Newmarch House

Performance Report

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**Commission ID:** 0974

**Provider name:** Anglican Community Services

**Site Audit date:** 12 January 2021 to 15 January 2021

**Date of Performance Report:** 21 February 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | 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) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | 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) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* The Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the Site Audit report received 11 February 2021.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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.

Most sampled consumers consider that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose.

For example:

Consumers and representatives said staff are respectful and address them by their preferred names. There was no negative feedback about staff interactions with consumers.

Consumers said they are asked about their preferences and can maintain their identity.

Consumers believe their privacy is respected.

The service has a system to gather meaningful information about the consumers interests and social history. Staff generally demonstrate an understanding of individual consumers preferences, interests and family situation, including the maintenance of relationships.

There is no system to identify the appropriate decision maker for consumers other than through the initial preadmission request for who the first and second contact should be. Gaps were identified with staffs’ understanding of person responsible concept; there was some negative feedback about this.

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

## Assessment of Standard 1 Requirements

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

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

The Assessment Team found the service demonstrates that each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Consumers and representatives repeatedly spoke with appreciation and regard for the service’s staff. Diversity is identified in the entry assessment to the service. The Key to Me document identifies cultural background, family and people important to the consumer. Religious diversity is also identified with several consumers of other faiths receiving in-home support. Staff continue to receive education and training on respecting consumer choice, and how to effectively show respect and dignity to each consumer. The consumer community also discusses and evaluate activities of the home at Resident and Relative meetings which is chaired by a resident representative to ensure ongoing satisfaction and feedback for new initiatives of their preference. Several initiatives have been implemented in response to the previous performance report, with the Assessment Team confirming these are now sufficient.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

*Care and services are culturally safe.*

The Assessment Team found the service demonstrates that care and services are culturally safe.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

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

The Assessment Team found the service does not demonstrate that each consumer is supported to exercise choice and independence, including to make decisions about their own care and the way care and services are delivered; and make decisions about when family, friends, carers or others should be involved in their care; and communicate their decisions; and make connections with others and maintain relationships of choice, including intimate relationships.

The Assessment Team provided information that the service has processes in place to enable consumers to exercise choice in relation to the day to day care and services they received. However, the organisation does not have systems and processes to ensure that the consumer’s wishes and decisions about when family, friends and others are involved in their care is sought by the service or followed. This issue was also identified in the review audit of 30 June to 3 July 2020.

Although contacts have been accessed for some consumers there is no system to ensure the contact is the appropriate or acceptable person responsible for the consumer. The service has no assessment of capacity process for consumers making their own decisions.

The approved provider submitted a response that clarified and provided additional detail concerning the issues identified during the performance review. The approved provider refutes the findings and recommendation of the Assessment Team. This response includes their Capacity and Consent policy and Resident consent forms. The response also provides examples of how the service has utilised these processes to identify the appropriate person responsible, if required, and how and when they are to be involved. The approved provider has acknowledged that consumers wishes, and capacity can change over time, and has implemented continuous improvement to review the person responsible information with consumers to identify if they are still appropriate. I have reviewed this information and accept that the examples supplied, provide evidence of these processes being followed prior to the performance review.

I have considered the Assessment Team’s report and the approved providers response, and accept the service is aware of their responsibilities in providing support to each consumer to exercise their choice and independence. The service understands capacity as it relates to each consumer and also when to involve external stakeholders such as guardianship and family in accordance with consumers’ wishes.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that each consumer is supported to take risks to enable them to live the best life they can.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. The service has a risk management process in place to support limited risk taking by consumers when they identify their choices. The approved provider acknowledged the need to improve consumers ability to take risks with informed decision making. Education on risk taking, choice and the new risk-taking processes was supplied to staff. Additional supporting documentation and assessment processes were added to the electronic case management system, to enable further improvements in the approved providers approach to risk taking for consumers. Consumers were engaged on what activities they would like to do, with a number of consumers undertaking risk-taking activities such as cooking their own breakfasts, or those with swallowing difficulties taking the risk with more solid, regular food.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that 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 was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. There are systems to provide consumers and representatives with a range of information including emails, case conferences, newsletters and phone contacts. Management said case conferences are now regularly held where information is provided to the consumer and representatives. The service has a regular newsletter; the December 2020 was reviewed, and it notes current visiting restrictions; being active being safe, falls risk minimisation information about the Anglicare television and radio programs, Café opening hours, food safety tips; feedback forms; staff acknowledgement award nominations. The service’s enunciator was heard providing some information about spiritual activities for consumers.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that each consumer’s privacy is respected, and personal information is kept confidential.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. There were no concerns raised about management of private information. Computers are password protected and paper documentation was kept locked in staff offices. Staff handover was observed to occur in staff offices. Consumers said staff knock prior to entering their bedrooms. Staff said they provide consumers with privacy to support maintenance of their relationships. There are policies regarding protection of personal information relating to the privacy and the protection of consumer information. Education was provided for staff in the maintenance of private information. There is a process where staff sign confidentiality agreements in relation to this.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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.

