer dignity.

Information is not provided to each consumer in a way that is current, accurate and timely, or communicated clearly and easy to understand, and it does not always enable them to exercise choice. Many issues were raised about staff communication and about management’s response when issues are raised.

Generally, each consumer’s privacy is respected, and personal information is kept confidential however, some deficits were identified.

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

## Assessment of Standard 1 Requirements

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

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

The assessment team found that while consumers and representatives repeatedly spoke with appreciation and regard for the service’s regular staff, issues were raised about agency staff including not being familiar with consumers’ needs including their culture and diversity as well as areas of importance to the consumer.

Staff availability has also impacted negatively on the maintenance of consumer dignity.

In their response, the approved provider submitted information about the issues raised by the assessment team. Despite the approved provider describing an admission process where information is available to all staff, including agency staff, about consumers unique care needs as reflected in their ‘Key to Me’ lifestyle assessment, consumer feedback overwhelmingly supports that it hasn’t been used when delivering care and services which show regard for each consumers identity, culture and diversity. While the approved provider described action, it has taken to reduce delays for consumers in receiving care when they use their call bell, consumers remain dissatisfied with call bell response times. Most examples provided by the assessment team where these delays contributed to dignity being compromised, were not disputed by approved provider.

While the approved provider submitted information about actions they’ve taken since the review audit to address staff practices and knowledge which influence consumer dignity such as managing continence issues; consumers wearing other consumers clothes; essential personal equipment not having clear instructions for use; and identifying consumers with clinical risks, they did not provide information to support that the service was compliant with this requirement at the time of the review audit. The approved provider confirmed that the feedback from consumers related to a period when there was exceptionally high use of agency staff.

I am of the view that the approved provider does not comply with this requirement as consumers are not always treated with dignity and respect.

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

*Care and services are culturally safe.*

### 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 found that the service has processes in place to enable consumers to exercise choice in relation to the day to day care and services they receive. However, the organisation does not have systems and processes to ensure that the consumer’s wishes and decisions about when family, friends and other are involved in their care is sought or followed.

In their response, the approved provider submitted information to address the issues raised by the assessment team about consumer satisfaction with the opportunities to exercise choice and independence and specifically to maintain relationships in line with their wishes. They confirm that consumers have been restricted in movement and visitation and acknowledge consumer and representative frustration about this. They acknowledge that communication channels during the COVID 19 outbreak (the outbreak), were not tailored to meet each consumers preference.

While the approved provider submitted information about actions taken since the review audit and during and since the outbreak, consumers and representatives remain dissatisfied and describe limited opportunities for choice in maintaining connections and relationships with others. I am not persuaded that approved provider was compliant at time of the review audit.

I am of the view that the approved provider does not comply with this requirement as consumers are not adequately supported to exercise choice and independence.

### 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 found that some consumers lead the best life they can although the COVID – 19 outbreak brought about unexpected and unwelcome restrictions on consumers’ freedoms. Some staff could not describe how they support consumers who want to take risks or how they manage them. The care plan documents did not have details of consumers interests or instructions for how to support them to take risks.

Most consumers and representative’s express relief the outbreak is over and are pleased to be having some freedoms. Despite this, some consumers said they are not always supported to take risks to enable them to live the best life they can.

In their response, the approved provider acknowledges the need to improve consumers ability to take risks with informed decision making. Education on risk taking, choice and processes are planned as part of future staff development. An organisational Continuous Improvement Plan has been put in place which includes additional supporting documentation and assessment processes through their electronic case management system to enable further improvements in the approved providers approach to risk taking for residents.

As the approved provider does not dispute the findings of the assessment team I am of the view that the approved provider does not comply with this requirement as consumers are not supported to take risks to enable them to live the best life they can.

### 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 found that although there are some systems to provide consumers and representatives information there was considerable negative feedback about communication between the consumer and/or decision maker and management.

Representatives provided feedback about frustrations experienced when trying to communicate or obtain accurate information from staff. Negative feedback relates both through the recent outbreak and at other times.

There was feedback about the phone system repeatedly not being answered.

Complaints are not always recognised or followed up and resolved.

In their response, the approved provider acknowledges the enormity it required to not only resource practically but the increased need for consumer information and access, especially in such a volatile and fast changing and unfamiliar environment. They described how this was undoubtedly stretched with most regular staff standing down, agency staff supervision and resourcing requirements, increased time for infection control and outbreak management, conversion of the facility to ‘Hospital in the Home’ and time needed to ensure resident basic care needs where prioritised.

While I acknowledge that the approved provider was under extraordinary time and resource pressures, I have not been provided with any information to confirm that the service is providing information to each consumer which is current, accurate and timely, in a way that was easily understood and meets their needs. I recognise that improvements are being implemented and the approved provider has received some positive feedback about this, however the consumers and representatives sampled, remain dissatisfied.

I am of the view that the approved provider does not comply with this requirement as consumers are not provided with accurate information that is clear and contemporaneous which enables them to exercise choice effectively.

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

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

The assessment team found that generally, each consumer’s privacy is respected and personal information is kept confidential however several deficits were observed by the assessment team during the course of the review audit and this was corroborated in care file documentation. Staff have sat in and listened to consumer and representative private conversations. Some private information has not been maintained as confidential and kept safe and private.

In their response, the approved provider acknowledges that private information as identified in the report was not managed with acceptable practice.

I am of the view that the approved provider does not comply with this requirement as consumers privacy is not respected and personal information kept confidential.

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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.

Some sampled consumers did not consider that they feel like partners in the ongoing assessment and planning of their care and services.

For example:

Most consumers and their representatives expressed concerns that consumers needs are not adequately addressed and do not always optimise their health and wellbeing.

The care planning documents did not evidence comprehensive assessment and planning for each of the consumers sampled.

Care plans are not individualised relative to the risks to each consumers health and well-being.

Care assessment and planning did not always identify or address each consumer’s current needs. The care planning documents for the sampled consumers did not reflect that the consumer and others are active partners in consumers clinical/personal decisions or are consulted at the time assessment and planning decisions are made. Care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Quality Standard is assessed as Non-compliant as five 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 found that significant risks that can impact consumers health and well-being are poorly managed. Risks are not considered in assessment and planning to inform the delivery of safe and effective care to each consumer in relation to diabetes and insulin management, prevention and management of urinary tract infection, fluid intake, falls prevention and management and bowel management. There has not always been reassessment of consumer risk following incidents.

In their response the approved provider did not dispute the recommendation of the assessment team. They agreed that during the outbreak there were significant issues with diabetes management which was compounded by agency staff levels, skill level and staff consistency. They did not provide any information to address the issues identified with prevention and management of urinary tract infection, fluid intake, falls prevention and management and bowel management.

The approved provider admits that documentation may not have been comprehensively completed. While they are of the view that the assessment and planning with consideration of risk was appropriate, they did not supply any information to substantiate that changes occurred in response to identified risks at the time, concerning assessment of care needs for the sampled consumers. I acknowledge that the service has implemented improvements since the review audit to address gaps identified by the assessment team.

