Orana Gardens

Performance Report

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**Commission ID:** 0479

**Provider name:** Orana Gardens Ltd

**Site Audit date:** 22 June 2021 to 24 June 2021

**Date of Performance Report:** 13 August 2021

# 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) | Non-compliant |
| Requirement 1(3)(c) | Non-compliant |
| Requirement 1(3)(d) | Non-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) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-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) | Non-compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment conducted 22 to 24 June 2021, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 3 August 2021.

# 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

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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and testing staff understanding and application of the requirements under this Standard. The team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

The Assessment Team interviewed consumers and representatives who considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and are given information which enables them to exercise choice and understand their rights and the services available to them. Consumers and representatives said consumers are supported to make choices, including to take some risks in life. However, a system is not in place to identify, assess and manage those risks to support consumer choice. For the consumers sampled there was a lack of risk assessment and management to support their choices about activities with associated risk.

Consumers say they feel valued for who they are. However, the Assessment Team observed some staff do not understand respectful language and what treating consumers with dignity and respect means in practice.

#### The Assessment Team found that there are some processes to support each consumer to make decisions about their own care and services and to communicate those decisions. Consumers sampled, are supported to develop, and maintain relationships with others. However, it has not been demonstrated there is a process to ensure the service support the staff to manage issues of consent and work out a consumer’s ability to make decisions.

Consumers are satisfied care and services, including personal care, are undertaken in a way that respects their privacy. Observed delivery of care and services is respectful of consumer privacy.

Furthermore, consumers, representatives, and staff provided information which indicates the staff do not recognise, understand or respect the unique cultural identity of some consumers. Staff could not describe how they adapt the way care and services are provided so this is culturally safe for each consumer.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team found that most consumers and representatives said the consumer is treated with dignity and respect. Consumers say they feel valued for who they are. However, some consumers and representatives provided information this has not always been the case. Other information gathered showed some staff do not have an understanding of respectful language and what treating consumers with dignity and respect means in practice.

The Assessment Team spoke with consumers who spoke of staff speaking in their own language, other than English when making the consumers bed and when they are assisting with personal care. One consumer said, “They do it all the time”. These consumers spoke of this behaviour making them feel uncomfortable and they were not sure if the staff were making fun of them. They did not feel respected.

The Assessment Team also interviewed staff who consistently spoke about consumers in a way that indicated respect and an understanding of their personal circumstances and life journey. For example, several of the staff interviewed referred to consumers in the Special Care Unit (SCU) as “demented” and having “childlike behaviour”.

The approved provider responded to the Assessment Team’s report with a ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’ and advised that the CEO and Facility Manager commenced meetings with all staff commencing Monday 26 July 2021 to discuss the identified issues, this included memorandums released to staff. I have considered the additional information, however, acknowledge that it will take some time to demonstrate compliance with the issues identified for this requirement.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

*Care and services are culturally safe.*

The Assessment Team found that consumers, representatives, and staff provided information which indicates the staff do not recognise, understand or respect the unique cultural identity of some consumers. Staff could not describe how they adapt the way care and services are provided so they are culturally safe for each consumer.

The Assessment Team found that the service has not demonstrated through their assessment and planning process that they are proactive in supporting the cultural safety of care and services for their consumers. The care planning documents of consumers who the service identified as Aboriginal or Torres Strait Islander did not show their specific cultural needs.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The service advised that the service has now implemented a cultural program and will arrange cultural support from the community and include individual programs and activities for consumers who wish to participate. Consumers documentation will be reviewed and updated regarding cultural needs information and strategies to support them, attendance and outcomes for each consumer will be documented in assessments and care plans.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

#### The Assessment Team found that there are some documented processes to support each consumer to make decisions about their own care and services and to communicate those decisions. Consumers sampled, are supported to develop, and maintain relationships with others. However, it has not been demonstrated there is a process to ensure the service support the staff to manage issues of consent and work out a consumer’s ability to make decisions.

The Assessment Team identified that the organisation has policies and procedures with guidance for management and staff about consumer choice and decision making. The service’s choice and decision-making policy and procedures state that consumer decision-making arrangements are to be identified prior to or at the time of admission to the service. Also, if the consumer’s decision-making capacity fluctuates, appropriate assessments must be completed, and referral made to the consumer’s general practitioner for an assessment of capacity. This has not always occurred for consumers living with cognitive impairment.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The service disputed the team’s finding, stating that this process occurs from the admission of consumers into the service, during the cognitive assessment and is reflected in the care planning process. However, the team was advised that a consumer with cognitive impairment did not understand a lot of what they were signing, therefore the consumer may not have had capacity to make informed consent. The approved provider included in the ‘Plan for Continuous Improvement’ that they would conduct face to face education for all staff and undertake PAS to determine consumer’s capacity and capability to give informed consent.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team interviewed consumers and representatives who said consumers are supported to make choices including to take some risks in life. However, for the consumers sampled, the service did not demonstrate it has a system for and an understanding of the need to identify, assess and manage risks to support consumer choice, while supporting them to identify and minimise any risks associated with living their best life.

The Assessment Team reviewed care and service records for consumers who were identified as supported to take risks. These show no or minimal consideration of risk or lack of comprehensive risk assessment.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The service advised that they reviewing and re-commencing the case conference schedule with all consumers/representatives. And for consumers who make a choice to do something that has an identified risk a waiver or risk assessment is to be completed by all relevant parties.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

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

# 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

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

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

The Assessment Team found that most sampled consumers did not consider that they feel like partners in the ongoing assessment and planning of their care and services.

The Assessment Team interviewed consumers and representatives who said they have not been involved in the process of assessment and care planning. The results of interviews with consumers or their representatives does not demonstrate they are aware of the consumer’s care plan.

The Assessment Team reviewed care planning documentation which shows minimal consultation with consumers and/or their representatives and lack of case conferencing to discuss consumer’s care needs.Whilst the service has commenced a process to discuss outcomes of assessment and planning with consumers, the process is ongoing and has not been completed for most consumers.

#### Review of care documentation showed that risks to consumers’ health and well-being are not addressed in consumer care plans. The care documentation does not identify strategies or interventions to monitor and mitigate the risks to inform the delivery of safe and effective care. For consumers sampled who have recently entered the service, assessment and care planning does not address the consumer’s individual needs.