* Consumers and/or representatives generally were not aware they had a care plan or how to access it.
* Review of care documentation indicated that consumers and/or representatives are not always consulted during care plan review.
* Assessments and care planning documents were not always updated or reviewed to reflect current needs, goals and preferences of consumers.
* Comprehensive review of care plans is not conducted regularly; and care plans are not always reviewed or updated when circumstances change, or incidents occur.
* There is a lack of systems in place to monitor and assess risks associated with the use of antipsychotic medications as chemical restraint.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found the service demonstrates that assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. The organisation reviewed all their written materials on assessment, care planning and documentation on 29 September 2020 that supported staff to undertake assessment and planning. It assists staff determine what assessments are to be completed and when. Education was provided to all staff on these processes, and Registered nurses were able to describe how they use assessment and planning to inform how they deliver safe and effective care. Care coordinators and registered nurses said falls risk assessments are competed after each fall and consumers are referred to one of the physiotherapists for review. Registered nurses interviewed were able to articulate the processes that are in place to assess and re-assess the changing needs of the consumer. Assessments are repeated and reviewed whenever there is a change in the consumer condition or six-monthly. The Assessment Team observed that personal health and safety risk assessments were conducted on consumers undertaking high risk activities. Care plans were individualised relative to the risks to each consumer’s health.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that 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 provided information that care planning documentation does not routinely record or address consumer’s current needs, goals and preferences. For consumers receiving end of life care, care plans are not always updated to include changes in their care needs and their palliative care wishes and goals. Staff are not familiar with individual consumers’ current needs, goals and preferences in their care.

The approved provider in their response, disputed some of the Assessment Teams findings of the service at the time of the audit, and clarified some information presented in the report. The approved provider also included some examples of care plans with preferences for those consumers. In the response is a plan for continuous improvement, care plans, supplemental information and assessments related to the consumers highlighted in the Assessment Team’s report. The approved provider acknowledged their responsibilities for this requirement and identified several areas for improvement.

I have considered the Assessment Team’s report and the approved providers response, and accept the service has captured the current needs, goals, and preferences for some of their consumers, however this was not evident for a number of consumers highlighted during the performance review at the time, and staff were not always familiar with those needs and preferences. The approved provider has supplied a plan for continuous improvement and has not refuted all of the Assessment Team’s findings of the service at the time of the audit. The approved provider will need to monitor and evaluate these changes carefully to ensure they are effective and are sustainable.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

*The organisation demonstrates that assessment and planning:*

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

The Assessment Team found the organisation does not demonstrate that assessment and planning 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

The Assessment Team provided information that a review of assessment and care plan documentation identifies minimal or no documentation to indicate that there is ongoing consultation with the consumer and/or their representatives when care plans are reviewed.

The approved provider in their response, has supplied additional supporting information and evidence, including excerpts from progress notes, care plans and assessments. This additional information available at the time of the audit, clarifies the involvement of the consumer and others during assessment and planning.

I have considered the Assessment Team’s report and the approved providers response, and accept the service is aware of their responsibilities for this requirement. The additional information and clarification demonstrates the organisation has an ongoing partnership with the consumer and others during assessment and planning.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the outcomes of assessment and planning are not 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 provided information that while the service demonstrated that it has made care plans available for consumers and representatives, most consumers and/or representatives interviewed were not aware of their care plan or how to access it. While registered nurses said they communicate with consumers and/or representatives via telephone or in-person about changes in their health or well-being the Assessment Team found that care plans sampled did not reflect the consumers, needs, goals and preferences.

The approved provider in their response, stated that consumers are offered a copy of their care plan and this is provided to their room and placed behind the door with their permission. The provider was aware that consumers may not understand this document was their care plan and have initiated a continuous improvement to assist staff in helping consumers and their representatives understand this document and provide a copy as required.

I have considered the Assessment Team’s report and the approved providers response. I find that the approved provider has failed to adequately communicate to consumers and their representatives that a copy of their care plan is available, has not communicate the importance of this document or ensured that it effectively communicates the outcomes of assessment and planning.

I have reviewed these findings and consider that the organisation is non-compliant with this requirement.

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

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

The Assessment Team found the service does not 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.

The Assessment Team provided information that comprehensive review of care plans is not conducted regularly, and care plans are also not reflective of the changes, when circumstances change, or when incidents occur. For consumers, the care plans did not always reflect current care needs of the consumers.

The approved provider in their response, disputed some of the Assessment Teams findings of the service at the time of the audit, and clarified some information presented in the report. The approved provider also acknowledged they have some improvements still outstanding in this requirement. The approved provider also included some examples of incident reports and subsequent investigations, and assessments related to the consumers highlighted in the Assessment Team’s report. However, the approved provider in their response, has not addressed the concerns of the Assessment Team in relation to this requirement. The approved provider has not demonstrated that care and services are reviewed regularly for effectiveness, or when incidents or circumstances change, that may have an impact on consumers at the service. They have not demonstrated that incidents are all investigated in a suitable time frame, and effectively in a way that minimises impact on consumers.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. The approved provider has supplied a plan for continuous improvement and has not refuted all of the Assessment Team’s findings of the service at the time of the audit. The approved provider will need to monitor and evaluate these changes carefully to ensure they are effective and are sustainable

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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.