I am of the view that the approved provider does not comply with this requirement as I am not confident that at the time of the review audit, risks to consumers health and well-being adequately informed the delivery of safe and effective care and services.

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

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

The assessment team found that most consumers and their representatives expressed concerns that consumers’ needs are not adequately addressed and are impacting on their health and wellbeing. Corresponding evidence was consistently noted in care documentation where consumers’ needs, and preferences are not identified or addressed in accordance with the consumer’s expressed wishes or in a timely manner.

In their response, the approved provider does not dispute the recommendation of the team. They acknowledge that not all specific details concerning current needs, goals and preferences were reflected in the required documentation, for the sampled consumers. While the approved provider has stated that all consumers at the Service have had discussions about end of life wishes, no information was submitted to confirm this. I acknowledge that an improvement plan has been commenced following the review audit to ensure psychological needs are identified and reflected in consumer care plans.

I am of the view that the approved provider does not comply with this requirement as consumers needs, goals and preferences are not adequately considered in their assessment and planning.

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

*The organisation demonstrates that assessment and planning:*

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

The assessment team found that assessment and planning do not always show ongoing partnership with consumers, their representatives or others. Representatives said decisions about care for their family member were made without the input or consultation with others that are involve in consumers care.

In their response, the approved provider admits that their usual expectations concerning consultation may not have been apparent or documented appropriately. They also agree that the nutritionist did not always consult with consumers.

While I have considered the approved providers statement that this was due to atypical circumstances associated with COVID 19 and consumers not being able to be reviewed face to face, I was not provided with any information to consider which demonstrates that the service adapted the way they partnered with consumers during this time, and included their wishes in assessment, planning and review of care and services. I am not persuaded that there has been adequate partnership with consumers and others in their assessment and planning. While I recognise that the Service is in the process of reviewing its ICARE assessment forms to include consultation evidence, this has not been completed and was not in use at the time of the review audit.

I am of the view that the approved provider does not comply with this requirement as assessment and planning at the service did not adequately demonstrate ongoing partnership with consumers, representatives and other involved in their care.

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

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

The assessment team found that there were inconsistencies observed in consumers’ assessment and planning documentation. This showed that outcomes of assessment and planning are not effectively communicated to consumers or others involved. There is consistent evidence that consumers and their representatives are not readily provided with a copy of consumer’s care plans.

The assessment team and approved provider disagree about information provided to consumers/representatives in the form of their care plans. While the approved provider stated that the sampled consumers/representatives did receive the requested care plans, there was no information provided to substantiate this. The volume of consumers/representatives who requested a care plan or outcome of assessment, indicates that it was not usual practice at the time of the review audit, to proactively provide consumers/representatives with this information.

In the absence of contrary evidence to that of the assessment team, I have preferred the evidence of the team. I am not persuaded that at the time of the review audit, that consumers and their representatives had the outcomes of assessment communicated to them effectively.

I acknowledge that the service has implemented a continuous improvement item following the review audit to improve support to consumers and representatives to access their records. I also acknowledge that the service states it has offered a care conference to all consumers and representatives post outbreak to discuss clinical changes, medications, referrals, review of care plan and advance care planning discussion. I was not however provided with documentation to support that these conferences have occurred.

On balance, I am of the view that the approved provider does not comply with this requirement as the outcomes of assessment and planning at the service were not adequately communicated and a care and services plan was not made readily available.

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

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

The assessment team found that care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Although incidents are included on some occasions in care plans, incidents have not been investigated and are not always reviewed to reflect cause and minimise risk to consumers. Many recent changes were made to the care of consumers who have diabetes. Care plans have not always shown the recent changes. During and following the COVID -19 outbreak, care plans were not reviewed to reflect changes to consumer’s condition and end of life processes or consumer preferences. Some reviews of consumer care and services were found to have been completed by staff who were unfamiliar with the consumers including their use of agency designation.

While the approved provider confirmed in their response that it has a process in place for initial and regular re-assessment and care plan reviews, and states that all consumers have been reassessed post outbreak, no documentation was provided to substantiate that this has occurred in practice.

The approved provider admits that there was a large cohort of Agency and non Newmarch staff working during the outbreak and that they were unfamiliar with Aged Care and the requirement for updating assessments at the time. While I recognise that the service moved from an electronic case management system to a paper-based system during the outbreak, I am not convinced that this was responsible for care and services not being reviewed regularly for effectiveness and when circumstances change, or incidents happen.

I acknowledge that the service is now using a clinical risk management tool which they state they are reviewing daily for high risk consumers and will provide education to staff, however, I am not satisfied that this new process was established and effective at the time of the review audit.

I am of the view that the approved provider does not comply with this requirement as care and services were not adequately reviewed for effectiveness and when incidents impact on the needs, goals and preferences of the consumer.

# 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 sampled the experience of consumers – their care plans and assessments were reviewed and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

While some sampled consumers consider that they receive personal care and clinical care that is safe and right for them, most do not.

For example:

Concerns were raised by consumers and representatives about the access to health professionals for advice and review.

Concerns were raised about incident management and consultation and follow up to support consumer care and minimise further risk to consumers.

Each consumer does not get safe and effective personal care and/or which is tailored to their needs or optimises their health and well-being.

Skin care, falls management, medication management continence care, end of life care, nutrition and hydration and incident management does not always meet consumer needs and does not optimise consumer health and well-being.

Although there has been recent review of chemical restraint both physical and chemical restraint use has been high.

The Quality Standard is assessed as Non-compliant as seven 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 that each consumer does not get safe and effective personal care and/or, clinical care that is tailored to their needs or optimises their health and well-being.

Skin care, falls management, medication management continence care, end of life care, nutrition and hydration and incident management is not consistent with the organisations work instructions and does not always meet consumer needs and does not optimise consumer health and well-being.

Staff do not all demonstrate an understanding of best practice care provision.

While the approved provider disagreed in their response with some of the case level information in the review audit report, they did not dispute the recommendation of the team. They agreed that during the outbreak there were significant issues with diabetes management which was compounded by agency staff levels, skill level and staff consistency. They also admit that documentation may not have been comprehensively completed. They admitted there was shortages of staff and a large cohort of Agency staff, many who may not have possessed the required clinical skill and experience needed in an Aged Care setting. They agree there were deficits in documentation and in following expected procedures.

The approved provider acknowledges that there have been several concerns raised in the Review Audit where consumer care has not been best practice, ensuring appropriate outcomes and needs being fully met. In their response they have stated that they are committed to upskilling staff and have continuous improvement initiatives in place to meet best practice in the areas of falls management, diabetes management, skin integrity and pressure injury prevention and management, wound care, weight management, and medication management.

While I acknowledge the unique circumstances relating to staffing at the service, I do not agree with the approved providers statement that it is to be expected that pressure areas are likely when they had insufficient staff. I do not consider that it is acceptable that poor consumer health outcomes are to be expected, nor accepted.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that each consumer gets safe and effective personal care which is best practice, tailored to their needs and optimises their health and well-being.