#### The Assessment Team identified that care planning documentation does not routinely record consumers’ current needs, goals and preferences and outlines minimal interventions to address various aspects of consumer’s care. For consumers receiving end of life care, care plans do not always reflect changes in their care needs, including their palliative care wishes and goals.

#### The Assessment Team interviewed staff who said care planning documentation is reviewed on a regular basis, however it was not evident that comprehensive review of care plans was conducted for effectiveness when circumstances change, or when incidents occur that impact on the needs, goals or preferences of consumers. Care planning documentation lists minimal interventions to address and prevent reoccurrence of incidents in the future to minimise harm to consumers.

## 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 reviewed care documentation which showed that risks to consumers’ health and well-being are not addressed in consumer care plans. The care documentation does not identify strategies or interventions to monitor and mitigate the risks to inform the delivery of safe and effective care. For consumers sampled who have recently entered the service, assessment and care planning does not address the consumer’s individual needs.

The Assessment Team identified that a number of consumers have a form of restraint, either as a chemical restraint or physical restraint (i.e. lap belt), however there were no risk assessments completed to identify the risks associated with the use of restraint or strategies that are in place to mitigate the risks.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that they have prioritised the completion of all care plans across the organisation, which has increased the completion of plans currently at 50 compared to 11 when the audit occurred. The three-month care plan review process has been reviewed and a more robust system along with education will be put in place. This process will include an accountability system for the Registered Nurses for completion. Consumers and representatives are now involved in the review process and are provided a copy for signing prior to completion and offered a copy of the finalised plan. I acknowledge the action that the provider has undertaken, however it will take some time to demonstrate compliance with the issues identified for this requirement.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 identified that the service has transferred from a previous electronic care planning system to the current electronic care planning system in October 2020. The service’s electronic documentation system generates a summary and a detailed (extended) care plan for consumers from the completion of various relevant assessments. The generated care plan outlines observations, goals and interventions for various care domains including but not limited to; skin integrity, behaviour, nutrition and hydration.

The Assessment Team were advised that due to the transition, eighty-four (out of 114) consumers have had all relevant assessments completed and recorded in their care plans and the process is ongoing. However, it is noted for sampled consumers who have had care planning process completed, assessment and care planning documentation does not adequately identify and address consumer’s current needs, goals and preferences, including advance care planning and end of life care needs.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that they have undertaken a review and re-commenced case conference schedule with all consumers / representatives. During case conferences Advanced Care Directives, and end of life management plans are reviewed and completed for all consumers.

 I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 obtained feedback from consumers and representatives that does not support their ongoing involvement in assessment and care planning. Care documentation reviewed shows minimal consultation with consumers and/or their representatives and lack of case conferencing to discuss consumer’s care needs. Whilst some care documentation shows input from external providers such as dieticians and speech pathologists, this is not the case where external providers are not involved when required such as behaviour support services for consumers displaying challenging behaviours. For some consumers, when recommendations are provided by external providers such as Dementia Support Australia (DSA), it is not completely incorporated into consumer care plans.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the case conferences ceased by past management in August 2020, which was identified in their external review and added to the action plan, these have now been reinstated, as such a plan of case conferences commenced two weeks prior to the site visit and continue, with either face to face for telephone conferences. The service has successfully recruited a Clinical Care Manager and will have a senior mentoring nurse work with registered nurses on the floor for three months to improve practices. The service will also provide external providers access to the ICARE system to ensure assessments are completed and input into care plans.

I find that the approved provider is not compliant with this requirement at the time of assessment

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

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

The Assessment Team found that most consumers and/or representatives provided feedback that supports they are not aware of the consumer’s care plan and do not know about or have not had the care plan made readily available to them. Whilst the service has commenced a process to discuss outcomes of assessment and planning with consumers, the service was unable to demonstrate implementation of this requirement during the Site Audit.

The Assessment Team identified that eleven (out of 114) consumers have read their care plans, and have made changes and signed the care plans, which have been uploaded to their electronic care planning system. Whilst the process has commenced, it is noted that outcomes of assessment and planning have only been discussed with minimal consumers at the service.

The Assessment Team found for those that had had care conferences, the outcomes of care conferences are not always reflected in consumer care plans. For the consumers who have seen their care plan and have had outcomes of assessment and planning discussed with them, they expressed dissatisfaction with the process, stating there was a lot of incorrect information in there.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that a new process has been introduced where consumers and/or representatives are involved in the care plan process. Consumers and/or representatives are required to sign off on their care plans and are offered a copy of the final version.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 reviewed sampled consumer’s care plans and found they do not show evidence of comprehensive review for effectiveness when circumstances change, when incidents occur or when the needs of consumers change. The Assessment Team found that for a consumer with a pressure injury, the care plan was not reviewed and did not list any interventions to minimise and manage the occurrence of the pressure injuries. It was also identified following an incident of behaviour, an incident report was completed for the victim, however not for the other consumer and the behaviour management plan was not reviewed in a timely manner to implement strategies to prevent instances of similar nature in the future.

The Assessment Team found that for most consumers, there was a lack of incident investigation to prevent further incidents and reduce harm to consumers. It is noted in some cases, incidents are not reported, therefore, the effectiveness of care is not reviewed. It was also noted by the Assessment Team that there had been some reportable instances that had not been reported to the *Serious Incident Response Scheme* (SIRS), required under legislation enacted 1 April 2021.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the new Clinical Care Manager will have clinical oversight across all care plan changes and reviews. The Clinical Care Manager will have a priority task of reviewing and updating all behaviour management plans to make them more individualised. The provider will conduct face to face education with staff on Accident and Incident Management and Risk Management.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# 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

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

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

The Assessment Team found that most consumers/representatives expressed satisfaction with the way personal and clinical care was provided at the service. However, one consumer representative expressed that they were delays in responding to decline in the clinical condition of their relative. One consumer expressed that the use of bed rails was not his choice.

#### The Assessment Team found that while consumers (or representatives on their behalf) generally provided satisfactory feedback about clinical and personal care, the review of care and service records does not support that clinical care provided to the consumers sampled is best practice and optimises consumers’ health and wellbeing. Wound photos are taken without a measuring ruler and are not taken in a consistent manner to monitor and review the progress of wounds. Deficits were identified in behaviour management and restraint management, monitoring and review. The service does not demonstrate an understanding of legislated restraint requirements and care documentation reviewed does not show that restraint is used as a last resort.