Consumer feedback was generally mixed in relation to clinical care. However, the service was not able to demonstrate that consumers are consistently receiving personal and clinical care that is best practice, safe or effective. The service did not indicate effective management of high impact or high prevalence risks, especially in the areas of diabetes, nutrition/choking, pain, wound and restraint/behaviour. The Assessment Team identified systemic deficits in care documentation. For example:

* Review of care documentation reflected there were deficits in areas including, but not limited to pain, wound, blood pressure and diabetes management.
* Clinical documentation reflected that medical officer’s directives were not always followed, incidents were not always reported to and not all wounds/bruises were monitored appropriately.
* Consumers receiving palliative care at the service had delays in being reviewed by medical officers/palliative nurse.
* Change in consumer’s health was not always recognised to in a timely manner and appropriate interventions were not done to maximise consumer’s well-being.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service does not demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.

The Assessment Team provided information that consumers are not consistently receiving personal and clinical care that is based on best practice, especially in the areas of pain, wound or blood pressure management, nor is care tailored to their needs, and/or optimises their health and well-being.

The approved provider in their response refuted the Assessment Team’s report as simple documentation errors, and believes each consumer gets safe and effective personal and clinical care. Their response included pain charts, assessments and escalation to the organisation internal specialists for strategy review. However, appendix 17 of the response did not contain evidence of escalation and prescribing of pain relief for the consumer, as it was dated prior to the prn medication regime in the report. It was noted in the response several times of information being located in the wrong areas of the documentation, but there are also cases where there is no evidence that care took place at all. I accept that pain was monitored for some consumers as highlighted in the response, although not in line with the service’s practice. I also accept the evidence of bruising being monitored regularly. It is difficult to ascertain that clinical care is effective, if documentation is incorrect, or information is located in progress notes instead of charting. Clinical documentation is not only evidence and a historical record, but also assists staff in understanding the consumer and designing strategies in line with best practice to provide better care for the consumer. The approved provider has acknowledged documentation needs to be improved, but they have not taken the opportunity to review their consumers to identify if the issues identified, are indicative of issues with other consumers in their care.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. I am not confident that consumers at the service get safe and effective personal and clinical care that is either best practice or is tailored to their needs, especially in the areas of pain, wound and blood pressure management.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team provided information that the service records and trends high impact or high prevalence risks associated with the care of each consumer; however, review of clinical documentation for consumers does not always indicate effective management of these risks as per service’s procedures, especially in the areas of diabetes, behaviour/restraint and nutrition/choking.

The approved provider in their response, disputed some of the Assessment Teams findings of the service at the time of the audit, and clarified some information presented in the report. The approved provider also acknowledged they have some improvements still outstanding in this requirement.

* Nutrition/Choking – One consumer noted in the report has accepted certain risks while eating, with the service acknowledging their responsibilities to assist minimise that risk for the consumer. The response refuted some information; however, the approved provider did not provide any response to the observation of this consumer in an unsuitable position for eating by himself and no way for staff to passively supervise the consumer while eating.
* Behaviour/restraint – For one consumer who had recently had a trial of reduced psychotropic medications, I find the response is acceptable and valid, however appendix 10 had the care conference discussing restraint, but did not contain a signed consent form, as mentioned in the response.

For one consumer for whom diazepam (anti-anxiety) medication is prescribed as PRN; there is no response to the Assessment Team’s observation that her notes do not show other non-pharmaceutical strategies being trialled prior to administering the PRN medication, in accordance with best practice guidelines for the minimisation of restraint.

* Diabetes management – For one consumer who was administered insulin pens, I am satisfied this matter has been dealt with.

For one consumer for whom the service initiated a best practice initiative of measuring his ketones when his blood glucose level was above 20mmol/L; it is noted that care staff did not follow the instructions for this. There is no indication if this initiative was trialled for other consumers and whether care staff followed these directives for other consumers, or whether the issue of not following instructions prompted any recourse or continuous improvement from management. This consumer also required blood pressure monitoring; with care staff failing to follow the directives of the GP.

The approved provider acknowledged they have some improvements in wound care still outstanding.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. While the approved provider refuted some of the Assessment Team’s findings, there are still elements where staff are not fully aware of their responsibilities or understand effective management of high impact or high prevalence risks or consistently follow the directives of senior staff or medical professionals.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that 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 provided information that for consumers who have passed away at the service, palliative care was not effectively provided to maximise that consumer’s comfort. The Assessment Team identified deficits in clinical care, and delays were also noted in seeking assistance from relevant health professionals.

The approved provider in their response, disputed some of the Assessment Teams findings of the service at the time of the audit, and clarified some information presented in the report.

The evidence provided in the response did not demonstrate that staff were monitoring one consumer’s pain for the days in question (27 December 2020, 31 December 2020 and 6 January 2020) however, progress notes for 31 December 2020 by Palliative Care Team record ‘stated she recently has pain even though she does not appear to be in pain’. I note this consumer experienced a two day delay in antibiotics being commenced due to her GP failing to respond to calls.

The provider failed to respond to issues relating to the second consumer named in the Assessment Team’s report. I note that the Assessment Team’s report contains a statement by the consumer’s daughter that the service was unable to manage her mother’s pain. This representative stated she could hear her mother calling out in pain and had been continually asking the service to manage her mother’s pain in late October/early November 2020 prior to a syringe driver being inserted. This consumer experienced a three delay in having her pain re-addressed and treated in November 2020 due to her GP failing to respond to calls.