### 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 that there is a lack of effective management of high impact and/or high prevalence risks associated with the care of each consumer. Incidents have not had rigorous investigation to improve outcomes for consumers. Falls are not always documented as incidents and bed sensors have not worked or are not in place. Although there is generally review following falls, strategies are not effective to reduce recurrence.

Diabetic management is high risk and of high prevalence. Medication management is high risk to consumers and of high prevalence. There have been many medication incidents and consumers do not always have their medications administered as prescribed.

While the approved provider disagreed with some of the case level information in the review audit report, they did not dispute the recommendation of the assessment team. They described the challenges they encountered with the provision of care to consumers during the outbreak especially in relation to high impact and high prevalent risks. Clinical leads needed to be replaced and replacement staff sent did not meet the skills or standards required in this position. One was dismissed during this period due to performance concerns. Agency Registered Nurses, not familiar to Aged Care, a Covid-19 environment and presenting with varying skill levels & Knowledge also made it challenging meeting consumers care needs appropriately.

In their response, the approved provider specifically addressed the issues raised by the assessment team about medication management. They undertook a review and identified that many errors were associated with a lack of understanding of their electronic case management system despite education, verbal and visual reminders. Following the review audit, they have taken performance management action where necessary following the investigation of other medication incidents.

The approved provider admits that documentation has not met their expectations.

The service has responded to the issues raised by the assessment team following the review audit by implementing an organisational continuous improvement initiative.

On balance, when considering all of the information before me, I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

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

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

The assessment team found that the service did not demonstrate the needs goals and preferences of each consumer nearing the end of life are recognised and addressed; that their comfort is maximised or that their dignity is preserved. While aspects of end of life care provision are shown as compassionate and caring others are not. There were deficits in skin integrity, pain management, preservation of dignity and consumer choice prior to, during and following the COVID-19 outbreak at the service.

High agency staff usage meant there were issues with staff knowledge prior to the outbreak. The COVID-19 outbreak also resulted in staff being unfamiliar with the consumer’s needs, preferences and their history. Consumers and their decision makers had to make rapid choices within the limited options available.

While I accept that actions were taken by the approved provider to minimise suffering, such as:

* Pastoral carers and lifestyle staff visited all consumers regularly;
* a Catholic Priest came to say the consumers ‘last rights’ as well as using ‘facetime’ to ensure this occurred;
* psychologist also visited all residents and conducted GCD. High scores for depression were referred to the doctor to review; and
* ‘Stop & Watch’ forms for referring changes and pain observed by carers;

I cannot ignore their statement that there were times, due to staff shortages, that medications may have been administered later than usual and documentation was not as rigorous as it could have been.

I have not been provided information by the approved provider concerning the sampled consumers which confirms that the unique needs goals and preferences for each consumer nearing the end of their life were addressed and their comfort maximised.

On balance, I am persuaded by the evidence of the assessment team that while some aspects of end of life care demonstrated compassion and care, other aspects did not.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that consumers needs, goals and preferences of consumers nearing the end of their life were recognised.

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

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

The assessment team found that deterioration in consumer condition is not always recognised and responded to in a timely manner. There was negative impact to consumers due to lack of clinical oversight in relation to the deteriorating consumer.

While the approved provider disagreed with the assessment team about some aspects of case level information, they did not dispute the recommendation of the team. The approved provider recognises that the identified concerns in the report are not the expected standard of recognising and responding to consumer condition changes. They have implemented continuous improvement activities to address the issues raised by the assessment team.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that deterioration or a change in the consumers mental health, cognitive or physical function, capacity or condition is recognised and responded to appropriately.

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

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

The assessment team found that information about the consumer’s condition, needs and preferences is not always documented or communicated within the organisation, and with others where responsibility for care is shared.

Communication has been highlighted as a concern by numerous individuals. Family members expressed anger and disappointment about how they were informed about care issues.

In their response, the approved provider did not dispute the recommendation of the assessment team. It acknowledged that the outbreak and large usage of Agency support staff, increased communication demands, and altered documentation process from the electronic case management system to paper based and this caused variances within documentation and communication with families.

While an initial communication team and hotline were put in place, it was identified that this was not enough in meeting families concerns. With the support of the NSW public health, assistance was given to establish a communication team of registered nurses. This assisted in meeting the greater demand for communication during this period.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

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

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

The assessment team found that there have not always been timely and appropriate referrals to individuals, other organisations and providers of other care and services such as dieticians, physiotherapists. Representatives expressed dissatisfaction with access to some services.

While the approved provider stated that telehealth and phone appointments occurred with providers during the period of lockdown and that their usual practice is to refer to speech pathologists, dietician’s, nutritionists, podiatrists, geriatrician’s, dentists, ophthalmologists and psychologists, they did not submit any information concerning the sampled consumers which confirms referrals were made and that service delivery was modified to accommodate visitor restrictions.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate appropriate referral to individuals or other organisations where relevant.

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

*Minimisation of infection related risks through implementing:*

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

The assessment team found that staff do not follow organisation policy in monitoring and management of infections. There has been high incidence of infections including urinary tract infections. Deficits were found in staff infection control practices and cleaning of equipment including during the COVID 19 outbreak.

Despite the approved providers description of infection control process being in place prior to the outbreak of COVID 19, they acknowledge the difficulty the outbreak presented in maintaining effective infection control.

They stated that the enormity of transitioning to a hospital in the home, a significant cohort of agency staff and skill mix, varying directives and advice from various stakeholders and managing an unprecedented event and infection management processes in a facility designed to be a home and not a hospital, tested their process.

They acknowledge issues relating to staff understanding procedure and responding appropriately as evidenced by PPE compliance issues, and transmission of positive cases amongst staff which they believe was possibly a result of socialising outside of work and traveling on public transport and cars together.

Since the review audit and outbreak the approved provider has conducted an internal and external root cause analysis to identify learnings to inform future outbreak management.

While the approved provider disagreed with the assessment team about some case level information concerning the identification of urinary tract infections, it did not dispute the recommendation of the assessment team.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate appropriate knowledge and practice concerning infection control.

# STANDARD 4 NON-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 team also examined relevant documents.

Some sampled consumers consider 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.

For example:

Although there were some issues relating to satisfaction with the meal service generally consumers are satisfied with the choice, variety and quality of the meals provided.

Consumers confirmed they have not lived the life they want during the COVID -19 outbreak. Consumers expressed relief that “things are getting better”.

Many consumers are supported in their spiritual beliefs although there has been limited support for consumers who hold spiritual beliefs other than the Anglican faith.

Every consumer does not get safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, health, well-being and quality of life.

The lifestyle program has very limited activities documented and there is minimal accountability or evaluation of the program. Staff are unable to demonstrate consumer consultation.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-compliant

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

The assessment team found that every consumer does not get safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, health, well-being and quality of life.

Although interests and preferences are identified on entry to the service there is limited support for personal preferences to be met.

Most agency staff are unfamiliar with consumer needs, goals and preferences. Some of the permanent staff were also not aware of changes to consumers’ needs and preferences.

