Newmarch House

Performance Report

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**Commission ID:** 0974

**Provider name:** Anglican Community Services

**Review Audit date:** 15 November 2021 to 18 November 2021

**Date of Performance Report:** 20 January 2022

# Performance report prepared by

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# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Review Audit; the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s responses to the Review Audit report received 17 December 2021 and 10 January 2022
* Monitoring assessment contact record dated 12 December 2021.
* Infection control monitoring checklist completed at the Review Audit

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers are not consistently treated with dignity and respect. Feedback from consumers and representatives was mixed in relation to the way staff treated consumers with dignity and respect. Whilst most consumers and representatives are satisfied with how consumers are treated by long term staff, process at the Service have not been effective in ensuring all staff treat consumers with dignity and respect.

The service generally supports consumers and representatives to make decisions about the care and services they receive and who is involve in a consumers care. However, consumer decisions and choices are not always followed by staff and processes to involve representatives in decisions around palliative care have been inconsistent. The Service has implemented improvement activities in relation to support consumers choice and decision making.

Consumers indicated they are encouraged to do things for themselves and that staff know what is important to them. Consumers confirmed that their personal privacy is respected.

The service has processes to provide culturally safe care and services which are supported by the pastoral care team.

Consumers are supported to take risks to enable them to live the best life they can and where appropriate and measures to mitigate the risk are undertaken.

The provision of information to consumers is generally clear, easy to understand and enables consumers to exercise choice.

The service has processes which are generally followed by staff to ensure that consumers’ privacy and their personal information is kept confidential.

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

## Assessment of Standard 1 Requirements

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

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

The Assessment Team provided information that while most staff treat consumers with dignity and respect, there have been multiple instances in which staff practices do not demonstrate dignity and respect for consumers.

Consumers and representatives generally spoke positively about the long-term staff who work in the service and said they treat the consumers respectfully. However, consumers and representatives said the impact of insufficient staffing means that consumers are not treated respectfully, for example needing to wait an extended period for staff to respond to their requests for assistance. A Consumer representatives informed the Assessment Team of dissatisfaction with the way in which staff acted in the consumers room, another raised dissatisfaction with delays in notification of deterioration of a consumer and another about gaps in the provision of consumer care.

Staff generally spoke about consumers in a way that indicated respect and an understanding of their personal circumstances. Staff were consistently observed treating consumers with respect during their interactions with consumers throughout the review audit.

The Assessment Team reviewed incident data and identified reports of agency nursing staff not treating consumers with respect, as well as incident data in relation to continence care that did not maintain consumer dignity. The Assessment Team also referenced complaints information related delays in care, ants in a consumers bed and cold meals.

The Approved Provider provided a response that included clarifying information to the Assessment Team report, however the response did not specifically address matters raised in this requirement by the Assessment Team. I do note the work being undertaken by the Approved Provider in establishing a new staffing structure and recruitment of new management. This includes supervision of staff by senior clinical and management staff.

I note that whilst consumers and representatives provided positive feedback in relation to long term staff at the service, there was also negative feedback in relation to other staff and consumer interactions. I do also note that the Assessment Team observed staff practices to be consistently respectful during the Review Audit.

Whilst I acknowledge that the Approved Provider is undertaking improvement activities in relation to staffing, the positive feedback from consumers and representatives in relation to long term staff, as well as the observations from the Assessment Team, I find that this requirement is non-compliant based on the negative consumer and representative feedback, as well as reports of agency staff not treating consumers with respect that does not support that each consumer is treated with dignity and respect.

I find this requirement non-compliant

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

*Care and services are culturally safe.*

The Assessment Team provided information that the service has processes to provide culturally safe care and services. Information about consumers’ life history including spiritual and cultural needs is captured as part of the care planning documentation. Consumers and representatives did not raise any concerns about the service meeting their cultural and spiritual needs.

I find this requirement compliant.

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

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

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

The Assessment Team provided information that It is not evident that consumers and representatives are supported to make informed choices about the use of psychotropic medications and case conferences are not held regularly which does not enable consumers to participate in decisions about their care. The Assessment Team identified the service has processes to support consumers to exercise choice and independence in relation to maintaining connection and relationships with others and are provided with opportunities to exercise choice in relation to many daily aspects of their lives. Information is collected about who, and how, consumers want others to be involved in their care, however this information is not included in the clinical system to ensure staff are aware of these wishes and that they are followed by staff. The Assessment team also provided information relating to obtaining consent for the use of restraint.

I also note the Assessment Team Provided information indicating that consumers and representatives generally said consumers are able to make choices about their daily care needs, and the Assessment Team observed that consumers who did not wish to rise early are able to stay in bed until they want to. A range of meal choices are available and fresh fruit, snacks and beverages are available through the day in the servery area of each unit.

I note at the time of the Review Audit there was information provided that a representative had not being involved in palliative care decisions for their consumer, that staff were not consistently aware of consumers care preferences.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a plan for continuous improvement (dated 09 December 2021) that outlined actions that were completed in December 2021 related to process to determine consumer capacity to make decisions and to identify substitute decision makers. This completed improvement action is reported as resulting in all identified named consumers capacity assessed and documented to inform consent process. Mini mental now available in clinical manager for ongoing assessment and review. Training completed for staff on capacity and consent with 97% attendance.  Substitute decision makers reviewed, at scheduled care conference. The service has a case conference schedule and the changes in staffing and allocation of duties to senior clinical managers provide a system for ongoing consultation with consumers and representatives.

I find at the time of the Review Audit the service did not demonstrate that the systems established were consistently supporting 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. Consumers preferences were not consistently known by staff, and a representative had not been notified of a change of condition of a consumer and had not been able to contribute to decisions about the care provided. The effectiveness and sustainability of improvements implemented after the Review Audit have not had sufficient time to be determined to be effective.

I find this requirement is non-complaint.

### 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 provided information that consumers are supported to take risks to enable them to live the best life they can. Where appropriate, measures to mitigate the risk associated with activities that the consumer wishes to pursue are developed and documented in their care and services plan, however these actions are not always implemented. All consumers who were asked if there are things they would like to do that they are prevented from doing indicated there is nothing they could think of that they are prevented from doing.