The approved provider acknowledged they have made some minor improvements in their palliative care system by having the daily paper-based pain charts checked daily by the care coordinators.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. The approved provider has not been able to demonstrate that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved as cannot demonstrate that pain is effectively monitored and managed.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that 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 provided information that for some consumers, their care planning documents and/or progress notes; did not reflect the identification of and response to, deterioration or changes in function/capacity/condition.

The approved provider submitted a response that provides further information and the approved provider also refutes some of the information in the Assessment Teams report. Unfortunately, the information presented seems confusing. One consumer who has experienced a deterioration of their legs through a combination of ulcers and pressure injuries since October 2020, was escalated on the 27 November 2020. In that escalation was discussed he has been experiencing pain, and a suggestion to go onto regular pain medication for management. In the evidence provided was pain relief only for January 2021, and a pain chart commenced on 2 January 2021. A new pain assessment was completed 13 January 2021, the day after the performance assessment. There is no evidence to show that pain relief was effective in October or December when these issues first originated, or that the consumer has been assessed for regular pain relief since. The approved provider has acknowledged that care staff do not always complete charting, so relevant and important information is not handy to find, unless searched for within the historical progress notes record. This complicates being able to readily identify deterioration of a consumer in a timely manner.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. While the approved provider refuted some of the Assessment Team’s findings, I am not satisfied that staff always follow best practice in recording information, or follow the instructions given to them to be able to identify deterioration or changes in a consumer’s health or condition.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found the service demonstrates 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.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Additional education was provided to staff concerning communication. Specifically, clinical information and handover communication, along with keeping person’s responsible informed. The service has mechanisms to communicate information about the consumer’s condition, needs and preferences. Staff were able to describe various communication channels to ensure the effective communication regarding the care of consumers. The Assessment Team found that for most consumers, progress notes and handover documents provided adequate information to support effective and safe sharing of the consumer’s care.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that timely and appropriate referrals to individuals, other organisations and providers of other care and services, occurs.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Review of care documentation and staff knowledge demonstrated the service has documented procedures to make referrals to relevant health professionals to ensure effective consumer outcomes. Care manager and Registered nurses described the process of making referrals to relevant health professionals. They have a folder at the front reception with details of all allied health professionals. They can use the folder to allocate consumers to respective allied health professional when needed. In case of a referral to a specialist, they have initial discussions with the medical officer and then a referral is made to the relevant professional.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found the service demonstrates that minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics occurs.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. With the pandemic affecting the service, they found it difficult managing infection control while converting to a ‘hospital in the home’. With numerous staffing changes, this meant their transition to effective infection control took longer. The services have policies and procedures in relation to infection prevention and control and antimicrobial stewardship. Staff knowledge and observation demonstrated adherences to infection control practices. Staff interviewed in relation to standard and transmission-based precautions to prevent and control infections were able to describe how they apply infection control practices in their day to day work. They provided the examples of; following appropriate hand hygiene practices, wearing appropriate personal protective equipment (PPE) when required and wiping of equipment. All staff interviewed confirmed they have received donning and doffing of PPE and handwashing training/competency completed at the service. Cleaning staff stated they undertake touchpoint cleaning on surfaces three to four times per day.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

# STANDARD 4 COMPLIANT Services and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

Several sampled consumers did not 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.

The service is an Anglican faith-based organisation. The service has a pastoral support team to support consumers in their faith and care, consumers of other faiths are not always adequately supported in the choice of their faith. The Anglican mission is evident throughout the living environment and lifestyle program.

As a result of the COVID 19 outbreak the lifestyle program has been limited in its activities and community participation in the life of consumers. Lifestyle services and supports have only partially or not resumed since end of March 2020. The program is heavily reliant on family visits and religious activities provided on site.

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

## Assessment of Standard 4 Requirements

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

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

The Assessment Team found the service does not demonstrate that 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 provided information that for some consumers, they do not get safe and effective services and supports for daily living that meet their needs, goals and preferences and optimise 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 those personal preferences to be met. The service has also employed several new staff recently; with some of them, who are not familiar with consumer needs, goals and preferences. Lockdown restrictions over the past few months, following the earlier lockdown during the COVID-19 outbreak; resulted in very reduced group activities, and these have not been fully restored since that lockdown has been lifted. This has affected the well-being and quality of life of some consumers.

The approved provider in their response clarified some information from the Assessment Team’s report and also refuted some of the information. The response also contained evidence of activity schedules, and attendance records. The attached evidence shows the approved provider is aware of their responsibilities under this requirement and during the pandemic approached the activity level of consumers and what was permitted by health orders as best as they could. Information provided shows visitors and other faiths involvement at the home, along with music therapy for consumer enjoyment.

I have considered the Assessment Team’s report and the approved providers response, and accept the service is aware of their responsibilities for this requirement. The additional information and clarification demonstrates the organisation has an ongoing partnership with the consumer and others during the planning and conducting activities of interest to the consumer.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

The Assessment Team provided information that while the service is run by a faith-based organisation, and the service has a pastoral support team to support consumers in their faith and care; consumers of other faiths are not always adequately supported in the choice of their faith. Information derived from care and monitoring records indicate consumers from other faiths, mostly rely on their family’s support to maintain these connections.

The approved provider in their response clarified some information from the Assessment Team’s report and also refuted some of the information. The response also contained evidence of external providers of religious support attending, and other support such as provision of halal food and psychological services. The attached evidence shows the approved provider is aware of their responsibilities under this requirement and during the pandemic approached consumers and what was permitted by health orders as best as they could. Information provided shows visitors and other faiths involvement at the home, along with emotional and psychological support.