While the response of the approved provider described efforts at the time to provide safe and effective services and supports to meet consumer’s needs, goals and preferences, they agree that for the sampled consumers, the feedback from consumers to the assessment team was overwhelmingly negative and that agency staff were not familiar with their need’s goals and preferences. They did not provide information to explain why lifestyle assessments weren’t always current and didn’t reflect consumer’s current interests.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that consumers receive appropriate supports for daily living which meet consumers needs, goals and preferences and optimises their independence, health, well-being and quality of life.

### Requirement 4(3)(b) Non-compliant

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

The assessment team found that the service is an Anglican faith-based organisation and the Anglican mission is evident throughout the living environment and lifestyle program. Many of the lifestyle engagements are faith based including bible study, chapel and daily devotions. There is a chapel for Anglican church services.

While there is a pastoral support team and volunteers to support consumer faith and care, consumers of other faiths are not adequately supported in the choice of their faith. Information derived from care and monitoring records indicate consumers from other faiths mostly relied on their family’s support to maintain these connections.

The service has engaged the services of a psychologist; however, some consumers have had limited supports in relation to their emotional, spiritual and psychological well-being.

While the response of the approved provider described efforts at the time to provide consumers with services and supports for daily living to promote consumers emotional, spiritual and psychological well-being they acknowledge that consumers feedback indicated that the approved provider was not meeting consumer expectations when they’re feeling low.

In their response the approved provider described examples of support provided to consumers who are not from a Christian or Anglican background, however for the consumers sampled, no contrary evidence to that of the approved provider was submitted. There was also no additional information provided which demonstrates how the approved provider ensured the psychological well-being for the sampled consumers, where their representative had raised concerns.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that consumers receive services and supports for daily living which promote each consumer’s emotional, spiritual and psychological well-being, unless they are of an Anglican faith.

### Requirement 4(3)(c) Non-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 found that the lifestyle program has very limited activities documented and there is minimal accountability or evaluation of the program. Staff are unable to demonstrate consumer consultation. The program is heavily reliant on religious activities. Bus trips, other outings and community access and interactions have been cancelled since the end of March 2020. Volunteers who provide consumer support have also not visited.

Family have not been able to visit; window visits commenced then transitioned to socially distancing visits in designated areas and coordinated room visits commenced on Wednesday 1 July 2020.

The approved provider did not dispute the sampled consumer’s feedback that they felt that they had not been encouraged to participate in the community outside the service or to maintain relationships or do things of interest to them, especially during the outbreak. The approved providers response did not demonstrate how information in consumers care plans prior to the outbreak about how consumers participate in the community and maintain relationships, were modified during and following the outbreak, to ensure consumers were doing the things of interest to them.

The approved provider does not dispute that there is insufficient consultation with consumers about the activity program, or that there is inadequate variety of activities. They described their plans to commence a resident activity committee to discuss new activities and to seek elected representatives.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that it provides appropriate services and supports for daily living to assist each consumer participate in their community undertaking activities of interest to them or have social and personal relationships.

### Requirement 4(3)(d) Non-compliant

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

The assessment team found that information about the consumer’s condition, needs and preferences is not always communicated within the organisation, and with others where responsibility for care is shared. This was confirmed by staff who were interviewed during the review audit.

Communication was identified as a major deficit by consumers and representatives during the review audit.

The approved providers response to this requirement focused on the communication of clinical information, rather than providing information about how the service manages and shares information within the service and with others where responsibility for care is shared, about consumers preferences and needs. While they provided some information about one of the sampled consumers and the service’s communication, they did not respond to issues raised by the assessment team concerning the other four consumers.

The approved provider confirmed that poor communication of information within the service and between the service and representatives was experienced, due to moving between an electronic and paper-based case management system and the large volume of agency staff who were not familiar with consumers or Aged Care.

I acknowledge that the approved provider has begun responding to issues raised by the assessment team and is recruiting communication team members.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared at the time of the review audit.

### Requirement 4(3)(e) Non-compliant

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

The assessment team found that timely and appropriate referrals to individuals, other organisations and providers of other care and services are not evident.

The acting deputy manager and Care Manager said they were uncertain if any consumer has NDIS funding. On reviewing the consumer information, the Assessment Team identified two consumers. There was no evidence about the frequency or effectiveness of the volunteer visits.

The services described in the approved providers response, for which sampled consumers were referred related largely to clinical services. This is addressed in the compliance decision relating to 3(3)f.

The approved providers response did not describe how the service works with external organisations or uses volunteers to help supplement the lifestyle activities program offered within the service. This is despite the assessment team identifying two consumers who may be eligible for NDIS support.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate timely and appropriate referral to individuals, other organisations and providers of other care and service to support the lifestyle program offered at the service.

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

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

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

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

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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 team also examined relevant documents.

Most sampled consumers considered that they feel they belong in the service, and generally feel comfortable in the service environment. While some consumers said they feel safe issues relating to safety were identified.

Consumers indicated they mostly feel at home at the service and staff made their visitors welcome.

For example:

Consumers generally reported the service environment is comfortable and meets their needs.

Consumers said they feel at home in the service and enjoy the outdoor areas of the service and that cleaning services are satisfactory.

While consumers indicated they feel comfortable in the service and the service was generally clean, observations and documentation show that fittings and equipment are not always maintained to a high level and do not ensure the safety of consumers. In particular the call bell system is not reliable. Although action has been taken to rectify faults when they are reported, the safety of consumers cannot be ensured due to the intermittent nature of the defects. Some consumers are not supported to access the outdoor areas of the service when they wish to do so.

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.*

### 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 found that the living environment is generally clean and comfortable.

While consumers said they enjoy the amenities of the service and can move freely about, except in the recent COVID-19 outbreak and they generally did not express concern with the maintenance of the living environment, observations by the team indicated that the service environment was not well maintained. For example, the call bell system has been unreliable since at least April 2020, handrails, doors and walls were marked or damaged, a cytotoxic waste bin was observed near the maintenance area.

The deputy manager and building supervisor said that other than an annual WHS audit, the service does not have regular audits or monitoring to identify needed repairs or hazards.

In their response, the approved provider submitted information to address the issues raised by the assessment team. The approved provider did not dispute the observations of the assessment team concerning the maintenance of the environment. While they have stated that they have undertaken remedial action following the review audit, no documentation was submitted to confirm this. The approved provider also did not describe how they support consumers to move freely about the service where they need assistance to navigate doors to courtyards, and they remain unlocked, but closed.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that the service environment is safe, clean and well maintained.

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

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

The assessment team found that the service has not ensured that fittings and equipment are safe, clean, well maintained and suitable for the consumer.

While the service has some monitoring systems (preventative maintenance checks, biannual environmental audits, annual WHS inspections) to ensure that the furniture, fittings and equipment are in sound working order the assessment team observed safety of consumers may have been compromised where communication systems weren’t reliable. For example, the afterhours door bell and phone system and ‘Vocera’ staff communication system were not functioning effectively during the review audit.