Care documentation reviewed does not show effective management of high impact or high prevalence risks, especially in the areas of falls and behaviour management where consumers pose a risk to themselves or others. Staff do not demonstrate an understanding of behaviour management and the use of restraint. Care documentation reviewed shows either referrals have not been made or have not been made in a timely manner to behaviour specialist services for consumers who have displayed high risk challenging behaviours, posing a risk to themselves, other consumers and staff.

####  The Assessment Team found that incidents are not always reported and investigated to determine the contributing factors to implement strategies to prevent or reduce future incidents of similar nature. There have been a significant number of consumers from March to May 2021 who have lost weight and the collective trend of weight loss was not analysed and responded to in a timely manner.

The Assessment Team identified that for the consumers sampled who are receiving palliative care or have received end of life care at the service, deficits were identified in the delivery of care and services including lack of appropriate pain management.

#### Deterioration or change in consumer’s clinical condition has not been responded to in a timely manner where consumers have displayed ongoing challenging behaviours of aggression or have had recurrent falls or weight loss.

#### The Assessment Team identified deficits in systems that are in place for communicating information about the care of consumers. Clinical monitoring documentation is not always completed correctly or consistently, which does not ensure adequate information sharing within the organisation to ensure effective delivery of care to consumers.

#### The organisation has policies and procedures relating to infection control, outbreak management and antimicrobial stewardship including the process to minimise the use of antibiotics. Whilst staff demonstrated knowledge of minimising infection-related risks, few observations made by the Assessment Team did not demonstrate the use of appropriate infection prevention and control practices, especially for consumers who are isolated and waiting for COVID-19 test results.

### Assessment of Standard 3 Requirements

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

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

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

#### The Assessment Team found that while consumers (or representatives on their behalf) generally provided satisfactory feedback about clinical and personal care (in relation to this requirement), the review of care and service records does not support that clinical care provided to the consumers sampled is best practice and optimises consumers’ health and wellbeing.

#### The Assessment Team identified on review of documentation that skin integrity plans for a sampled consumer did not list any interventions to minimise or manage the occurrence of pressure injuries and no repositioning directives to promote wound healing. Wound photos are taken without a measuring ruler and are not taken in a consistent manner to monitor and review the progress of wounds. Deficits were identified in pain management, behaviour management and restraint management, monitoring and review. The service does not demonstrate an understanding of legislated restraint requirements, and care documentation reviewed does not show that restraint is used as a last resort.

#### The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider disputed some of the findings, however, has stated that they are currently reviewing the psychotropic register, will conduct education for staff on minimising restrictive practices, pain management, intervention techniques and use of individual behaviour charts prior to administration of medication and undertake a review of all restraint charts and provide education to staff on the use of restraints and correct documentation.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 reviewed care documentation and found it does not show effective management of high impact or high prevalence risks, especially in the areas of falls and behaviour management where consumers pose a risk to themselves or others. Incidents are not always investigated to determine the contributing factors and minimal strategies and interventions are implemented to prevent or reduce future incidents in relation to falls and behaviours. Staff do not always demonstrate an understanding of behaviour management. There have been a significant number of consumers over the past three months who have lost weight and the collective trend of weight loss was not analysed and responded to in a timely manner.

The Assessment Team reviewed incidents of aggression which shows an increase in the number of incidents. In March 2021, there were two incidents by two consumers, in April 2021, three incidents by two consumers and in May 2021, nine incidents by five consumers. It is also noted some incidents were not always lodged as an incident report and were not always reported to the Commission.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider agreed with the Assessment Team’s findings and has put measures in place to increase the compliance and management of high impact or high prevalence risks these include; face to face education for staff regarding high impact high prevalence risks including dementia, behaviour management and delirium. The CEO and facility manager have commenced meetings with all staff in relation to the identified issues and the service has implemented a weight loss program and food and fluid charts for consumers losing weight. The service has prioritised completion of all care plans

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

#### The Assessment Team found that for consumers who are receiving palliative care or have received end of life care at the service, palliative care was not effectively provided to maximise consumers’ comfort. Deficits were identified in clinical care nearing end of life which did not demonstrate that the consumer’s needs nearing end of life are being recognised and comfort maximised including appropriate pain management.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that they will undertake a review and re-commence case conference schedule with all consumers / representatives and ensure during these conferences that Advanced Care Directives, and end of life plans are completed.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team found that deterioration or change in consumer’s clinical condition has not been identified or responded to in a timely manner where consumers have displayed ongoing challenging behaviours of aggression or have had recurrent falls or weight loss. Consumer/representative feedback also expresses dissatisfaction with the delay in responding to a consumer’s declining condition.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that a new Clinical Care Manager has commenced following the resignation of previous Clinical Care Manager in August 2020. The provider has also advised that they have a Senior Mentoring Nurse work on the floor with registered nurses for a 3-month period to improve practices across registered nurses. Face to face education with staff and review of policy and flow chart regarding deteriorating consumers will also be conducted.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 identified deficits in systems that are in place for communicating information about the care of consumers. Sharing of information about the consumer’s care has not always occurred and care documentation is not always complete, accurate or consistent. Clinical monitoring documentation is not always completed consistently, which does not ensure adequate information sharing within the organisation to ensure effective delivery of care to consumers.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider agreed with the Assessment Team’s findings and advised that this was due to lack of clinical oversight in the previous 12 months with the transferring of care plans, reviews and updates. The provider advised that this had become evident on his commencement and they engaged the services of an external auditor to conduct an independent report which have all been included in the action plan. The provider has also advised that the restraint charts are now always consistently completed to identify and monitor the use of restraint.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team reviewed care plan documentation and identified that while care documentation for some consumers shows input from a range of health professionals including dieticians, speech pathologists and physiotherapists, referrals have not been made in a timely manner to behaviour specialist services for consumers who have displayed ongoing challenging behaviours and pose a risk to themselves and others.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the newly appointed Clinical Care Manager will oversee the referral process and escalate delays to the Facility Manager.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 identified that the organisation has policies and procedures relating to infection control, outbreak management and antimicrobial stewardship including the process to minimise the use of antibiotics. Whilst staff demonstrated knowledge of minimising infection-related risks, few observations made by the Assessment Team did not demonstrate the use of appropriate infection prevention and control practices, especially for consumers who are isolated and waiting for COVID-19 test results. The service does not have an oversight on infection control practices by a certified Infection Prevention and Control (IPC) lead. The IPC lead is currently a registered nurse who is in the process of completing the IPC course.