I have considered the Assessment Team’s report and the approved providers response, and accept the service is aware of their responsibilities for this requirement. The additional information and clarification demonstrates the organisation has an ongoing partnership with the consumer and others to provide ongoing emotional, spiritual and psychological support.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

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

The Assessment Team found the service demonstrates that services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment; and have social and personal relationships; and do the things of interest to them.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Family visits have recommenced and are restricted to visiting protocols under government guidelines. Many representatives state they while consumers can no longer participate in their community due to the COVID 19 restrictions, they have been sympathetic to the service’s visiting protocols in keeping consumers safe. Consumers and representatives sampled state they are able to visit as often as they can, and some representatives have been provided with exemptions for longer visits. Bus trips have also re-commenced for consumers who wish to go. Consumer care plans contained information about how consumers participate in the community and maintain their relationships.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that 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 was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Consumers and representatives stated they are happy with communication provided by the organisation regarding consumer’s condition, needs and preferences. Weekly Interdisciplinary meetings have commenced at the service assist staff from various disciplines to communicate the needs of consumers and consumers of concern. Participants include care staff, care manager, psychologist and leisure and lifestyle staff. discussion include including consumers of concern.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that timely and appropriate referrals to individuals, other organisations and providers of other care and services occurs.

The Assessment Team provided information that there was minimal evidence of current or recent referral to other services, or how they work with external organisations to help supplement the lifestyle activities offered within the service. For some consumers, their progress notes and leisure and recreation participation records, reflect the involvement of others in the provision of lifestyle supports such as referral to the pastoral care or leisure and lifestyle team, however most of the referrals to external services such as pastoral care services for Christian faiths other than Anglican and other visiting services are no long occurring.

The approved provider in their response clarified some information from the Assessment Team’s report and also refuted some of the information. The response also contained evidence of external providers attending, such as library service, translators and visitors, NDIS support, music therapist, psychologist, other denominations representatives, groups such as girl scouts, and community groups, and other support such as a pop-up shop. The attached evidence shows the approved provider is aware of their responsibilities under this requirement and during the pandemic approached consumers and what was permitted by health orders as best as they could. Information provided shows visitors and other faiths involvement at the home, along with emotional and psychological support. The approved provider has acknowledged that they have yet to evaluate some of the new programs and will continue to review these are effective.

I have considered the Assessment Team’s report and the approved providers response, and accept the service is aware of their responsibilities for this requirement. The additional information and clarification demonstrates the organisation has an ongoing partnership with the consumer and others to provide ongoing emotional, spiritual and psychological support.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that meals are provided, and they are varied and of suitable quality and quantity.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service demonstrates that equipment is provided, and it is safe, suitable, clean and well maintained.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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 at home in the service and generally feel safe and comfortable in the service environment.

For example:

Most consumers and representatives interviewed said that staff are friendly and made them feel welcome. Representatives stated that their loved ones feel safe at the service.

Representatives stated that consumers enjoyed the community feel of the home when they come to visit, and the outdoor courtyard areas were pleasant and well maintained.

Consumers and representatives stated they feel comfortable in the service and that it was a safe and clean environment. Observations and documentation show that fittings and equipment are maintained to ensure the safety of consumers. Consumers can generally access the outdoor areas when they wish to do so.

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

## Assessment of Standard 5 Requirements

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

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

The Assessment Team found the service demonstrates that the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

*The service environment:*

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

The Assessment Team found the service demonstrates that the service environment is safe, clean, well maintained and comfortable; and enables consumers to move freely, both indoors and outdoors.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Call bell system was replaced and deficits within preventative and reactive maintenance were addressed. The onsite maintenance staff also maintain a schedule of preventative maintenance for the service environment such as water testing, testing and tagging, fire safety equipment maintenance and cleaning of air conditioning vents. Maintenance staff monitor when contractors are due to arrive via a schedule of maintenance for equipment and services. Ongoing day to day maintenance is managed by maintenance staff who receive written requests from care staff. Small repairs are usually undertaken on site and larger repairs provided by licenced contractors such as electricians and plumbers. The maintenance staff have a system to monitor outstanding maintenance requests. Consumers interviewed state they are able to move freely around their rooms and common areas independently or with assistance from staff, including outdoors. Consumers and representatives say the living areas are kept clean and well maintained and feel the service provides a safe environment.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Call bell system was replaced and deficits within preventative and reactive maintenance were addressed. The service has a system to ensure that furniture, fittings and equipment are safe, clean and well maintained. Consumers and representatives generally reported that furniture and equipment were clean and well maintained. Observations of the service environment and maintenance documentation reviewed indicates that maintenance work is monitored and actioned as required

I have reviewed these findings and consider that the organisation is compliant with this requirement.

# 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.

Most sampled consumers consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken.

For example:

Consumers interviewed felt they could make complaints and felt safe to do so.

There was mixed feedback about satisfaction with changes were made at the service in response to complaints and feedback.

There is limited evidence to demonstrate that feedback and complaints result in improved care and services. Systemic concerns have not been promptly reviewed to resolve issues.