I note the Assessment Team provided an example of actions not taken in support of a consumers choice not to be hospitalised post a fall. Whilst I note a deficit in the documentation of the management of this risk, I note the consumers choice to take the risk was respected.

Based on the Assessment Team information I find this requirement compliant.

### 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 provided information that the service provides information to each consumer in a range of ways. The information is generally clear, easy to understand and enables consumers to exercise choice.

Consumers and representatives indicated they are generally aware of what is happening in the service. Consumers confirmed they have access to information through the newsletter, menus are displayed, and activity calendars are provided.

Based on the Assessment Team information I find this requirement compliant.

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

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

The Assessment Team provided information that the service has processes which are generally followed by staff to ensure that consumers’ privacy and their personal information is kept confidential. Consumers and representatives generally spoke highly of the ways that staff are respectful of consumers’ privacy. I note one representative raised concerns around staff socialising in their consumers room.

The Assessment Team observed staff were consistently delivering care and services that was respectful of consumer privacy. Information was generally observed to be securely stored and nurses stations were locked, requiring swipe card access. However, in one area of the service consumer information was not always kept confidential.

Based on the balance of positive Assessment Team information I find this requirement compliant.

# 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

Some sampled consumers consider that they feel like partners in the ongoing assessment and planning of their care and services.

The care planning documents for the sampled consumers do not consistently reflect that the consumer and others are active partners in consumers’ clinical/personal decisions or are consulted at the time assessment and planning decisions are made.

While care and services plans are generally reviewed this is not always effective, and does not always account for when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Care plans are not always individualised relative to the risks to each consumers health and well-being.

Care assessment and planning did not always identify or address each consumer’s current needs.

Care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

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

## Assessment of Standard 2 Requirements

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

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

The Assessment Team provided information that significant risks that may impact consumers health and well-being are inconsistently managed. Risks are not always considered in assessment and planning to inform the delivery of safe and effective care to each consumer. There has not always been reassessment of consumer risk following incidents.

The Assessment team provided information relating to various named consumers. Information provided related to behaviour management, pain management, medication management, physiotherapist/mobility/equipment management, sleep management and consumer representative involvement in care planning.

The Assessment Team also noted a continuous improvement activity commenced in October 2021 aims to improve assessment and care planning improvement.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, education and training records, revised staffing structure, and a summary of actions taken for all named consumers.

I acknowledge the Approved Provider has been implementing improvement activities in relation to assessment and care planning. This includes education for registered nurses, and a revised staffing structure with improved clinical monitoring.

In relation to the named consumers, the Approved Provided has clarified errors in the Review Audit report relating to behaviours of concern for a named consumer, noting the behaviour reported by the Assessment Team was not occurring. Reassessment and updated care planning documentation has been undertaken for all the named consumers still residing at the Service. Case conferences have been conducted with representatives named in the report. The Approved Provider reports improved satisfaction with communication and care provision as reported via these case conferences. Required equipment has been acquired for relevant named consumers.

Whilst I acknowledge the Approved Provider has been implementing improvement actions in relation to this Requirement and has conducted reassessment and updated care plans post the Review Audit, I find that at the time of the Review Audit based on the information provided by the Assessment Team that the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that some consumers and their representatives expressed concerns that consumers’ needs are not adequately addressed and are impacting on their health and wellbeing. Documentation was consistently noted in care documentation where consumers’ needs, and preferences are not identified or addressed in accordance with the consumer’s expressed wishes or in a timely manner.

The Assessment team provided information relating to various named consumers. Information provided included assessment and care planning documents related to pain, palliative care, skin integrity, medication management and falls management.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, education and training records, revised staffing structure, and a summary of actions taken for all named consumers.

I acknowledge the Approved Provider has been implementing improvement activities in relation to assessment and care planning. This includes education for registered nurses, and a revised staffing structure with improved clinical monitoring.

In relation to the named consumers palliating or on end of life planning, the Approved Provider has held case conference with the representatives and care planning documents have been updated to reflect current care needs and preferences.

In relation to the named consumer and medication management, this consumer has been reviewed by the medical officer and the consumer is no longer self-medicating.

In relation to the named consumers with skin integrity management or wound management issues the Approved Provider has reassessed all named consumers, wound care records and care planning documentation has been updated to reflect current care needs. Education continues to be provided to staff on wound care and skin integrity management. The nurse advisor and senior clinical staff are continuing to monitor skin integrity and wound management for consumers.

In relation to the named consumer and falls management, the consumer has been reviewed by an occupational therapist, new equipment including a sensor mat and low bed have been provided and the consumers rearrange to improve safety.

Whilst I acknowledge the Approved Provider has been implementing improvement actions in relation to this Requirement and has conducted reassessment and updated care plans post the Review Audit, I find that at the time of the Review Audit based on the information provided by the Assessment Team that the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

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

*The organisation demonstrates that assessment and planning:*

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

The Assessment Team provided information that there was inconsistent consumer/representative feedback regarding partnership in care. There has not been adequate assessment or consultation regarding restrictive practices including psychotropic medications and chemical restraint.

There was considerable feedback about changes in the service management team. The Assessment Team was told continuity of planning and care provision has been compromised due to management and staff changes. The Assessment Team reviewed the status of case conference and reported 53 consumers/representative case conference were overdue or had not occurred. The Assessment identified named consumers who had had changes in care provision without evidence from the service of ongoing case conferencing.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, education and training records, revised staffing structure, and a summary of actions taken for all named consumers.

I acknowledge the Approved Provider has been implementing improvement activities in relation to case conferences and ensuring consumers and/or their representative are partners in their care. This included an audit of current status of case conferences, and for named consumers reassessment and care planning updates have occurred and consumers and/or representatives involved in ongoing discussions supporting care provision.

Whilst I acknowledge the Approved Provider has been implementing improvement actions in relation to this Requirement, I find that at the time of the Review Audit based on the information provided by the Assessment Team, including representative feedback, that the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

### 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 provided information that outcomes of assessment and planning are sometimes communicated to the consumer and documented in a care and services plan. It was unclear how many consumers and representatives have been provided with access to their care plans. Management have commenced a system to monitor consumer and representative access to care plans. Management said they do not have any consolidated information as to which consumers and/or representatives have been offered and provided with care plans.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan.