The Assessment Team observed several breaches to infection prevention and control practices including the hydration station in the Lodge area of the service not having wipes next to it to clean the tap after each use. The temperature monitoring chart on the vaccination fridge that stores the influenza vaccinations directs to check the temperature of the fridge twice daily. However, on several instances in June 2021, for example, on 16, 17 and 18 June 2021, the temperature was only checked once per day.

The Assessment Team were not alerted whilst on site that two consumers were isolated due to a cough and were tested for COVID-19. This was only known by the team by observing the PPE placement outside the consumers’ rooms. When the isolation measures were checked for these consumers, it was noted their doors were left open increasing the risk of transmission. Consumers were sitting close to the door of their rooms. Whilst the appropriate PPE and waste bins were placed outside and inside of the room, the waste bag outside one consumer’s room was noted to be half full and touching the floor, increasing the risk of cross-contamination

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the issue of the doors being left open has been addressed with staff. The IPC lead commenced the course and is now in the final stages of completing the required course. The provider also advised that the Local Health District IP&C CNC has assisted the facility since February 2021 to review any IPC matters.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# STANDARD 4 NON-COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

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

The Assessment Team found that most sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

#### Consumers and staff described the lifestyle services and supports used to optimise the quality of life for consumers. Consumers confirmed they are supported to maintain their independence and they are supported by staff in activities for daily living that they enjoy.

The Assessment Team interviewed consumers and their representatives where feedback was mixed in relation to services and supports for the consumer’s emotional, spiritual, and psychological well-being team. Some consumers spoke positively about being supported to maintain their personal and social relationships and to be engaged in their interests. However, others provided feedback about a lack of support for these things to occur.

The Assessment Team reviewed consumer care and service records shows some consumers sampled are well supported, but others are not. They show the needs of some consumers have not been identified and/or the services and supports have not been provided. Staff said they recognise when consumers are feeling low and try to spend a few moments chatting with the consumers when they are feeling low.

The Assessment Team found that the service can generally demonstrate sharing of information about the consumer’s condition. Staff are aware of consumers’ needs and preferences and could discuss these in relation to lifestyle supports and services.

#### The Assessment Team received mixed feedback from consumers about the food. Whilst the meals were varied and of suitable quality and quantity, consumers consistently provided feedback that meals delivered to rooms are cold. The service has not demonstrated that they monitor nutritional and hydration intake to prevent weight loss or gain.

Observations, staff interviews, and documentation reviewed shows equipment for food services, cleaning, laundry, maintenance, and recreational and social activities is available, clean, safe and well-maintained.

## Assessment of Standard 4 Requirements

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

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

The Assessment Team found that consumers are not getting effective services and supports needed (with meals) and this is impacting on their health and wellbeing. Consumers are not being assisted with their meals and meals are taken away before the consumer has eaten them. There are limited one to one activities available for consumers and one consumer felt trapped and unable to go alone to shops and do things of interest to them.

The Assessment Team observed meals that had been left with consumers who were slumped in their chairs asleep, the Assessment Team returned 20 minutes later, and both consumers were in the same position with their meals still in front of them untouched. The Assessment Team also observed a meal tray left for a consumer who was slouched in the bed, none of the lids had been removed from the hot meal. Some time later a staff member was pushing a trolley past and asked if the consumer needed a hand with the food, there was no response heard from the consumer and the staff member took the tray away untouched. Another consumer was observed slumped in their bed with a care staff member spooning pureed food into the consumers mouth, the consumer was not in an upright position for safe eating and swallowing.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that meal reviews are part of the updated action plan/PCI. All meals that are not eaten are escalated and the consumer is reviewed. The provider also advised that the issue with the consumer who felt that they were unable to leave the service now has a risk waiver to attend the local shopping Centre.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

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

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

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

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

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

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

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

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

#### The Assessment Team found that overall consumers provided mixed feedback about the food. Whilst they said meals were varied and of suitable quality and quantity, consumers consistently provided feedback that meals delivered to rooms are cold. The service provides opportunities for consumers to give feedback about the food and generally consumers believed adjustments are made to the menu in response to their feedback.

The Assessment Team observed a consumer with significant weight loss decline both the hot midday meal and sandwiches, there were no other finger food options offered, despite this being on the care plan recommendations from the dietician.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the CEO and Facility Manager had commenced meetings with all staff commencing Monday 26 July 2021 to discuss the identified issues. They will also be undertaking a one-month review and recording all meal temperatures.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

# 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

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

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

The Assessment Team interviewed consumers and representatives who considered that they feel they belong in the service and feel safe and comfortable in the service environment. Consumers confirmed they feel safe and at home living in the service and they can freely access outdoor areas. Consumers and representatives sampled reported the service is clean and well maintained. Most consumers and representatives provided feedback about the furniture, fittings and equipment being safe, clean, and well maintained.

The Assessment Team considered maintenance records, consumer feedback and observations which showed that overall furniture, fittings, and equipment were clean, safe and regularly maintained, and were suitable for consumers.

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

However, the Assessment Team observed that the service environment does not adequately incorporate dementia enabling environmental principles and this has had an adverse impact on some consumers independence, safety, and quality of life. Some consumers have not been enabled to move freely indoors and outdoors. The organisation has not kept up to date with their legal obligations for fire safety assessments and has not demonstrated the environment is safe.

The Assessment Team also identified that there were inconsistencies across the service in the processes for checking and cleaning consumer equipment.

## Assessment of Standard 5 Requirements

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

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

The Assessment Team observed some areas of the service environment are welcoming, easy to understand and optimise a sense of belonging, independence, interaction and function. However, However, the special care unit service environment has not been optimised for people living with cognitive impairment, including those with dementia. It does not promote a welcoming and easy to understand environment that optimises each consumer’s sense of belonging and function. It does not have well-defined pathways both inside and outside where the consumer is guided past points of interest and opportunities to engage in activities or social interactions to support movement and engagement.