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

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found that consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. 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. The service’s entry pack which contains a consumer handbook is provided to all new consumers. The consumer handbook was reviewed in September 2020 and has information relating to continuous improvement, satisfaction surveys; notes open disclosure; ACQSC and external complaints; advocacy network and seniors rights service and health care complaints commission, The Charter of Aged Care Rights was observed displayed in the service and in the welcome pack.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Brochures and information in the various languages prevalent within the service, are available. There are brochures for advocacy services in the foyer of the service, language services and other methods for raising and resolving complaints. There was information evident about consumer rights. There was no negative feedback about access to complaints information or avenues to assist in resolving issues.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

### 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 the service does not demonstrate that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team provided information that while improvements have been made to the complaints process, and training has been provided relating to the principles of open disclosure, some representative’s expressed concern that actions taken following incidents is ad hoc or does not improve outcomes for the consumer’s, and also said there has not been any apology or acknowledgement of error. The service now has a system to support principles of open disclosure although evidence showed it has not yet been fully embedded at the service. Evidence points to open disclosure being recently demonstrated in relation to resolving external complaints.

The approved provider submitted a response that provides further information and the approved provider also refutes some of the information in the Assessment Teams report. While the response details some of the concerns raised in the report, it has not addressed all of the issues raised in the Assessment Teams report.

I note one consumer’s representative raised a complaint with the service about the clinical care provided but was not satisfied with the response by management and so sought external complaints resolution. Furthermore, five consumers/their representatives raised complaints about the failure of their GP to attend the service. This GP was responsible for nineteen consumers at the service and there were longstanding issues of him failing to attend to and see his patients which management were aware of. Appropriate action was not taken to resolve this issue speedily resulting in significant deficiencies in wound care provided to one consumer, another consumer experiencing unnecessary pain and anxiety, and their representatives expressing frustration and anger. Information provided by the approved provider did not demonstrate that open disclosure was conducted in response to these complaints in October/November 2020.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. While the approved provider refuted some of the Assessment Team’s findings, I am not satisfied that the service always takes appropriate action to resolve complaints and provides an apology with an explanation and why things have happened and what they are doing to prevent it from happening again.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team provided information that while the number of complaints has decreased, trending shows complaints of a similar nature have been occurring since the review audit of 30 June to 3 July 2020. Management acknowledged communication has been a common theme which they have worked to improve although there remains some negative feedback. There are currently external complaints about care provision. A series of concerns about access to a medical officer has not been resolved in a timely fashion, and this matter was not escalated when it became evident it was not able to be promptly resolved.

The approved provider submitted a response that provides further information and the approved provider also refutes some of the information in the Assessment Teams report. The approved provider provided an undated excerpt from the service’s improvement log detailing specific examples of continuous improvement arising from consumer feedback however it has not explained how the service monitors and evaluates changes made to ensure improvements to the quality of care and services has been achieved. There were five complaints about a medical officer failing to attend or conduct themselves in a manner that the service expected and these complaints do not appear in the excerpt of the service’s improvement log provided. The service’s response to this issue was to replace them with another doctor. There is no mention of how the service will monitor or recognise other unprofessional conduct from visiting professionals, or how it will prevent this type of behaviour in future.

There is no mention of how the service is dealing with communication issues at the service, or how it communicates successful continuous improvements at the service to its staff, consumers and representatives. This is done, so they are aware that the service is responding to these complaints and opportunities, and making the service better with those improvements, giving stakeholders confidence in the service.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. While the approved provider refuted some of the Assessment Team’s findings, the service will require further improvements to meet this requirement.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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 considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. However, most consumers and representatives agreed that the service does not have sufficient staff to provide safe, quality care and services.

Several representatives stated that while staff are caring and respectful, they are often rushed and don’t have enough time to provide adequate care to all consumers.

Staff interviewed stated there were not enough staff in some areas to care for the needs of consumers.

Consumers and representatives generally felt that staff were trained in their roles however incidents relating to consumer personal and clinical care indicates that staff training is not effective for them to perform their roles.

The service has a system in place to monitor staff performance and this is undertaken on an annual basis or as required.

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

## Assessment of Standard 7 Requirements

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

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

The Assessment Team found the service does not 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.

The Assessment Team provided information that feedback from consumers, representatives and staff claimed that the service has insufficient staff. While the service has taken on more staff to meet the requirement of sanctions, however the allocations of staff to the service areas do not appear to be effective in delivering safe and quality care and services. Feedback included consumers being rushed during care and services, and staff not able to promptly acknowledge call bells or provide the care needed in a reasonable time.

The approved provider in their response has refuted some of the information presented in the Assessment Team’s report, and provided additional detail on staffing structures, mix of staff, and ratios of staff. While it is acknowledged in the evidence the service seems to have sufficient staff, above ‘industry benchmarks’; this requirement is satisfied by results for the consumers with safe and quality care and services. It is also accepted that call bells appear to be within reasonable time frames. However, during this performance review, several clinical outcomes have not been satisfied, requiring improvements from the service and its workforce. The response from the approved provider also has not detailed how the service will improve perceptions of staff and consumers of being rushed during cares. This is an issue that will require careful consideration by management, especially when management believes there are sufficient staff engaged at the service.