I acknowledge the Approved Provider has been implementing improvement activities in relation to ensuring consumers and/or their representatives have access to care plans and the outcomes of assessment and planning is communicated effectively.

Whilst I acknowledge the Approved Provider has been implementing improvement actions in relation to this Requirement, I find that at the time of the Review Audit based on the information provided by the Assessment Team, including that management reported they were not able to provide the Assessment Team with information on which consumers/representatives had been provided with care plans, that the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that the service is not able to demonstrate care and services are regularly reviewed, and when circumstances change or when incidents impact on the needs, goals and preferences of consumers. While staff confirm they have a schedule for regular review of consumers’ care plans, the Assessment Team identified that when incidents occur the service does not identify, manage and resolve incidents effectively to reduce or help prevent further incidents occurring.

For the consumers sampled, care and service records do not reflect the identification of and timely response to deterioration or changes in condition. The Assessment Team references named consumers who had changes in care needs not effectively managed, including deterioration in pressure injuries and the use of restrictive practices.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, education and training records, revised staffing structure, and a summary of actions taken for all named consumers.

I acknowledge the Approved Provider has been implementing improvement activities in relation to assessment and care planning. This includes education for registered nurses, and a revised staffing structure with improved clinical monitoring. New monitoring tools/checklists have been developed to track changes in consumers care needs. A revised incident management process has also been implemented that includes providing information to the consumer and/or representative. Improvements have been implemented in relation to wound care and monitoring wounds.

In relation to the named consumers, the Approved Provider has reviewed all named consumers. Reassessment have occurred with care plans updated.

Whilst I acknowledge the Approved Provider has been implementing improvement actions in relation to this Requirement and has conducted reassessment and updated care plans post the Review Audit, the effectiveness and sustainability of these improvements is yet to be determined. I find that at the time of the Review Audit based on the information provided by the Assessment Team that the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

# 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

Some sampled consumers consider that they receive personal care and clinical care that is safe and right for them. However, several consumers/representatives raised issues regarding aspects of care including falls prevention, pain and wound management.

The Approved Provider was not able to demonstrate that each consumer gets consistently safe and effective personal care, clinical care, or both personal care and clinical care. There have been deficits in the effective management of high impact or high prevalence risks associated with the care of each consumer.

The needs, goals and preferences of consumers nearing the end of life are generally recognised and addressed. however, their comfort is not consistently maximised, or their dignity preserved.

Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is not consistently recognised and responded to in a timely manner.

Information about the consumer’s condition, needs and preferences is not consistently documented and communicated within the organisation, and with others where responsibility for care is shared.

Timely and appropriate referrals to individuals, other organisations and providers of other care and services does not consistently occur and processes to minimisation of infection related risks have not been effective.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team provided information that there is high incidence of skin integrity issues including pressure injuries. Pain management is not always effective, and consumers are not as free from pain as possible. Restrictive practices, including chemical, physical and environmental restraint, has not been managed or minimised to optimise consumer wellbeing and is not demonstrated to be best practice.

The Assessment team provided information on names consumers including issues relating to care provision. Areas of concern raised included issues relating to pain management, wound management, updating care documentation to include care directives from external providers and recording and acting on preferences from a representative in relation to palliative care. As well as issues relation to falls management and prevention, bowel management, behaviour management, and nutrition and hydration.

Feedback from sampled representative included negative feedback in relation to the provision of care.

The Assessment Team provided information on the restrictive practice including there is high use of restrictive practices in the service. There remains high use of bedrails at the service. There is high use of psychotropic medications some of which are considered chemical restraint. There is poor staff knowledge about restraint and restrictive practices. Some restraint authorisations are not current, some consumers have not been identified as having restraint and there has not been adequate review of some psychotropic medications. Management confirmed psychotropic medication consents are signed annually by the consumer/representative. Some diagnosis provided as the indication for psychotropic medications was not evident in consumer diagnosis or other information reviewed. The Assessment team provided a range of information on named consumers and the types of restrictive practice or chemical restraint in use. The assessment team also referenced audit results and external pharmacy reports.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan and supporting documentation demonstrating improvement actions taken since the Review Audit. Also included were policies and procedures for the care and clinical governance framework, position descriptions and responsibilities for senior clinical roles, terms of reference for committees, named consumers action plan, audit reports, external provider reports, a restrictive practice report and wound summary analysis and a clinical development improvement plan. Correspondence with the Aged Care Quality and Safety Commission was also included.

In relation to the named consumers, the Approved Provider has undertaken a review of all consumers named in the Review Audit report. Where required actions have been taken to review the consumers, included reassessments, referrals to medical officers or allied health staff, changes to care plans and increased monitoring of consumers care needs. Where required consumers have been reassessed for pain, wound care, behaviour management, bowel management, palliative care needs, mobility needs and falls management.

In relation to restrictive practice, the Approved Provider has reviewed all named consumers. I acknowledge that the Approved Provider has been working to reduce the use of restrictive practice, including the use of chemical restraint. Recent internal audit results demonstrate that the Service follows restrictive practice legislation.

The Approved Provider has provided ongoing education to registered nurses and care staff and has continued to enhance the monitoring process for the delivery of care.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to personal and clinical care systems and practices and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022.

However, based on the information provided by Assessment Team, and the feedback provided by consumers and representatives I find that at the time of the Review Audit the Approved Provider did not demonstrate 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.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that management of high impact or high prevalence risks associated with the care of each consumer has been ineffective. There has been high incidence of skin integrity breeches and also pressure injuries with deterioration. Ineffective staff practices have not minimised risk of injury to consumers. Consumer falls and infections have been high, falls have resulted in poor outcomes for some consumers. Medication management is not effective to minimise risk to consumers. There have been many medication incidents, some with potential high impact to consumers. High risk medications have not been not been effectively managed; there is minimal investigation into incidents to minimise risk and/or improve outcomes for consumers.

The Assessment team provided information on names consumers including issues relating to medication management, wound management, pain management and falls.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report, including corrections in errors reported by the Assessment Team. Also provided was a detailed response for actions taken in relation to the named consumers, correspondence with the Aged Care Quality and Safety Commission, actions taken in relation to wound management, pain management, medication management and improvements to the collection and analysis of clinical incident data. A named consumer action plan was also provided.