The call bell and sensor alert system is not reliable which puts the safety of all consumers reliant of the system at risk of not being attended to when they need assistance. An incident report on 17 May 2020 record two incidents involving consumers whose call bell was noted to malfunctioning on that day.

In their response, the approved provider acknowledges that there have been some periods during the Covid-19 outbreak that some call bells have been found not to be functioning despite an earlier audit which they state the system was found compliant. The approved provider reports and this have been escalated and rectified. The approved provider has continued to work with the call bell provider to ensure this system is compliant. The approved provider stated that an additional full audit has been conducted with full compliance however no date was provided or documents to support this. They state that a replacement and upgrading the call bell system has been fast tracked. Challenges with Agency staff connecting bed sensors correctly has also been identified by the service. The call bells and bed sensors continue to be checked ensuring compliance and safety. Education has been provided by the contractor with staff. Despite the approved providers statements of a functioning call bell system, no documentary evidence was supplied to refute the observations of the assessment team at the time of the review audit.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

# STANDARD 6 NON-COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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 team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Some sampled consumers considered that they are encouraged and supported to give feedback and make complaints. However, most consumers did not feel appropriate action is taken in response to complaints.

For example:

Consumers felt that they are aware of and able to provide feedback and raise complaints. However, they indicated that complaints are not effectively responded to and/or addressed.

Consumers have not seen changes made at the service in response to complaints and feedback. For example, many consumers and representatives said that they have raised concerns on many occasions but that the problems continue to occur. Some consumers believed that the responses to complaints are a “PR exercise” and issues are not genuinely addressed. In addition, some consumers and representatives felt that the underlying systemic issues related to complaints are not addressed.

The service does not demonstrate that actions are taken to resolve complaints satisfactorily and/or that actions to address the complaints are implemented and evaluated. There is limited evidence to demonstrate that feedback and complaints result in improved care and services.

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

## Assessment of Standard 6 Requirements

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

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

The assessment team found that the service has avenues for raising complaints which are made known to consumers through brochures, newsletters and handbooks. Consumers indicate they are aware of avenues through which they can raise concerns. However, the organisation’s policies and procedures for complaint management do not demonstrate consideration has been given to ensuring effective complaint mechanisms to support and encourage feedback and complaints.

In their response, the approved provider described many complaints and actions taken by the service to address and resolve those complaints that were raised both during the outbreak and following the review audit. However, no supporting information was provided by the approved provider which demonstrates how they encourage and support consumers to make complaints, which is contrary to the assessment team’s observations that policies and procedures and information available to consumers and representatives does not effectively encourage or support them to make complaints.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that complaints and feedback systems are effectively facilitated for consumers.

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

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

The assessment team found that aside from brochures for advocacy services in the foyer of the service, the service did not evidence ways in which the service ensures that consumers are aware of and have access to advocates, language services and other methods for raising and resolving complaints. While the external complaint mechanism brochures are available in languages other than English, none of these brochures are languages that are identified as being spoken by consumers in the service and there are no brochures in the languages that are spoken by consumers living in the service.

In the service’s complaints documentation there was mention of an OPAN (older persons advocacy network) webinar although staff did not mention this.

In their response, the approved provider described how they conducted webinars and a visit during the outbreak involving OPAN and the Senior’s Rights Service. While I have no reason to doubt that this occurred, there was no supporting information provided to support this statement. The approved provider also did not address how staff were not aware of these advocacy services, webinars and visits.

On balance, considering the information before me, I am of the view that it is more likely than not, that the approved provider does not comply with this requirement as the service did not adequately demonstrate that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

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

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

The assessment team found that the service has been receiving large numbers of complaints since the middle of 2019. No action has been undertaken to determine the cause of complaints and to satisfactorily resolve issues. Consumer and representatives report that the service is not responsive and/or not effectively resolving their concerns. Documentation for the complaint system is haphazard and does not enable tracking of complaint issues to ensure their satisfactory resolution.

The policies and procedures guiding complaint management are not comprehensive and do not provide guidance about use of external complaint agencies relevant to residential aged care.

The policies do not include any requirement for open disclosure.

In their response, the approved provider recognises improvement is required in managing complaints to ensure consumer satisfaction and that this is well documented. They do not dispute that their policy does not articulate an open disclosure framework. They agree with the assessment team that especially during the outbreak, documentation to responses is limited. I accept however, that the service has attempted to take actions to address concerns raised by consumers.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

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

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

The assessment team found that the service has not ensured that feedback and complaints are reviewed and used to improve the quality of care and services. Complaints have been at a high level for an extended period of time. Complaints of a similar nature have been occurring since the middle of 2019, for example complaints about various aspects of care and staffing, however effective actions have not always been taken to address the ongoing identified issues. There is limited evidence of analysis of complaints to identify the reasons for ongoing complaints which have not been effectively resolved.

In their response, the approved provider described improvements which have resulted from individual complaints during the outbreak. They did not however provide any information to support that the service has a mature and longstanding practice of systematically and regularly reviewing complaints for themes and common issues and developing action plans to address them.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

# 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 sampled consumers did not consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

For example:

All consumers and representatives indicated that staff are kind and caring most or all of the time.

Consumers and representatives generally said that regular care staff are “good” but raised concerns about the skills of agency staff.

Some consumers and representatives felt staffing levels are not adequate.

The Assessment Team found that -

* Call bell response reports demonstrate that call bells are not responded to in a timely manner.
* The workforce does not demonstrate knowledge and competence to carry out their roles effectively.
* The service does not ensure that staff are adequately trained, supported and performance is not monitored and responded to.

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) Non-compliant

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

The assessment team found that consumers, staff and management acknowledge that the service has a history of insufficient staff. The service has taken very recent action to improve staffing levels through the introduction of a new roster which commenced on day two of the review audit. However, call bell response times and feedback demonstrate that consumers’ needs are not always met in a timely manner. The service is unable to demonstrate that the newly implemented roster and the mix of the workforce will ensure the delivery and management of safe and quality care and services.

In their response, the approved provider submitted information about the issues raised by the assessment team. I acknowledge the changes made by the service relating to a new roster and how agency staff are contracted which were commenced during the review audit. I also recognise that according to averages stated by the approved provider in their response, improvements have been achieved concerning call bell response times since the review audit. This is however contrary to the data obtained by the assessment team, which indicates a large volume of call bells unanswered within 10-15 minutes. While I have no reason to doubt the accuracy of the information provided by the approved provider, I was not provided with call bell reports to substantiate the approved providers average figures provided.

I have also considered that the improvements described at the service have been recent, and the service has not yet demonstrated sustained improvement. In making my finding, I have considered the consumers feedback and experience, and that there was agreement from Management at the time of the review audit, that there were issues with the availability and skill mix of staff which were evident prior to the outbreak and review audit.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

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

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

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

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

The assessment team found that consumers and representatives provided feedback about deficiencies in care and services related to staff knowledge. The service is reliant on agency staff for the operation of the service. There is limited education and training of agency staff; many consumers, representatives and staff reported on the lack of knowledge of agency staff. Deficiencies in staff knowledge and skills were identified in all Standards during the review audit.