The Assessment Team identified that consumers do not have the option of going outside or engaging in activities or social interactions outside the special care unit. Their living environment consists of a small living room with a television, or they have a hallway they can walk up and down, or they stay in their bedroom. The courtyard to the special care unit has well maintained outdoor furniture, however, the area was concrete with no flowering plants or greenery observed. The entry to the courtyard was not easy to navigate by someone who has a cognitive impairment. The only entry to this area was through a tiled room with a sink. The consumers would need to navigate several doors and different floors to reach the outside courtyard. None of the consumers in the special care unit were observed to access this area throughout the Site Audit.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that work had commenced on the dementia unit prior to the Assessment Teams visit, which includes painting of walls in dementia safe colours for area identification. The outdoor walking areas has also been reviewed with walking signs, directional arrows on walking path to entice consumers to move outdoors, doors to be left unlocked for ease of moving freely indoors and outdoors. I have considered this additional information and feel that the service has put actions into place prior to the Assessment Teams visit to address the non-compliance in this requirement.

I find that the approved provider is compliant with this requirement.

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

*The service environment:*

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

The Assessment Team found that consumers and representatives generally considered the service environment to be clean, well maintained and comfortable. Most consumers said they can use the outdoors when they choose. The organisation has not kept up to date with their obligations for fire safety assessments and has not demonstrated the environment is safe.

The Assessment Team also identified that the Annual Fire Safety Statement dated 1 May 2019, was not current. Under the NSW Government, Environmental Planning and Assessment Regulation (2000), an annual fire safety statement must be issued each year by an accredited fire safety practitioner. This has not been completed by the organisation for two years. Management stated that the fire safety practitioner has been organised to visit the service the week after the Site Audit.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised the organisation had commissioned an independent building contractor to review the changes to fire compliance and the building code in 2019. However, due to previous management failings, the required in-roof fire rated walls were not conducted. The construction has been ongoing for the past month, work is due to be completed the week ending 6 August with Wormald attending to inspect and issue fire safety certificate by end of August. I have considered the additional information and have acknowledged that the works to improve the fire safety commenced prior to the Assessment Teams visit and should be complete at the end of August.

I find that the approved provider is compliant with this requirement.

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

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

The Assessment Team found that overall consumers were satisfied that the furniture fittings and equipment are safe, clean, well maintained, and meeting their needs. The Assessment Team observed the furniture, most fittings and equipment are suitable for consumers and are safe, clean and well maintained. However, there were inconsistencies in staff knowledge regarding whose responsibility it was to clean the consumers’ personal mobility equipment

The Assessment Team spoke to consumers who advised that their mobility equipment had never been cleaned by staff. One consumer was observed to be in a wheelchair that appeared too small for comfortable use and told the Assessment Team that pain was experienced when sitting for prolonged periods. The Assessment Team asked the consumer if an Occupational Therapist had assessed the suitability of the wheelchair, to which the consumer said this had never happened, on raising this with staff, the consumer advised that a different wheelchair had been wheeled into the room later that day and was told, that it was the new wheelchair. The consumer said there was no discussion with anyone and no assessment had been conducted by the Physiotherapist or an Occupational Therapist. The consumer had not even had the chance to sit in the wheelchair.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that a review by an Occupational Therapist had now taken place for all consumers with mobility aids.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# 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

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

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

The Assessment Team found that most of the sampled consumers said that they are encouraged and supported to give feedback and make complaints, but that the action taken was inadequate and did not resolve the issue.

The Assessment Team interviewed consumers and representatives who mostly felt safe in raising complaints with the service and knew how to do this, however, were not aware of how to escalate the complaint further, should they be dissatisfied with the response by the service. Some consumers felt that changes were made to services in response to complaints and feedback but those who recognised this, said that this was mostly around the quality of the food and it had been a slow process.

The Assessment Team identified that there was a complaints folder, however no register was in place to clearly identify and track the written complaints and their response timeframes, it was also noted that there were few complaints documented. For most complaints received verbally, documentation of the complaint, response by the service and the outcome of the complaint was limited. There was no evidence that the service used open disclosure for the few complaints documented.

The Assessment Team identified that the organisation has a feedback and complaints systems and processes to capture information at regular intervals. The service has a complaints and feedback policy that staff are familiar with. However, once the complaint or feedback has been received by the service, the procedures in place to address the complaint and to provide feedback are unclear. They do not include a timeframe for the response, especially when follow-up is required to address care issues. There is a lack of information in the service’s complaints and feedback policy about management of a complaint or feedback once the they are handed to the service manager. As a result, consumers and representatives are unaware of how or whether their complaint was handled.

The Assessment Team found that overall there was minimal evidence that the service incorporates input and feedback from consumers, carers, the workforce and others in the plan for continuous improvement, beyond the improvements made to the service menu that was driven by consumer feedback.

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

The Assessment Team found that the service was unable to demonstrate appropriate action is taken in response to complaints, and an open disclosure process is used when things go wrong. Most consumers and representatives were not informed by the service about the status of their verbal or written complaints. Most consumers and representatives who made complaints about care issues said that they were not satisfied with the outcomes, or their complaints had not been resolved.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised the identified issues were raised prior to current management and were being rectified. The provider advised that other complaints have been dealt with effectively since this time. The provider advised that the complaints policy will be reviewed to ensure timeframes are adhered to and will be distributed to staff.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team found that the service was unable to sufficiently demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. One clear example of complaints that were used to improve the quality of services is related to the service menu. However, complaints not addressed in the plan for continuous improvement include the quality of care delivered, whether consumers were being assisted with basic activities of daily living, and consumers feeling ‘trapped’ in their environment with significant impacts on their physical and emotional wellbeing. The Assessment Team could not find documentation that showed the quality of clinical care delivered to consumers had improved as a result of any informal or formal complaints made by consumers and/or their representatives, including verbal or written feedback made in the last six months.

The Assessment Team identified that in addition to complaints about food, the plan for continuous improvement included improvement actions for some other areas contained in feedback and complaints records such as staff shortages, call bell reliability, afternoon showering and bed times, and variety of recreational activities. While some of these issues were marked as ongoing on the plan, the issue of showering and going to bed too early was marked as complete on 3 June 2021. However, consumer feedback received by the Assessment Team from a representative showed this issue has not been resolved.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised the previous management were unable to sufficiently demonstrate feedback and complaints are reviewed and used to improve the quality of care services, however this has now commenced and is now the embedded process.

I find that the approved provider is not compliant with this requirement at the time of assessment.