In relation to the named consumers, the Approved Provider has undertaken a review of all consumers named in the Review Audit report. Where required actions have been taken to review the consumers, included reassessments, referrals to medical officers or allied health staff, changes to care plans and increased monitoring of consumers care needs. Where required consumers have been reassessed for pain, wound care, behaviour management, mobility needs and falls management.

The Approved Provider has implemented improved monitoring process to monitor high impact or high prevalence risks to consumers. Terms of reference were provided for a weekly clinical review meetings and monthly clinical risk committee meetings. Senior clinical staff have specific responsibilities to the oversight and review of clinical incidents and monitoring clinical risks. Ongoing education is being provided to registered nurses.

I acknowledge the actions taken by the Approved Provider, including actions taken for named consumers and the development of improved monitoring process for high impact and/or high prevalent risks. I note the improvement actions taken in relation to wound care, pain management, and medication management. I accept that there were issues with Agency staff in relation to reporting and acting on incidents and that actions have taken to address this.

However, I find that at the time of the Review Audit, based on the information provided by the Assessment Team and consumer/representative feedback, that the Approved Provider was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

I find this requirement is non-compliant.

### 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 provided information that the needs, goals and preferences of consumers nearing the end of life are not always recognised and/or addressed in a timely manner and comfort is not always maximised or their dignity preserved.

Whilst there is evidence staff are caring at the end of consumer’s life there were examples of end of life care process not being commenced until late in the consumer end of life pathway. For named consumers issues were identified in aspects of care provision including continence and skin care and repositioning not maintained to support maximum comfort for dying consumers.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan and supporting documentation demonstrating improvements taken in relation to this requirement. The Approved Provider did not provide specific information in relation to deceased named consumers. Increased monitoring and review process have been implemented that will support monitoring this requirement.

I acknowledge the Approved Provider has been implementing improvements to the assessment, delivery and monitoring of care provision to consumers. However, based on the information provided by the Assessment team, as well as the negative feedback from representatives, I find that at the time of the Review Audit the Approved Provider did not demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

I find this requirement is non-compliant.

### 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 provided information that deterioration in consumer condition is not always recognised and responded to in a timely manner. There has been negative impact to consumers due to lack of effective clinical oversight in relation to the deteriorating consumer.

Deterioration in pressure injuries have not identified in a timely way for named consumers. Staff have not followed organisational directives relating to the deteriorating consumer. Deterioration of pressure injuries was not adequately identified or addressed.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as information in relation to the care and clinical governance framework, terms of reference for the weekly clinical review meetings, education for registered nurses and roles and responsibilities for senior clinical staff. Also included was a named consumer action plan.

In relation to named consumers, the Approved Provider has where required reviewed and reassessed the named consumers, care documentation has been updated and consumer have been referred to medical officers or allied health specialists as needed.

Processes for improved clinical monitoring have been implemented, including additional training for registered nurses on Organisational policies and procedures, improved clinical oversight and monitoring of staff practices and care delivery including weekly clinical review meetings and monthly clinical risk meetings. Additional senior clinical staff have been employed to ensure consumers care is delivered in accordance with care plans and deterioration is identified and acted upon. Full reviews of skin integrity and wound care have been completed and improvements identified, planned and implemented.

Whilst I acknowledge the improvement activities and the improved results in care outcomes outlined in the Approved Provider response on 10 January 2022, I find that at the time of the Review Audit the Approved Provider did not 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. I based this finding on the information provided by the Assessment team and the feedback provided by consumers and representatives.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that although the service has systems to support communication of consumer’s condition, needs and preference they are not well communicated within the organisation and with others where responsibility is shared. Dissatisfaction was expressed by several consumers and/or representative regarding communication in the service.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as information that is provided to consumers and representatives in relation to open disclosure and incident management, the feedback mechanisms available and a copy of the Service newsletter. A quality improvement plan was also provided and outlined improvement activities in relation to improved communication with consumers and representatives. For named consumers specific management and feedback plans have been established. Case conferences have been held with named consumers representatives where needed and copies of care plans provided.

Whilst I acknowledge the improvement activities and the improved communication outcomes outlined in the Approved Provider response on 10 January 2022, I find that at the time of the Review Audit the Approved Provider did not demonstrate 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.

I based this finding on the information provided by the Assessment team and the feedback provided by consumers and representatives.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that only some consumers have timely and appropriate referrals to individuals, other organisations and providers of other care and services. The organisation has support services such as dementia and palliative clinical nurse consultants. Speech pathologist and dietician services were seen to be available when required. There has been inconsistent access to physiotherapy, occupational therapy services and medical officers.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well a named consumer action plan, and a quality improvement plan and supporting documentation. I note a physiotherapist commenced working at the Service the week of the Review Audit.

In relation to the named consumers appropriate referrals have been actioned to the occupational therapist, external wound consultants, physiotherapist and medical officers. Changes in care provision have been implemented as needed following these referrals. I note the difficulties the Approved Provider has had in relation to access to medical officers. I also note the work being undertaken in education, monitoring and support for registered nurses in relation to Organisational policies and procedures, included relating to this requirement.

Whilst I acknowledge the improvement activities and the improved clinical outcomes outlined in the Approved Provider response on 10 January 2022, I find that at the time of the Review Audit the Approved Provider did not demonstrate Timely and appropriate referrals to individuals, other organisations and providers of other care and services. I based this on the identification of delays in referrals by the Assessment Team and feedback provided by representatives during the Review Audit.

I find this requirement is non-compliant.

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team provided information that the organisation has process to monitor infections and antibiotic use. However, staff practices within the service have not been effective in minimising infection related risks or promoting principles of antimicrobial stewardship. Consumer infection incidence is high and risk of infection through skin integrity breeches is also high. Review of consumer files and infection and prescribing data found issues with obtaining pathology to support optimal care and minimising risks of antibiotic resistance. For named consumers medication incidents show antibiotics and other medications have not always been administered as prescribed to support minimisation and management of infections.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as information on education being provided to care and clinical staff to prevent and minimize infection, such as actions taken to reduce urinary tract infections. All medication incidents have been investigated and a named consumer action plan outlines the improvement actions taken to improve care provision.