In their response, the approved provider submitted information about the issues raised by the assessment team.

While I acknowledge that the approved provider took steps to educate agency staff in donning and doffing PPE, handwashing and infection control, the assessment teams evidence demonstrates these staff were unfamiliar with the broader working environment expectations at the service, and the consumer’s needs, goals and preferences.

I am of the view that the failures observed by the assessment team across all standards, together with consumer dissatisfaction documented in the complaints register and voiced to the assessment team about staff competency and familiarity with their needs, goals and preferences, support the finding that service is not compliant with this requirement. I am not convinced that staff competency was assessed and managed across all care and service domains, despite having role descriptions with responsibilities and accountabilities, toolbox talks and orientation.

No role descriptions were provided which articulate competencies, nor were any records submitted to substantiate that competency has been assessed or confirmed for any staff.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

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

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

The assessment team found that while the organisation has a detailed induction program for permanent staff, there are no induction programs for leadership roles. There is limited induction for agency staff. The service has not ensured that staff complete compulsory education components. Multiple deficiencies identified across all Standards demonstrate that the workforce has not been trained, equipped and supported to deliver the outcomes required by these standards.

In their response, the approved provider affirmed that there is a difference in practice at the service in how training, recruitment and competency is assured between permanent and agency staff. As previously described in the compliance decision for 7(3)a, there has been a large volume of agency staff used at the service, which pre-dates the outbreak and the review audit.

No response was provided about staff whom the assessment team identified did not possess the minimum requirements for their role. No information was provided about the training needs for lifestyle or other care or non-clinical staff. No information was provided to substantiate that staff who do not meet competency when first assessed are provided education and training to support them to deliver the outcomes required of the standards.

I acknowledge that the approved provider has responded to the feedback from the assessment team and is in the process of updating the induction processes for clinical and management staff, however I am not persuaded that this demonstrates compliance at the time of the review audit.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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).

Most sampled consumers do not consider that the organisation is well run and that they can partner in improving the delivery of care and services.

The Assessment Team received mixed feedback in relation to this requirement. Consumers generally believe that the organisation has not effectively managed the outbreak and feel there were issues in how the service was managed prior to the outbreak. Some feel that the management and staff are “doing their best” or “trying hard”. Many consumers expressed support for the organisation and the difficulties faced.

The organisation does not have systems and processes to ensure that the services are accountable for the delivery of their care and services. Deficiencies were identified in relation to most governance systems. Effective risk management systems and practices are not in place and while documented clinical governance framework is in place, it has not ensured that clinical needs are assessed or that clinical needs are met.

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.*

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

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

The assessment team found that the organisation does not have systems and processes to ensure that the service is accountable for the delivery of their care and services.

Management were able to describe a number of ways in which the governing body is involved in the organisation, including changes to warfarin management which occurred as a result of a significant incident. They said significant incidents and issues, including any non-compliance with the Aged Care Quality Standards is discussed at a Board level. They said in relation to COVID-19 the Board held special meetings to discuss preparedness for COVID-19 risks. They said the Board visits services on a rotational basis to keep in touch with what occurs in service.

However, the organisation has not undertaken significant changes in relation to the new Quality Standards.

In their response to this requirement, the approved provider did not describe how the organisation promotes safe, inclusive and quality care. There were no examples provided of changes made, driven by the board in response to consumer feedback. While their response described the organisation response to a safety issue of the call bell system not being reliable, there was no information about a system for the routine and regular involvement of the Board in other significant incidents relating to the safety of consumers. The response did not demonstrate how the Board satisfies itself that the Quality Standards are being met within the service where policies do not align to the new standards.

While policies are being reviewed in response to the assessment teams’ recommendations, I am not persuaded that the service was compliant with this requirement at the time of the review audit. I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

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

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

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

The assessment team found that the organisation does not have effective information systems. Continuous improvement activities are not effective in ensuring that services are effectively monitored and deficiencies identified. Workforce governance systems have not ensured the service’s workforce mix, allocation, skills and knowledge meet the needs of consumers. The organisation has not ensured compliance regulatory compliance in relation to the Aged Care Quality Standards. Feedback and complaint mechanisms are not effective and responsive.

In their response, the approved provider submitted information about the issues raised by the assessment team.

Despite them confirming having a continuous improvement system in place, they did not explain why this has not translated to improvements at the service which meet consumers expectations. Please refer to compliance findings relating to standard 6 for more information on my reasoning.

While I accept that the service is making changes to address the issues raised by the assessment team concerning workforce management, I am of the view that the failure to comply with several requirements in Standard 7 shows that the governance system relating to workforce management was not effective at the time of the review audit.

I accept that since the review audit, the service is making efforts to improve information management, however, their response did not adequately demonstrate how staff can readily access current information they need about consumers. I am satisfied that the compliance findings relating to information management elsewhere in the standards, confirm that information is not effectively communicated at the service.

I am also satisfied that the compliance finding in standard 6 where all four requirements are found non-compliant, supports that the Service does not have an effective feedback and complaints governance system.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that they have effective organisation wide governance systems.

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

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

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

The assessment team found that whilst a documented clinical framework is in place, it has not been effective in identifying high impact or high prevalence risks associated with the care of consumers. Deficiencies were identified in Standard one and four are the subject of the compliance decision on these requirements. This corroborates the failure or the risk management system in supporting consumers to live the best life they can. Staff were asked whether policies had been discussed with them and what they meant for them in a practical way. Staff responded that they had been educated about some of the policies however they were not all able to provide examples of their relevance to their work.

In their response, the approved provider accepts that they need to be more proactive in the management of clinical risk. While they submitted their improved clinical risk monitoring tool for consumers, it is noted that this tool only records the number of clinical risks, it does not assign a severity or consequence rating, nor does it determine a frequency of occurrence of each risk. Its effectiveness is limited as it is a point in time measurement and may not identify consumers at risk who have a low number of clinical risks, but where there is a high likelihood of potential for harm to the consumer. It does not monitor clinical trends for consumers over time.

I recognise that the approved provider is taking steps to measure their performance regarding clinical risk monitoring by undertaking external benchmarking. However, no data was provided concerning current performance.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that they have effective risk management systems and practices.

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

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

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

The assessment team found that whilst a documented clinical governance framework is in place, it has not ensured that clinical needs are assessed or that clinical needs are met. Refer to the compliance decision concerning Standard 2 and Standard 3 regarding multiple deficiencies identified in relation to assessment, planning and delivery of clinical care.

Deficits were identified with antimicrobial stewardship. Staff did not follow procedures in terms of monitoring of infections and processes prior to the prescribing of antibiotics. The CM said she has engaged with medical officers to ensure they are aware of organisational processes.

The service does not have an open disclosure policy. Open disclosure is not overtly practiced although at times apologies have been seen to be made through some complaints processes.

While I have no reason to doubt the approved providers statement in their response that the service monitors infection rates monthly at their quality meetings, data or meeting minutes were not provided to substantiate this. While the approved provider described their antimicrobial management processes, including discussion at the medication advisory committee, they did not explain why staff were observed to not be following the procedures. The effectiveness of the antimicrobial stewardship framework appears compromised where the framework is not well understood by staff.