I have considered the Assessment Team’s report and the approved providers response and accept the Assessment Team’s findings. While the approved provider refuted some of the Assessment Team’s findings, the service will require further improvements to meet this requirement.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found that the service demonstrates that workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found the service does not demonstrate that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team provided information that the service has systems to ensure staff have qualifications for their roles and training including mandatory training has been provided to new and existing staff in the past 12 months.

The Assessment Team also noted that representative feedback and consumer records indicate that not all consumers are receiving clinical care to optimise health and well-being and that training has not effectively been provided or understood to ensure the workforce is competent to effectively perform their roles.

The approved provider has chosen not to specifically address this requirement.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

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

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

The Assessment Team found that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Initiatives included making sure induction was role specific and ensured that all roles were filled by suitably trained staff. Staff interviewed said they all had training relevant to their roles in the past few months, including induction, mandatory training and other online training. Staff recalled having had Standards training sometime in the past 18 months. Most consumers and representatives interviewed stated they felt that staff are generally well trained and know what they are doing. Training documentation indicated that staff have received appropriate and adequate training to deliver care and services required by the Standards.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

The Assessment Team found that the service demonstrates that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

Some sampled consumers consider that the organisation is well run and that they can partner in improving the delivery of care and services.

For example:

While some consumers and representatives are satisfied with service is well run some expressed concern about the future management and commitment to staffing. Some representatives have been dissatisfied with resolution of complaints.

Most consumers and representatives are pleased with the improvements which have been made following to COVID-19 outbreak.

There have been organisational governance reviews resulting in improved alignment of the service polices to the Quality Standards. Staff training has been provided to support staff understanding of these improvements.

Although improvements have been made, including organisational review of some governance systems and processes, some deficits remain including in staff understanding of some aspects of the Quality Standards. Some governance and oversight systems are not yet embedded into the practices of staff including the management of high impact or high prevalence risks associated with the care of consumers.

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

## Assessment of Standard 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.*

The Assessment Team found that the service demonstrates that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

### Requirement 8(3)(b) Compliant

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

The Assessment Team found that the service demonstrates that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The service was found non-compliant in this requirement in a previous performance review and has since embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The Assessment Team has provided information that the service now meets this requirement. Management said the organisation encourages involvement of consumers through the resident and relative meetings which are chaired by a consumer. There is also a food focus group with is also chaired by a consumer. These avenues for involvement did not occur during the outbreak, however, a food focus meetings and resident meetings have recommenced. Consumers and representatives said they have been consulted about care and service delivery. While there was limited feedback about consumer engagement in development, delivery and evaluation of services consumers believe they are supported to provide feedback and have opportunities for input.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

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

The Assessment Team found the service does not demonstrate effective organisation wide governance systems relating to information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.

The Assessment Team provided information that while improvements have been made to the organisational governance systems. Some areas require further improvement as demonstrated in the not met recommendations from the reaccreditation audit.

#### Information management

The Assessment Team identified issues related to inconsistent documentation of decision-making support, clinical and assessment information, and complaints management and human resources information such as staff meetings and staff surveys.

The approved provider in their response, acknowledged their responsibilities for this requirement. The approved provider has also supplied a plan for continuous improvement and has not refuted the Assessment Teams findings of the service at the time of the audit. The approved provider has implemented a series of improvements designed to assist management improve their communications at the service. The approved provider will need to monitor and evaluate these changes carefully to ensure they are effective and are sustainable.

#### Continuous improvement

The Assessment Team identified issues related to feedback systems and audits providing opportunities for improvement in an effective manner.

The approved provider in their response, acknowledged their responsibilities for this requirement. The approved provider has also supplied a plan for continuous improvement and has not refuted the Assessment Teams findings of the service at the time of the audit. The approved provider has implemented a series of improvements designed to assist management improve their auditing of systems. The approved provider will need to monitor and evaluate these changes carefully to ensure they are effective and are sustainable.

#### Financial governance

The Assessment Team identified no issues currently in financial governance.

#### Workforce governance, including the assignment of clear responsibilities and accountabilities

The Assessment Team identified issues related to workforce capabilities to meet consumer’s needs, goals and preferences, and their availability and area allocations.

The approved provider has refuted the Assessment Team’s findings justifying staff numbers and call bell response times but does not address staff capabilities in meeting consumers care needs, goals, and preferences.

#### Regulatory compliance

The Assessment Team identified issues related to the Aged Care Quality Standards as evidence by the deficiencies identified during the performance review, psychotropic medication usage, notification to stakeholders regarding re-accreditation and incident reporting.

The approved provider has refuted the Assessment Team’s report in relation to the reduction in psychotropic medication usage, and I have accepted the evidence submitted.

#### Feedback and complaints

The Assessment Team identified issues related to feedback systems and how these provided opportunities for improvement in the delivery of care and services.

The approved provider stated that all external complaints have now been resolved and they are currently reviewing their complaints and feedback systems. The approved provider will need to monitor and review these improvements over a period of time to ensure they are effective.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

### Requirement 8(3)(d) 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 the service has effective risk management systems and practices, including managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can.

The service was found non-compliant in this requirement in a previous performance review and has embarked on continuous improvement initiatives to meet the standards and improve their service for consumers. The service has developed a clinical risk register to improve risk management systems. The risk register assesses each individual resident areas including nutrition, mobility, diabetes, behavioural management, medications and complex care.