I accept that the use of agency staff has impacted this requirement, as identified by the Approved Provider and that actions have been taken to ensure improved staffing at the service, including increased recruitment on clinical staff. As well as increased clinical education for care and registered staff. Improved staff and care monitoring processes have been implemented.

I acknowledge the improvement activities and the improved clinical outcomes outlined in the Approved Provider response on 10 January 2022, including a reduction in overall consumer infections and improved pathology and medication management process.

However, based on the information provided by the Assessment Team and representative feedback about deficits in the management and prevention of infections for named consumers, I find that at the time of the Review Audit the Approved Provider did not demonstrate effective *minimisation of infection related risks.*

I find this requirement is non-compliant.

# STANDARD 4 NON-COMPLIANTServices and supports 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

Generally, consumers indicated that they are able to pursue their interests and that that they are able to optimise their quality of life. However, while most consumers are able to participate in a program of varied activities, there are limited supports for consumers living with dementia or for consumers who require supports to pursue individualised activities.

Consumers provided feedback that their spiritual and emotional needs are met by regular visits from the pastoral care team. Consumers confirmed that they are supported to keep in touch with people who are important to them.

Consumers indicated they are satisfied with quantity and quality of meals provided.

The service has processes to meet each consumer’s needs, goals and preferences to optimise their independence, health, well-being and quality of life. The pastoral care team supports consumers emotional, spiritual and psychological well-being.

Changes in a consumer’s condition, needs or preferences in relation to lifestyle services and supports are communication through staff handover, progress notes and care plans.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-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 provided information that consumers and representatives indicated they are satisfied with the supports they receive for daily living. Staff are generally knowledgeable about consumers’ needs and preferences and there is a process for taking the consumer’s life history, cultural needs and preferences into consideration in order to meet each consumer’s needs, goals and preferences to optimise their independence, health, well-being and quality of life.

Based on information provided by the Assessment Team I find this requirement compliant

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

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

The Assessment Team provided information that the service has processes to support consumers emotional, spiritual and psychological well-being. Access to professional services supplement the emotional supports provided by the pastoral care team to ensure consumers psychological well-being. Consumers are supported to pursue their spiritual needs.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

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

The Assessment Team provided information that there are services and supports for daily living to assist consumers to participate in their community and to have social and personal relationships. Most consumers are supported to do things that are of interest to them. However, there are limited supports for consumers living with dementia or for consumers who require supports to pursue individualised activities.

Staff interviews identified that resources allocated to consumers, particularly in the secure living accommodation could not be located. Staff also informed the assessment team that whilst consumers in the secure living accommodation could attend all general activities, that this did not occur and most consumers residing in this accommodation did not attend the general activities. Specific activities for these consumers including a “resi-action” program are not consistently undertaken. Documentation reviewed by the Assessment Team indicated that for named consumers there was limited activities of choice being undertaken.

The Approved Provider provided a response that included clarifying information to the Assessment Team report, however the response and attached quality improvement plan did not specifically address matters raised in relation to this requirement.

Based on the information provided by the Assessment Team, I find that at the time of the Review Audit the Service did not have process to ensure Services and supports for daily living assist each consumer to do the things of interest to them. Process to monitor care staff implementing lifestyle plans has not been effective. Processes to ensure allocated resources are available to consumers have not been effective.

I find this requirement non-compliant

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

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

The Assessment Team provided information that changes in a consumer’s condition, needs or preferences in relation to lifestyle services and supports are communication through staff handover, progress notes and care plans. Lifestyle staff and pastoral care staff regularly speak with consumers. Staff demonstrated an understanding of the need to comply with relevant privacy polices when sharing information with other organisations or individuals.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

The Assessment Team provided information that the service undertakes timely and appropriate referrals to individuals and other organisations, particularly in relation to the provision of spiritual services and emotional and psychological supports.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

The Assessment Team provided information that feedback received from consumers and representatives regarding the quality, quantity and variety of food available to them was consistently positive. Food preparation areas were observed to be clean and tidy and catering staff demonstrated an understanding of consumers’ dietary preferences and requirements.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

The Assessment Team provided information that the service has processes in place to ensure equipment is safe, suitable, clean and well maintained. Staff demonstrated an understanding of the reporting process for managing any issues with equipment.

Based on information provided by the Assessment Team I find this requirement compliant.

# STANDARD 5 NON-COMPLIANTOrganisation’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

Overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment.

Most consumers interviewed said they felt safe within the service, however some issues with service systems impact on consumers safety.

Consumers provided negative feedback in relation to ongoing issues with the reliability of the call bell system, reporting delays in the provision of care as a result. The service’s call bell system is not working in a manner that upholds each consumers safety. Management acknowledge the issues with the system have been longstanding. An upgrade was undertaken; however, issues remain.

Consumers interviewed felt the service was homely, a nice place to live, and a welcoming environment for their families and friends, particularly the café area and gardens.

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

## Assessment of Standard 5 Requirements

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

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

The Assessment Team provided information that the service environment is welcoming and easy to navigate. The service has plans and programs in place to ensure that each consumer’s sense of belonging, independence, interaction and function is optimised. Consumers were observed interacting in groups, with their families and guests and independently, accessing various areas throughout the service with ease and comfort.

Based on information provided by the Assessment Team I find this requirement compliant.

### 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 provided information that the service environment is clean, safe, comfortable and maintained well. Most consumers can move freely within the service and the enclosed garden areas within the service. Consumers residing in the secure Wentworth Heights wing are not able to access all parts of the service without assistance from staff but have direct access to an outdoor area.

Based on information provided by the Assessment Team I find this requirement compliant.

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

The Assessment Team provided information that equipment is not always safe, well maintained and suitable for the consumer. Several large equipment systems are currently not in working order, including the call bell system, which is faulty resulting phantom calls, some calls not registering on the staff’s Vocera alert and calls not escalating through the system. The Assessment Team reported other equipment including air conditioning, refrigeration and hot water boilers as being broken and waiting repairs.

Consumers interviewed said they were satisfied with the furniture and fittings and believed that the service was a safe, clean and well maintained generally, but expressed frustration with the call bell system impacting their care and, in some instances, resulting in injury.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as quality improvement plans, call bell reports and correspondence with the company responsible for the installation and maintenance of the call bell system. The Approved Provider has acknowledged the importance of a working call bell system for consumers.