The service did not dispute that they did not have a framework that requires open disclosure when things don’t go as planned. I accept that they have taken actions since the review audit to remedy this situation however, no open disclosure policy was provided in their response nor education records demonstrating staff’s instruction in its implementation.

While a policy relating to the minimising the use of restraint was provided to the assessment team, the providers response did not address why staff could not describe what the policy meant for them in practical terms, nor why some staff said they have not been trained in its application. The approved provider acknowledges that a more robust process for the management of psychotropic medication is needed and a new tool is being developed for implementation.

I am of the view that the approved provider does not comply with this requirement as the service did not adequately demonstrate that they have an effective clinical governance framework.

# Areas for improvement

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

### Requirement 1(3)(a)

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

The service must demonstrate that:

* All categories of staff whether permanent or agency treat each consumer with dignity and respect and in a way that shows regard for the identity, culture and diversity.
* All staff know about consumers needs including their culture and diversity.
* Dignity of consumers isn’t compromised by waiting for care due to staffing levels, skill mix and knowledge of staff.

**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.*

The service must demonstrate that:

* It has a system to ensure consumers wishes and decisions about when family, friends and others are involved in their care is sought or followed.
* iCare assessment forms are reviewed to improve details of consumers preferences eg. showering preferences, wake and bed retirement preferences.
* It has delivered the proposed training to staff for Person Centred Care and choice and decision making.
* Lifestyle staff continue to facilitative conversations between consumers and their significant others which aligns with the consumers preference.

**Requirement 1(3)(d)**

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

The service must demonstrate that:

* They have undertaken their proposed training on risk taking, choice and associated processes and have confirmed staff competency in this area.
* They have undertaken the proposed improvements in their continuous improvement plan relating to the assessment process in iCare to support consumers to take risks to enable them to live the best life they can.

**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.*

The service must demonstrate that:

* Consumer and representative satisfaction improve, concerning the communication of contemporaneous information.
* Consumers and representatives can describe the information they get to help them make decisions.
* Staff can describe the different ways they provide information to consumers to assist them with making decisions, including for those with cognitive impairment.

### 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.*

The service must demonstrate that:

* Significant risks that can impact consumers health and well-being are considered when planning care and services. Specific areas of concern are diabetes and insulin management, prevention and management of urinary tract infection, fluid intake, falls prevention and management and bowel management.
* There is evidence of reassessment of consumer risks following incidents.
* This practice is consistent regardless of whether staff are permanent or Agency.
* Documentation concerning each consumer confirms that risks associated with the care of that consumer have been considered in their assessment and planning of appropriate care and services.

### 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.*

The service must demonstrate that:

* Consumers and their representatives are satisfied that assessment and planning include their concerns about consumers’ where they are impacting on their health and wellbeing.
* Care documentation will show that consumers’ needs, and preferences are identified or addressed in accordance with the consumer’s expressed wishes and in a timely manner.

### 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.*

The service must demonstrate that:

* Representatives confirm that decisions about care for their family member are made with the input or consultation with others that are involve in consumers care.
* Care documentation shows that consultation has occurred with the consumer and others who are involved in their care.

### Requirement 2(3)(d)

*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 must demonstrate that:

* Outcomes of assessment and planning are effectively communicated to consumers or others involved.
* There is consistent evidence that consumers and their representatives are readily and proactively provided with a copy of consumer’s care plans, such that they don’t need to request it.
* Consumers and representatives feel supported to access their records.

### 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.*

The service must demonstrate that:

* 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. For example, where changes were made to the care of consumers who have diabetes, Care plans are updated to reflect the recent changes.
* Incidents are investigated and reviewed to reflect cause and minimise risk to consumers.
* Reviews of consumer care and services are completed by staff who were familiar with the consumer.

### 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.*

The service must demonstrate that:

* Skin care, falls management, medication management continence care, end of life care, nutrition and hydration and incident management is consistent with the organisations work instructions and meets consumer needs and optimises consumer health and well-being.
* All staff demonstrate an understanding of best practice care provision.

### Requirement 3(3)(b)

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

The service must demonstrate that:

* There is effective management of high impact and/or high prevalence risks associated with the care of each consumer such as diabetic and medication management.
* Incidents have rigorous investigation to improve outcomes for consumers.
* Falls are documented as incidents and bed sensors are working and in use.
* Strategies that are implemented following falls are reviewed for effectiveness and there is a reduction in recurrence.
* There are appropriate and sufficient controls put in place to ensure that staff possess the required skill to identify and manage high prevalence and high impact risks (see Standard 7)
* Documentation confirms that effective management of high impact and high prevalence risks is occurring.

### Requirement 3(3)(c)

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

The service must demonstrate that:

* Skin integrity, pain management, preservation of dignity and consumer choice occurs no matter what the circumstances.
* Staff are familiar with the consumer’s needs, preferences and their history.
* Consumers and their decision makers have enough time to make choices within the limited options available.
* Medications are administered on time and documentation meets the organisations expectations.
* Care plans contain unique needs goals and preferences for each consumer nearing the end of their life and these are addressed and their comfort maximised.

### Requirement 3(3)(d)

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

The service must demonstrate that:

* Deterioration in consumer condition is recognised and responded to in a timely manner.
* There is no negative impact to consumers due to lack of clinical oversight in relation to the deteriorating consumer.

### 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.*

The service must demonstrate that:

* Information about the consumer’s condition, needs and preferences is always documented or communicated within the organisation, and with others where responsibility for care is shared.
* Consumers and representatives are satisfied with the communication of information.

### Requirement 3(3)(f)

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

The service must demonstrate that:

* There is evidence of timely and appropriate referrals to individuals, other organisations and providers of other care and services such as dieticians, physiotherapists.
* Representatives are satisfied with access to services.
* Referral and service delivery is modified during unexpected situations including visitor restrictions, to ensure appropriate referral and service delivery occur.

### 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.*

The service must demonstrate that:

* Staff follow organisation policy in monitoring and management of infections.
* No deficits are observed in staff infection control practices and cleaning of equipment.

**Requirement 4(3)(a)**

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

The service must demonstrate that:

* Services and supports provided for daily living, meet consumers expectations.
* All categories of staff regardless of permanent or agency, are familiar with consumers needs, goals and preferences with respect to services and supports for daily living.
* Consumers needs, goals and preferences identified in their care plans are delivered by the service for all consumers.
* Lifestyle assessments reflect current needs, goals and preferences for consumers.

**Requirement 4(3)(b)**

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

The service must demonstrate that:

* Consumers can describe ways that the service supports them when they feel low.
* Staff can describe ways that they provide support to consumers when they feel low.
* Consumer and representative satisfaction about services and supports provided by the Service improves.
* Staff know all consumers needs and preferences regardless of their faith and can describe how they support them in their spiritual well-being.
* Where representatives are concerned about consumers psychological well-being, appropriate action is taken to assess and support the consumers mental health.