# 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

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

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

The Assessment Team found that overall sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The Assessment Team interviewed consumers who felt that there are inadequate numbers of staff at the service. Consumers provided feedback that due to staff shortages that they had to wait for personal care or medications.

On balance the organisation was unable to demonstrate it has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

The Assessment Team interviewed staff who provided feedback that staffing levels, particularly in the afternoon shift, were inadequate to provide safe and quality care. The highest care staff shortfall occurred in the afternoon shift where there were five days out of seven with attendance down by one to two care staff, during the week Sunday 13 June 2021 to Saturday 19 June 2021. Call bell response times greater than 10 minutes were highest during shifts that were two staff down.

The Assessment Team observed trends in clinical indicators, care documentation and incident reports that show that for more than six months, there has been sustained skill and knowledge deficits displayed by staff in the management of high impact high prevalence risks to consumers across the service, in areas such as responsive behaviours, restraint, pain, wounds, weight loss, palliative care, falls and infection control.

The Assessment Team identified that although the service has a training plan that includes dementia and delirium training scheduled for the end of July 2021, training records show there has been minimal training in this area for staff (including behavioural management) in the last 12 months. It was also identified that the IPC lead does not hold the required qualification to perform the role.

The sustained deficits in planning, delivery and evaluation of care and services in areas of high impact high prevalence risk, is also indicative of insufficient oversight and management of clinical competence and performance at both individual and organisational level.

## 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 service was not able to demonstrate 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. Service management is in the process of recruiting more care staff. However, staff from the afternoon shift, which had the highest staff shortfall and the highest number of call response times over 10 minutes, reported that due to unfilled shifts, they are stretched and having to make “hard decisions” as to which consumers they should assist when it gets busy, and this is impacting their capacity to provide safe and effective care for all consumers. The lack of an experienced care manager has impacted the service’s capacity to provide effective clinical oversight evidenced by continued negative trends in key clinical indicators.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that Dubbo does not have agency staff available and the provider would use agency staff if they were unable to fill roles. The provider advised that the recruitment of staff is ongoing, but we have no unfilled rostered hours, it is the sick leave that creates a shortage. The provider also advised that they are trying to get the call bell times down, as originally it was 15 minutes.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

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

The Assessment Team found that the service was unable to sufficiently demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Overall there was evidence of a lack of staff competence regarding the effective management of high impact high prevalence risks to consumers across the service, in areas such as responsive behaviours and restraint, pain, wounds, weight loss, palliative care, falls and infection control.

The Assessment Team found on the third day of the Site Audit, two consumers were isolated due to coughs and were tested for COVID-19. However, the Assessment Team observed their doors were left open and the consumers were seated next to their doorways increasing the risk of infection transmission, despite repeatedly requesting that staff ensure the doors were closed. The care staff member said they had moved the consumers to the other side of their rooms, but the consumers kept moving back. This raises competency issues in relation to communicating the importance of safe infection control practices to consumers and their families.

The Assessment Team also noted throughout their visit a substantial lack of competence in the management of high impact and high prevalence risks including, behaviour management and restraint management monitoring and review, pain management and monitoring, wound management, weight loss, palliative care, falls, infection control for consumers awaiting test results for COVID-19 and reporting requirements for SIRS.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that a training needs analysis has been developed and all staff will undertake face to face education in high risk high prevalence areas.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team found that the service was unable to sufficiently demonstrate that its workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. The service’s new management team has recently commenced the rollout of a new training program to address skill shortfalls in key areas of care and service delivery, and a recruitment strategy to increase the number of clinical and care staff, as well as to hire a clinical care manager. However, the training that has been provided to date has not been effective in addressing the sustained skill deficits evidenced by the continued increase in key areas of clinical risk such as behaviour, weight and falls management, and the accuracy and completeness of care planning and assessment.

#### The Assessment Team identified that although the service has a plan that includes dementia and delirium training scheduled for the end of July 2021, training records provided show there has been minimal training in this area for staff (including behavioural management) in the last 12 months. Despite increases in high risk aggressive behavioural incidents over that time, the lack of action taken by the service to build staff skills and confidence in this area has meant the risks to consumers’ health, safety and wellbeing have continued to increase. There was one recorded training program for this area on 24 March 2021 that was completed by one staff member.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that a training needs analysis has been developed and all staff will undertake face to face education in high risk high prevalence areas. The provider advised that the training program will cover key risk areas identified through the audit.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 interviewed care staff who confirmed that they have annual performance reviews, and registered nurses said they conduct performance reviews with care staff. The service demonstrated how it effectively performance managed staff following a medication incident that resulted in a consumer’s hospital admission. The IPC Lead is responsible for monitoring and coaching staff in correct infection control practices. However, the service has been unable to recruit a clinical care manager since February 2021. The extent of the deficiencies in care planning and provision in areas of high impact/high prevalence risk at the service, is evidence that insufficient oversight and remediation of clinical competence and performance has occurred at the individual staff level.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that following a protracted recruitment process, a new Clinical Care Manager commenced on 2 August 2021. The provider agrees that not having a Clinical Care Manager in place for the previous 12 months, has impacted on the services ability to maintain strict clinical oversight and support to care staff, ultimately affecting consumers. I acknowledge the providers response and the action plans including the recruitment of a new Clinical Care Manager, however it will take some time to demonstrate compliance with the issues identified in this requirement.

I find that the approved provider is not compliant with this requirement.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

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

The Assessment Team interviewed consumers who considered that the organisation is well run and that they can partner in improving the delivery of care and services, but some consumers spoke of a shortage of staff. Some sampled consumers were able to provide examples of how they are involved in the development, delivery and evaluation of care and services. One consumer regularly attends resident meetings, and the suggestion of a feedback and complaints box had been implemented by the organisation.

However, the service was unable to demonstrate a sufficiently effective governance system, including clinical governance, and adequate engagement of consumers and representatives to ensure the delivery of safe, quality care and services.

The board/governing body did not demonstrate that it is accountable for the delivery of safe, inclusive and quality care and services. The board meeting minutes from April and May 2021 showed the board endorsed clinical indicator reports that showed sustained increases in individual and organisational high impact and high prevalence risks in areas such as weight loss, and aggressive behaviours. But the reports included minimal organisational strategies to manage and prevent the negative trends. One consumer representative said they had complained “a dozen times” about the consumer’s care to the service, but the complaints had not been resolved.