Whilst I acknowledge that there was equipment waiting repairs at the time of the Review Audit, there was no impact of the equipment not being available reported by the Assessment Team and the Approved Provider had taken actions to support staff who would use this equipment, including temporary alternative equipment provided. I accept the Approved Provider position that delays in equipment repairs had been impacted by COVID-19 pandemic.

In relation to the call bell system, I accept that the Approved Provider has had ongoing and extensive communication with the system supplier, I acknowledge that the core issue has been identified and corrective actions are planned, I also accept that the Approved Providers information technology department has been working to improve the reliability of the system while the Service awaits repairs, however this has not resolved all ongoing issues. The expected completion date for repairs is March 2022.

I have considered the response from the Approved Provider and I acknowledge that that the Approved Provider is actively working with the suppling company to address the ongoing issues.

However, I find that at the time of the Review Audit, consumer and staff feedback indicated the ongoing issues with the call bell system were impacting on the delivery of timely care to Consumers, and I note the issue is ongoing.

I find this requirement non-compliant.

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Consumers and representatives are aware of complaints systems and processes. Consumers and representatives said they are familiar with the avenues for raising complaints in the service.

Consumers and representatives expressed frustration about the lack of improvement following complaints. Concern were also raised regarding transparency following the making of complaints including aspects of open disclosure.

Feedback and complaints are not consistently reviewed and used to improve the quality of care and services.

Consumers have access to advocates and support to make complaints including consideration of cultural diversity and opportunities to maintain confidentiality.

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 provided information that the service has complaints policies and processes to support the making of complaints and provision of feedback. Information about feedback and complaints processes is evident throughout the service and staff demonstrate knowledge of complaints processes. There are volunteers, advocates and pastoral care staff who support and listen to consumers and available to support feedback processes.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

The Assessment Team provided information that the service provides consumers and representatives with information regarding feedback processes through numerous avenues including notices, consumer handbook and through meetings. The service has information about advocacy services and also provides information about language services. There are volunteers including culturally matched volunteers as well as pastoral care staff and volunteers who support consumers and advocate on their behalf if needed. There was positive feedback about support provided specific to this requirement.

Based on information provided by the Assessment Team I find this requirement compliant.

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

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

The Assessment Team provided information that appropriate action is not always taken following complaints and open disclosure is not always exercised when things have gone wrong in the service. Consumers and representatives expressed dissatisfaction with the lack of action, or with the insufficiency of actions taken following their raising of a complaint. A number of consumers and representatives said “they have to chase” staff to follow up when they have complained. The majority of complaints have not been thoroughly investigated, with consideration of contributing factors such as staff practices, systems or processes. There has been limited evaluation of the outcomes of complaints and impact for the consumer.

Six of seven consumers, or representatives speaking on their behalf, said appropriate action was not taken in response to a complaint raised, and open disclosure process was not used in relation to the matter.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan that outlines a range of improvement activities related to this requirement. Improvement actions completed in December 2021 included open disclosure education conducted with 97% of staff. further mandatory Registered Nurse education workshops included further education on open disclosure. Improvements made to incident form for improvements in communication and clarity to open disclosure documentation. I also note the commencement of new management at the service.

Whilst I acknowledge the improvement actions taken by the Approved Provider, the effectiveness and sustainability of improvements has yet to be determined.

Based on the negative consumer and representative feedback provided to the Assessment Team, I find that at the time of the Review Audit the service did not have process to ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that the organisational quality processes monitor complaints and feedback although quality of care and services has not always been improved following complaints. A number of consumers and/or representatives expressed frustration about the ongoing nature of some of their concerns. Complaints expressed during the Review Audit, evident in complaints and feedback from consumers and representatives remains similar to those expressed in previous Commission reports; high agency staff use, insufficiency of staffing and aspects of care provision.

Complaints do not reflect evidence of thorough investigation, identification of contributing factors or root cause. The current complaints register does not always reflect all the information provided by the complainant resulting in discrepancies in complaints data. No evidence of analysis of complaints data was available.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan that outlines a range of improvement activities related to this requirement. In relation to the main areas of ongoing complaint, the Approved Provider has reviewed the staffing at the service, a new manager has been employed and ongoing recruitment strategies are being implemented to reduce the requirement on the need for agency staff and ensure sufficient staffing. A new staffing model is also being trialled. In relation to actions being taken to address deficits in care provision, the approved provider has introduced a revised clinical governance framework, improved incident and risk management processes, and provided clarification on the responsibilities for monitoring clinical care.

Whilst I acknowledge the improvement actions taken by the Approved Provider, the effectiveness and sustainability of improvements has yet to be determined.

Based on the negative consumer and representative feedback provided to the Assessment Team, I find that at the time of the Review Audit the service did not have process to ensure feedback and complaints are reviewed and used to improve the quality of care and services.

I find this requirement is non-compliant.

# 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

Consumers and representatives generally provided complimentary feedback and are most appreciative of regular staff. Feedback was provided about regular staff understanding consumer preferences and identity. However, negative feedback was provided in relation to the use of agency staff.

The Organisation was not able to demonstrate effective systems to ensure 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. Processes to ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles have not been effective.

The Organisation has not been able to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Regular assessment, monitoring and review of the performance of each member of the workforce is not consistently undertaken.

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

## Assessment of Standard 7 Requirements

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

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

The Assessment Team provided information that the workforce is not planned with the numbers and mix of staff deployed sufficient to enable the delivery of safe and quality care and services. There was considerable consumer and representative feedback about insufficiency of staff and staffs’ capacity to respond to calls for assistance in a timely manner. Negative feedback was provided on the use of agency staff and agency staff not provided care to the standard expected.

Five of the eight care staff interviewed said there was not always enough staff and the main issue was inconsistency. Care staff informed the Assessment Team that high use of agency nurses and care staff added additional pressure to the regular staff as agency staff do not know the consumers and require high levels of supervision and guidance. Management acknowledge that an unstable workforce is leading to variable care. Management provided information that the roster is currently under review and they are currently recruiting additional staff.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as position descriptions, roles and responsibility outlines, and a new care/staffing model. The Approved Provider has recognised the need to urgently increase the Newmarch House workforce to ensure the care needs of residents are met, and to reduce Newmarch House's reliance on an agency workforce. Active ongoing recruitment is occurring, and a new manager has been appointed.