**Requirement 4(3)(c)**

*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 service must demonstrate that:

* Consumer and representative feedback improve about the lifestyle activities program and how it assists them to maintain connections outside the service and with people significant to them.
* That consumers actively contribute to the selection of activities for the lifestyle activities program.
* The lifestyle activity program is evaluated for effectiveness in meeting consumer expectations.
* Despite restrictions associated with connecting with the community outside the Service, that the lifestyle activities program is modified to ensure that it is aligned to consumers needs, goals and preferences in their lifestyle plans.

**Requirement 4(3)(d)**

*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 must demonstrate that:

* There is a single case management system and that information is not required to move between an electronic and paper-based system.
* Representatives feel well informed and that needs goals and preferences of consumers is communicated with other organisations where care is shared.
* All staff regardless of whether they are permanent, or agency are aware of consumers needs, goals and preferences.

**Requirement 4(3)(e)**

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

The service must demonstrate that:

* They can describe how they work with external organisations or uses volunteers to help supplement the lifestyle activities program.
* They assess consumers’ needs for referral to an external organisation for services or supports for daily living, and where referral is deemed necessary, that the referral occurs in a timely way.

**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.*

The service must demonstrate that:

* The maintenance issues identified by the assessment team have been resolved and that new maintenance items are identified and resolved promptly.
* They can describe how they assist consumers to move freely through the service even when doors are closed.

### Requirement 5(3)(c)

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

The service must demonstrate that:

* The call bell system is operating effectively, and consumers safety is not compromised by long delays after requesting assistance.
* All communication systems at the service are functioning effectively.
* They have confirmed agency competency regarding connecting bed sensors

**Requirement 6(3)(a)**

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

The service must demonstrate that:

* the organisation’s policies and procedures for complaint management demonstrate consideration has been given to ensuring effective complaint mechanisms to support and encourage feedback and complaints.
* They can describe how they encourage and support consumers to make complaints.

### Requirement 6(3)(b)

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

The service must demonstrate that:

* Consumers are aware of and have access to advocates, language services and other methods for raising and resolving complaints.
* External complaint mechanism brochures are available in languages other than English and are in languages that are identified as being spoken by consumers in the service.
* Staff are aware of, and consumers are involved in OPAN (older persons advocacy network) webinars.

### Requirement 6(3)(c)

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

The service must demonstrate that:

* Action has been undertaken to determine the cause of complaints and to satisfactorily resolve issues.
* Consumer and representatives report that the service is responsive and/or effectively resolving their concerns.
* Documentation for the complaint system is organised and enables tracking of complaint issues to ensure their satisfactory resolution.
* The policies and procedures guiding complaint management are comprehensive and provide guidance about use of external complaint agencies relevant to residential aged care.
* The policies include an open disclosure framework.

### Requirement 6(3)(d)

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

The service must demonstrate that:

* It ensures that feedback and complaints are reviewed and used to improve the quality of care and services.
* Complaints of a similar nature have been identified and actions taken to prevent recurrence. For example, complaints about various aspects of care and staffing.
* There is sufficient evidence of analysis of complaints to identify the reasons for ongoing complaints which have not been effectively resolved.

### Requirement 7(3)(a)

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

The service must demonstrate that:

* There is sufficient staff to enable safe and quality care.
* The very recent action taken to improve staffing levels through the introduction of a new roster is evaluated for effectiveness.
* The recent improvement in call bell response times is maintained.
* Consumer and representative feedback improve about staff availability, skill mix and knowledge of consumer’s needs.

**Requirement 7(3)(c)**

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

The service must demonstrate that:

* Consumers and representatives provide positive feedback about care and services provided by staff being competent to perform their roles effectively.
* Agency and permanent staff receive the same oversight of their competency to perform their roles.
* All staff are familiar with the broader working environment expectations at the service, and the consumer’s needs, goals and preferences.
* Role descriptions for all positions at the service articulate competencies for the role.
* Records substantiate that competency has been assessed or confirmed for all staff.

### Requirement 7(3)(d)

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

The service must demonstrate that:

* There is a detailed induction program for permanent staff and agency staff and, leadership roles.
* Staff complete compulsory education components associated with their roles.
* Multiple deficiencies identified across all Standards are resolved and demonstrate that the workforce has been trained, equipped and supported to deliver the outcomes required by these standards.
* All staff possess the minimum requirements for their role.
* The training needs have been identified for lifestyle or other care or non-clinical staff.
* Information can be provided to substantiate that staff who do not meet competency when first assessed are provided education and training to support them to deliver the outcomes required of the standards.

### 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.*

The service must demonstrate that:

* They have systems and processes to ensure that the service is accountable for the delivery of safe care and services.
* Management can describe a number of ways in which the governing body is involved in the organisation’s response to significant clinical incidents.
* The Governing body can describe how the organisation promotes safe, inclusive and quality care.
* They can provide examples of changes made, driven by the board in response to consumer feedback.
* There is a system for the routine and regular involvement of the Board in other significant incidents relating to the safety of consumers.
* The Board can demonstrate how it satisfies itself that the Quality Standards are being met within the service and policies align to the new standards.

### Requirement 8(3)(c)

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

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

The service must demonstrate that:

* They can explain how the continuous improvement system in place, has translated to improvements at the service which meet consumers expectations.
* They make and sustain their proposed changes to address the issues raised by the assessment team concerning workforce management.
* They improve information management, in how staff can readily access current information they need about consumers.
* Findings relating to information management elsewhere in the standards, confirm that information is effectively communicated at the service.
* All four requirements in Standard six are found compliant, which demonstrates that the Service does have an effective feedback and complaints governance system.

### 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.*

The service must demonstrate that:

* It’s risk management systems are effective in identifying high impact or high prevalence risks associated with the care of consumers.
* Deficiencies in Standard one and four are resolved and demonstrate that the risk management system is supporting consumers to live the best life they can.
* Staff can confirm that policies had been discussed with them and what they mean for them in a practical way.
* Review their clinical risk monitoring tool for consumers, to ensure it can identify consumers at risk who have a low number of clinical risks, but where there is a high likelihood of potential for harm to the consumer.
* It monitors clinical trends for consumers over time.
* It measures its performance regarding clinical risk monitoring by undertaking external benchmarking and reports on performance.

### 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.*

The service must demonstrate that:

* Clinical needs are assessed, and clinical needs are met.
* Standard 2 and Standard 3 deficiencies in relation to assessment, planning and delivery of clinical care have been corrected.
* Deficits with antimicrobial stewardship have been corrected. For example, Staff follow procedures in terms of monitoring of infections and processes prior to the prescribing of antibiotics.
* The service provides evidence of an open disclosure policy. Open disclosure is overtly practiced, and apologies are made through the complaints processes.
* Information substantiates that the service monitors infection rates monthly at their quality meetings,
* Staff can describe what the minimising the use of restraint policy means for them in practical terms, and staff confirm that they have been trained in its application.
* The process for the management of psychotropic medication is strengthened and the proposed a new tool for monitoring is developed for implementation.