The Assessment Team found that there is minimal evidence that critical incident, complaint and feedback data are significant drivers for planned improvements to regulatory compliance in relation to effective, safe, quality care and services for consumers. There is sustained lack of follow through by the service to resolve consumer/representative complaints, or to check they are satisfied with resolution and outcomes, and to incorporate consumer/representative feedback into service improvements in the plan for continuous improvement.

## Assessment of Standard 8 Requirements

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

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

The Assessment Team found that the service did not demonstrate that it sufficiently engages consumers in the development, delivery and evaluation of care and services, and supports them in that engagement. The service engages consumers and their families/representatives to provide input into improved delivery of care and services through a range of consultation mechanisms, and by providing Information on how to give feedback through posters, and pamphlets located across the service. However, there is also evidence that there is a lack of service support for consumers with cognitive/communication challenges, to provide feedback on care and services, and the consumer representation at board meetings has recently ceased. The sustained lack of follow-through by the service to resolve consumer/representative complaints and feedback from representative meetings has the potential to undermine engagement in the feedback and evaluation process.

The Assessment Team interviewed care staff asking them how they assist consumers with cognitive impairment to make a complaint or provide feedback, they were unable to provide examples of communication tools and strategies they would use, beyond referring to family members for assistance. Minutes of resident and relative meetings showed that concerns raised by the group about areas such as late medication rounds and inadequate staffing were re-listed for three meetings with no resolution.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised the meetings to have recommenced and were on hold due to the COVID issues, locally and the new management. At the most recent meeting 14 July 2021 the concerns raised by the group such as late medication rounds and inadequate staffing were actioned. I have considered the additional information, however, acknowledge that it will take some time to demonstrate compliance with the issues identified for this requirement to ensure that the service engages the consumer in the development, delivery and evaluation of care and services.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

The Assessment Team found that the service was able to show that its governing body promotes a culture of safe, inclusive and quality care and services, however, it was unable to sufficiently demonstrate that the board is accountable for their delivery. Monthly board meeting minutes showed that the board had repeatedly endorsed reports on clinical indicator trends and actions, that lacked sufficient clinical trend and risk analyses. The reports also showed minimal identification and evaluation of individual consumer and organisational mitigation strategies to ensure consumers are receiving care and services that are safe, effective, integrated, high-quality and continuously improving.

The chairman and members of the board outlined how they promote a culture of safe and inclusive quality care which mainly related to refurbishments. The chairman noted that they “know about dementia assaults and have fixed them”, however increasing incident reports do not support this.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised the board chair and CEO are aware of the past failings due to not having a Clinical Care Manager in place. The CEO engaged an external auditor to assess the service against the Standards and identified a number of gaps. The Clinical Governance Committee (Sub Committee of the Board) is now chaired by a local Doctor (surgeon) and all clinical variances are to be discussed with a plan for presentation to the Board to ensure governance of these concerns.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

The Assessment Team found that overall the service was unable to sufficiently demonstrate it has effective organisation-wide governance systems to ensure safe, effective and quality care and services for consumers. There is evidence in relation to financial governance, of recent board approved funding submissions to support changing needs of consumers. However, outdated and incomplete information on the electronic care planning system indicates a lack of robust information management. The continuous improvement plan does not include outcomes for planned actions to enable tracking and evaluation of results, achievements, impact and effectiveness. There is minimal evidence that critical incident, complaint and feedback data are significant drivers for planned improvements to regulatory compliance and quality care delivery.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the new Clinical Care Manager will have clinical oversight across all care plan changes and reviews and will have a priority task of reviewing and updating all behaviour management plans to make them more individualised. A review of the PCI plan was commenced in May 2021 and is now includes outcomes for planned actions, evaluation of results, achievements, impact and effectiveness as the embedded process. The Finance and Risk Management Governance Committee (Sub Committee of the Board) is now chaired by a local Solicitor and all variances are discussed and a plan is requested to be presented to the Board to ensure governance of these concerns. The IPC lead is in the final stages of course completion and the service will continue to liaise with the CNC of the Local Area Health Service. The service will also conduct face to face education on complaints management and open disclosure and ensure that complaints are handled within timeframes. I acknowledge the actions that the provider has put in place, however it will take some time to demonstrate compliance in these areas.

I find that the approved provider is not compliant with this requirement at the time of assessment.

### 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 found that the service has comprehensive risk management policies and procedures. However, in practice, overall the organisation’s management of high impact and high prevalence risk is ineffective, negatively impacting consumer health safety and wellbeing. This is evidenced by care documentation, observed incident management and prevention practices, clinical indicator and training records and reports, and gaps in identification of, responding to and reporting abuse and neglect of consumers.

#### The Assessment Team found that care documentation did not show effective management of high impact or high prevalence risks for consumers, in areas such as of falls, behaviour management and weight loss. Incident management and quality indicator reports lack rigorous investigation and analysis to identify contributing factors. Overall, comprehensive strategies and interventions are not identified, implemented and evaluated at individual and organisational levels to successfully prevent an/or reduce future incidents and negative clinical trends in relation to falls, behaviours and weight loss.

The Assessment Team found that the service has a documented serious incident reporting policy. Management stated that all staff have completed a four stage SIRS/IMS training program. Review of incident reports, care documentation and SIRS service history records, showed that to date the service has made five reports since 1 April 2021 when SIRS commenced. However, the Assessment Team found that the service failed to report three Priority one SIRS incidents.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised identified the three ‘Priority One SIRS’ incidents as ‘Priority Two SIRS’ at the time. The provider advised that they will be conducting face to face education on high risk and high prevalence areas, behaviour management, dementia and delirium, accident and incident management, risk management including SIRS, Dignity of risk, person centred care and planning.

I find that the approved provider is not compliant with this requirement at the time of assessment.

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

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

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

The Assessment Team found that the service was unable to sufficiently demonstrate that where clinical care is provided there is an effective clinical governance framework that is used to ensure safe, quality consumer care and services. The organisation has a documented clinical governance framework, which includes policies on antimicrobial stewardship, minimising the use of restraint and open disclosure. Service management informed the Assessment Team it has been unable to recruit a care manager to oversee clinical governance since February 2021. However, the Assessment Team found evidence dating back to March 2020, that clinical governance of care planning had not been effective, and the issue is still not rectified.