Based on the feedback provided to the Assessment Team from consumers, representatives and staff about insufficient staff, as well as the reported impacts with delays in care and the number of non-compliant requirements being impacted by deficits in staffing I find that at the time of the Review Audit the Approved Provider did not demonstrated 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.

I find this requirement is not met.

### 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 provided information that consumers and representatives believe regular staff are kind and caring. Consumers and representatives provided complimentary feedback and are most appreciative of regular staff. Feedback was provided about regular staff understanding consumer preferences and identity. However, one representative provided examples to the Assessment Team of staff interactions they believe did not respect to their consumer.

The Assessment Team observed staff throughout the service interacting warmly, respectfully and kindly with consumers, demonstrating empathy and care when delivering care and services as well as in informal or social interactions in the communal spaces.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report, the Approved Provider is working with the representative who is concerned about some staff interactions to ensure their consumer receives the standard of care and respect that is expected by the representative.

Based on information provided by the Assessment Team I find this requirement compliant.

### 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 provided information that some of the workforce is competent and generally staff have appropriate qualifications for their roles. Issues were raised about some aspects of staff knowledge and skills and their capacity to effectively perform their roles. Issues were also raised about agency staff knowledge and skills. Consumers expressed frustration and dissatisfaction with agency staff and did believe agency staff are competent or effective in delivering care and services. Concerns were raised by consumers or their representative in relation to effective management of pain, and the management and prevention of falls. The Assessment team also identified staff knowledge deficits in relation to the assessment and management of consumers care needs and in managements handling of complaints.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, training and education records, a copy of the formalised training program, a copy of the clinical development training plan, as well as training materials. A revised staffing structure and ongoing recruitment results were also provided. The Approved Provider acknowledge the challenges that the use of Agency staff had placed on the Service.

I acknowledge that the Approved Provider has and continues to take actions to improve competency and knowledge of staff. A nurse educator has been providing ongoing education to care and registered staff and registered staff are being supported with a workshops and a clinical development improvement plan. I acknowledge the work the Approved Provider is taking to increase staffing levels and recruit suitable staff to senior clinical positions. I also note a new care manager has been appointed. The Approved Provider has taken actions to address underperforming agency staff, with feedback to providing agencies and the removal of unsuitable staff from the roster.

The improvements of the ongoing education of staff was demonstrated by the Approved Provider in the response received 10 January 2022, which identified a range of improved outcomes for consumers.

Whilst I acknowledge the improvements being achieved by the Approved Provider in the care of consumers, I find that at the time of the Review Audit the Approved Provider did not demonstrate the workforce was competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. I have based this finding on the information provided by the Assessment Team, feedback from consumers and representatives and the finding as outlined in this Performance report.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that although the service has recruitment and training processes and resources, they have not been effective in equipping staff to deliver outcomes required by these standards. Negative feedback was provided about gaps in management and staff skill and knowledge.

While the service has an education and training program for staff, there is limited evidence of cohesive monitoring and support of staff to ensure their understanding and ability to implement training and education. Deficiencies identified across the all Standards demonstrates recruitment, training and support provided to staff has not been sufficient to deliver the outcomes required by the Quality Standards. Deficits were identified in the onboarding and orientation of new permanent and temporary staff.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan, training and education records, a copy of the formalised training program, a copy of the clinical development training plan, as well as training materials. A revised staffing structure and results of ongoing recruitment was provided. Documentation outlining the specific roles and responsibility of senior clinical staff was also provided.

The improvements of the ongoing recruitment and training of staff was demonstrated by the Approved Provider in the response received 10 January 2022, which identified a range of improved outcomes for consumers and demonstrated improved compliance with the Quality Standards.

Whilst I acknowledge the work being undertaken by the Approved Provider in relation to the recruitment and training of staff, I find that at the time for the Review Audit the Approved Provider did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. I based this finding on the finding of non-compliance outlined in this Performance report, as well as the information provided by the Assessment Team.

I find this requirement is non-compliant.

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

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

The Assessment Team provided information that regular assessment, monitoring and review of the performance of each member of the workforce is not undertaken. Although the service has a process for annual staff review at least half of the workforce has not has a performance appraisal in the past year. Staff interviews confirmed that performance appraisals were not being conducted, and deficits in the management of complaints about staff performance was identified.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as a quality improvement plan outlining actions taken to improve this requirement, including education provided to staff, as well as process to monitor staff performance and processes for staff reflection on performance and feedback mechanism to staff on their performance

I acknowledge that the Approved Provider has implemented a range of actions to ensure regular review of staff performance. However, I find that the time of the Review Audit the Approved Provider did not demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have based this finding on information provided by the assessment team, including an ineffective annual staff appraisal process and a review of actions taken following complaints about staff performance did not demonstrate that a review of the staff performance was undertaken.

I find this requirement is non-compliant.

# 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

Consumers are generally engaged in the development, delivery and evaluation of care and services and are supported in that engagement. in mid-2021 the organisation implemented a consumer reference group to facilitate this engagement.

The Organisations governing body has not effectively established a culture of safe, inclusive and quality care and services. Deficits have been found in organisation wide governance systems, relating to a range of systems.

Risk management systems and practices have not been effectively implemented or monitored. And the Organisation has not implemented and effective clinical governance framework.

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

## Assessment of Standard 8 Requirements

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

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

The Assessment Team provided information that in mid-2021 the organisation implemented a consumer reference group which engages consumers in the development, delivery and evaluation of care and services.

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

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

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

The Assessment Team provided information that the organisation’s governing body has not been effective in promoting a culture of safe, inclusive and quality care and services. The governing body has failed to implement effective measure to addressing issues on ongoing non-compliance in relation to the Quality standards.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report. The Approved Provider acknowledge the issues outlined in the Review Audit and has given a commitment to deliver the highest standards of care and services. The Approved Provider pledged to continue to work with the nurse advisor and to continue to implement improvements at the Service.

Evidence of this commitment was demonstrated in the improved outcomes for consumers outlined in the response received 10 January 2022.