The organisation provided a documented risk management framework, including policies describing how:

* high impact or high prevalence risks associated with the care of consumers is managed.
* the abuse and neglect of consumers is identified and responded to.
* consumers are supported to live the best life they can.

Deficits were identified in the management of high impact and/or high prevalence risks as documented in requirement 3(3)(b) which will be further considered in the finding for Standard 8(3)(e).

The organisation has a system to identify and respond to abuse and neglect of consumers. Review of the consolidated register of reportable incidents found appropriate review and documentation. Consumers live the best life they can. Refer to Standard 4 for further information.

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Staff had been educated about the policies and some were able to provide examples of their relevance to their work.

I have reviewed these findings and consider that the organisation is compliant with this requirement.

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

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

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

The Assessment Team found the service does not demonstrate an effective clinical governance framework, including antimicrobial stewardship; minimising the use of restraint and open disclosure.

The Assessment Team provided information that while the service has a documented clinical governance framework in place; it has not ensured that clinical needs are assessed or that clinical needs are met. Deficits were identified in the management of high impact and/or high prevalence risks as documented in requirement 3(3)(b).

These same deficits were identified in the review audit 30 June to 3 July 2020 and although some improvement have been made, issues remain, and oversight of clinical systems has not identified the gaps.

The Assessment Team noted that improvements have been made to antimicrobial stewardship although there were some gaps in staff knowledge. The organisation has promoted use of open disclosure although it has not yet been widely used in the service. Deficits were identified in staff knowledge regarding restraint and a reduction in the use of chemical restraint was not been seen by the Assessment Team.

The approved provider refutes that the service has a clinical governance framework that is ineffective. The approved provider stated they did not train staff in antimicrobial stewardship during 2020 but have trained some staff in January 2021 and further training will be carried out in 2021. The approved provider, in their response, was able to demonstrate that the use of psychotropic medication has lessened over the last 12 months. The provider also stated that their staff understand open disclosure appropriate to their scope of practice and use it at the time of an incident, through case conferences, and at formal meetings with residents and their families when incidents occur.

I have considered the Assessment Team’s report and the approved providers response. Whilst I accept that the service has a clinical governance framework that meets the requirements minimising the use of restraint and some staff have knowledge around antimicrobial stewardship I believe the approved provider has further work to do to embed open disclosure. The approach described by the provider above was not fully evidenced on site by the Assessment Team.

That said, a clinical governance framework is not limited to these requirements. In the guidance material for this requirement it states, ‘Clinical governance is the set of relationships and responsibilities between the organisation’s governing body, executive, clinicians, consumers and others to achieve good clinical results. It puts systems in place for delivering safe, quality clinical care and for continuously improving services.’ With requirements in Standard 2 and 3 non-compliant and evidence of consumers not receiving quality clinical care, I do not agree the clinical governance framework is effective in identifying issues regarding less than optimal clinical care and services being provided to consumers.

I have considered the findings from this performance assessment and find that the service needs time to embed an effective clinical governance framework that delivers quality care and includes, but is not limited to, antimicrobial stewardship; minimising the use of restraint; and open disclosure.

I have reviewed these findings and consider that the organisation is not compliant with this requirement.

# Areas for improvement

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

**Standard 2**

### 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.*

Demonstrate that assessment and planning identifies and addresses the consumers current needs, goals and preferences.

### 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.*

Demonstrate that a copy of the care plan is readily available to consumers/their representatives and ensure that it effectively communicates the outcomes of assessment and planning.

### Requirement 2(3)(e)

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

Demonstrate that care and services are reviewed regularly for effectiveness, and when circumstances change, or when incidents impact on the needs, goals or preferences of the consumer, including when clinical deterioration is noted or indicated or when strategies implemented are no longer effective.

**Standard 3**

### Requirement 3(3)(a)

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

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

Demonstrate that care is appropriate to each consumer’s needs, and that it is reviewed and evaluated in a timely manner. Staff are trained, equipped and supported in best practice in pain and skin/wound management and relevant treatments and strategies are effectively documented.

### Requirement 3(3)(b)

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

Demonstrate that high impact and high prevalence risks are identified and monitored with staff equipped and supported in best practice in relation to pain management, pressure area care and wound care, and behaviour management.

### 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.

Demonstrate that the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved through effective systems to monitor and manage pain.

###  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.*

Demonstrate 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. Ensure staff are able to identify and respond to deterioration or changes in consumers in relation to wound and behaviour management.

**Standard 6**

### Requirement 6(3)(c)

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

Demonstrate the service has created an environment of trust, with a culture where people feel supported and are encouraged to identify and report negative events. Ensure that open disclosure is provided and encouraged, and this provides the service with opportunities to find and act on things that can improve their systems.

### Requirement 6(3)(d)

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

Demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. Ensure that when feedback or complaints are received the service fully explores the opportunities for improvement from that information. Ensure that communication is enabled to highlight to staff, consumers, and representatives, how the service is utilising feedback and complaints to drive their improvements

**Standard 7**

### 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.*

### Demonstrate the workforce is enabled to deliver safe and effective quality care and services.

### Requirement 7(3)(c)

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

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

**Standard 8**

### Requirement 8(3)(c)

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

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

Demonstrate effective governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

### Requirement 8(3)(e)

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

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

Demonstrate their clinical governance framework is effective in ensuring good quality care and results.