Whilst I acknowledge the commitment and action taken by the Approved Provider I find that at the time of the Review Audit organisation’s governing body has not been effective in promoting a culture of safe, inclusive and quality care and services. I have based my findings on the non-compliance outlined in this Performance report.

I find this requirement is non-compliant.

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

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

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

The Assessment Team provided information that the organisation does not have effective information management systems. Continuous improvement activities have not been effective in addressing ongoing issues on non-compliance. While the organisation has financial management systems, the organisation has not proactively identified and addressed issues related to sufficiency of staffing. Workforce governance has not been effective and regulatory compliance obligations have not been followed.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as quality improvement plans and supporting documents that demonstrated a range of improvement activities that had either commenced, were planned or completed in relation to information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance, and feedback and complaints.

In relation to information management, I note that deficits in information management have been identified through the Assessment Team report in relation to assessment and planning of care and maintaining accurate clinical records, as well as in relation to incident management, complaints handling, workforce management and governance.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to information management and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022.

In relation to continuous improvement, I note the level of non-compliance outlined in this Performance Report, I note that implemented improvements at the Service had not, at the time of the Review Audit, been effective in ensuring compliance with Aged Care Quality Standards.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to continuous improvement and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022. Recent audit results monitoring the Service compliance with the Aged Care Quality Standards have demonstrated improved outcomes for both consumers, staff and the Service.

In relation to financial governance the Assessment Team indicated that there was insufficient financial governance in relation to the provision of staffing. However, I note that the Approved Provider was working to established improved and stable staffing levels. I note since the Review Audit further recruitment and improvements to staffing are occurring.

In relation to workforce governance, I note the Assessment Team provided information in relation to sufficiency of staff, the competency of staff, the skills and knowledge of staff, the recruitment and onboarding of staff and monitoring staff performance.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to workforce governance and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022. I note that staff, including senior clinical and management staff have been recruited, have specific roles and responsibilities outlined and staff performance review processes have been reviewed. I note the revised staffing model and increased staffing levels that have been implemented since the Review Audit, as well the level and scope of training being provided.

In relation to regulatory compliance, the Assessment Team provided information of deficits in relation to restrictive practices, and the serious incident response scheme.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to workforce governance and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022. Specifically, the recent audit results demonstrating compliance with restrictive practice legislation. Also, the training provided to staff on the serious incident response scheme and improvement monitoring of regulatory compliance.

In relation to feedback and complaints, the Assessment team provided information that whilst consumers and representatives had access to and were willing to use the complaints and feedback mechanisms at the Service, they provided negative feedback on the handling and resolution of complaints.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to complaints and feedback and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022. The Service has clear responsibilities for management in complaints handling and improved communication channels with consumers and representatives.

Based on the information provided by the Assessment team, and the findings outlined in this Performance Report, I find that at the time of the Review Audit the Approved Provider did not demonstrate effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance, and feedback and complaints.

I find this requirement non-compliant.

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

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

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

The Assessment Team provided information that the organisation has not demonstrated that effective risk management systems and practices are in place in relation to managing high-impact and high-prevalence risks associated with the care of consumers, responding allegations of abuse of consumers or supporting all consumers to live the best life they can. The organisation has processes in place regarding these areas of care and service but has not been effective in identification, management and minimisation of risk to consumers in regard to this requirement.

In relation to managing high impact or high prevalence risks associated with the care of consumers the Assessment Team provided information of deficits in relation to medication management, wound care, restrictive practice and pain management.

In relation to identifying and responding to abuse and neglect of consumers, the Assessment Team provided information relating the identification of neglect and late submission of reports to the Serious Incident Response Scheme.

In relation to the management and prevention of incidents, the Assessment Team provided information of deficits in the collection and analysis of incidents.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as quality improvement plans outlining improvement activities in relation to medication management, wound management, restrictive practices and pain management. Staff have been provided training on the Serious Incident Response Scheme. The Approved Provider has also implemented changes to the collection and management of incidents.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to Effective risk management systems and practices and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022.

However, based on the information provided by the Assessment team, and the findings outlined in this Performance Report, I find that at the time of the Review Audit the Approved Provider did not demonstrate effective risk management systems and practices

I find this requirement non-compliant.

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

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

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

The Assessment Team provided information that although there is a documented clinical governance system including policies relating to antimicrobial stewardship, minimising use of restraint and open disclosure they have not been effective.

In relation to antimicrobial stewardship the Assessment Team provided information on an ineffective infection control program, including the management of pathology and antibiotic use.

In relation to minimising the use of restraints, the Assessment Team provided information in relation to deficits in restrictive practices, including the use of physical and chemical restraint.

In relation to open disclosure, the Assessment Team provided examples of where open disclosure had not been practiced as a matter of complaints handling, or when harm had occurred to consumers.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as quality improvement plans outlining improvement activities. A revised clinical governance framework has been implemented at the Service, with clear roles and responsibilities allocated to senior clinical staff to monitor the processes.

I acknowledge the improvement activities undertaken by the Approved Provider in relation to Effective risk management systems and practices and note the improved outcomes as outlined in the Approved Provider response received 10 January 2022.

I find, based on the information provided by the Assessment team, and the findings outlined in this Performance Report, that at the time of the Review Audit the Approved Provider did not demonstrate and effective clinical governance framework.

I find this requirement is non-compliant.

# Areas for improvement

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

* The Approved Provider must continue to implement the improvement activities as outlined in the plan for continuous improvement dated 7 January 2022.
* The Approved Provider must implement effective monitoring processes to ensure the ongoing effectiveness and sustainability of improvements.
* Ensure each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* Ensure each consumer is supported to exercise choice and independence, including involving substitute decision makers when required.
* Ensure 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
* Ensure assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.
* Ensure the organisation demonstrates 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.
* Ensure 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.
* Ensure 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.
* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, including wound care, pain management and the use of restrictive practice.
* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.
* Ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.
* Ensure 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 Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.
* Ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Implement process to minimisation of infection related risks.
* Ensure 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.
* Ensure furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer, including a working call bell system
* Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* Ensure 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.
* Ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards
* Ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Implement effective risk management systems and practices
* Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Implement a clinical governance framework