The Assessment Team found that significant gaps in clinical oversight were evident during the twelve months prior to the site audit, when the service had a Clinical Care Manager in place. Lack of current care plans was identified as an issue in the plan for continuous improvement on two occasions in 2020. The facility manager at the time raised the issue on 30 March 2020 and then again on 30 October 2020 when the plan stated, “case conferencing schedule not currently adhered to/non-existent.”

The Assessment Team found that review of restraint use does not indicate that the service is currently adhering to its restraint and restrictive practices prevention and management policy and procedure. It also shows the service does not demonstrate an understanding of legislated restraint requirements regarding use as last resort, appropriate consent, and restraint monitoring and review requirements.

The approved provider responded to the Assessment Team’s report with their ‘Detailed Response to Site Audit’ and ‘Plan for Continuous Improvement’. The provider advised that the previous staff were instrumental in the delays of care plans, case conferences and a number of other failing and are no longer with the organisation. The current ‘Plan for Continuous Improvement’ shows the priorities and timeframes to be adhered to.

I have found that the approved provider is not compliant with this requirement at the time of assessment.

# Areas for improvement

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

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

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

The approved provider must demonstrate:

* All staff use respectful language at all times and treat consumers with dignity and respect.
* Review and assess all consumer’s diversity and cultural needs and reflect these needs appropriately in assessments and care plans.
* Conduct education with all staff on dignity and respect.

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

*Care and services are culturally safe.*

The approved provider must demonstrate:

* Consumers documentation is reviewed and updated regarding cultural needs and strategies to support them.
* Attendance and outcomes for cultural activities for each consumer will be documented in assessments and care plans.

### 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 approved provider must demonstrate:

* Referrals are made, and assessments are conducted to determine consumer’s decision-making capacity for consumers with cognitive impairment.
* Conduct face to face education for all staff on informed consent.

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

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

The approved provider must demonstrate:

* Comprehensive risk assessment is conducted for consumers who take risks.

### 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 approved provider must demonstrate:

* Risks to consumers’ health and well-being are addressed in consumer care plans including strategies or interventions to monitor and mitigate the risks to inform the delivery of safe and effective care.
* Assessment and care planning address the consumer’s individual needs.
* Risks are identified, and assessments are discussed and completed with consumers and representatives.
* Risk assessments are completed to identify the risks associated with the use of restraint or strategies that are in place to mitigate the risks.
* Consumers and representatives are provided a copy of the finalised care plan.

### 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 approved provider must demonstrate:

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

### 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 approved provider must demonstrate:

* Consumers care plans are updated with information and recommendations from external providers.
* Face to face Advance Care Planning, person centred care and planning, dignity of risk, assessment, planning and consultation education to be provided to staff.

### 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 approved provider must demonstrate:

* Discuss outcomes and reviews of assessment and planning with consumers and representatives
* Ensure accurate information and outcomes of care conferences are reflected in consumer care plans.
* Consumers and/or representatives sign off on their care plans and are offered a copy of the final version.

### 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 approved provider must demonstrate:

* Comprehensive review of care plans is undertaken for effectiveness when circumstances change, when incidents occur or when the needs of consumers change.
* Interventions to minimise and manage the occurrence of incident are recorded in care plans.
* Incident reports and investigations are completed for all consumers if an incident occurs and if a behaviour concern, the behaviour management plan is reviewed in a timely manner to implement strategies to prevent instances of similar nature in the future.
* All reportable instances applicable to the [Serious Incident Response Scheme](https://agedcarequality-my.sharepoint.com/personal/melissa_buhagiar_agedcarequality_gov_au/Documents/Documents/Performance%20reviews/Orana%20Gardens/Aged%20Care%20Legislation%20Amendment%20%28Serious%20Incident%20Response%20Scheme%20and%20Other%20Measures%29%20Bill%202020)(SIRS), are reported to the Commission.
* Face to face education with staff on accident and incident management and risk management is conducted.

### 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 approved provider must demonstrate:

* Skin integrity plans list interventions to minimise or manage the occurrence of pressure injuries to promote wound healing.
* Provide education for staff on minimising restrictive practices, pain management, intervention techniques and use of individual behaviour charts prior to administration of medication
* Undertake a review of all restraint charts and provide education to staff on the use of restraints and correct documentation.

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

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

The approved provider must demonstrate:

* Staff can demonstrate their understanding of behaviour management.
* Weight loss is analysed and responded to in a timely manner.
* All incidents under the SIRS are reported to the Commission under legislated timeframes.
* Education is provided to staff for high impact or high prevalence risks.

###  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 approved provider must demonstrate:

* Palliative care is effectively provided to maximise consumers’ comfort.
* Consumer’s needs nearing end of life are being recognised and comfort maximised including appropriate pain management.

### 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 approved provider must demonstrate:

* Deterioration or change in consumer’s clinical condition is identified or responded to in a timely manner where consumers have displayed ongoing challenging behaviours of aggression or have had recurrent falls or weight loss.
* Face to face education for recognising deterioration is conducted with staff.
* Review of policy and flow chart regarding deteriorating consumers is conducted.

### 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 approved provider must demonstrate:

* Clinical monitoring documentation is consistently completed and communicated within the organisation.

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

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

The approved provider must demonstrate:

* Referrals for consumers are made in a timely manner and escalated if there is a delay.

### 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 approved provider must demonstrate:

* Infection control procedures are strictly adhered to
* Staff are educated on the importance of infection control and isolating consumers.

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

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

The approved provider must demonstrate:

* Consumers who require assistance with meals are assisted.
* All consumers are provided an opportunity to eat their meals with assistance if required, prior to it being taken away.
* Records of meals that are not eaten are escalated and the consumer is reviewed.

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

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

The approved provider must demonstrate:

* Consumers are given the opportunity to provide feedback on meals with improvements made if required.
* Consumers with significant weight loss are offered alternative meals or snacks as recommended by dietician

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

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

The approved provider must demonstrate:

* Occupational Therapist assesses mobility aids for consumer prior to their use.

### 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 approved provider must demonstrate:

* Outcomes of complaints are communicated to complainant.
* Complaints are actioned and documented.
* Open disclosure is used when things go wrong and staff are educated on the principles of open disclosure.

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

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

The approved provider must demonstrate:

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

### 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 approved provider must demonstrate:

* 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.
* Call bells are responded to in a timely manner.

### 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 approved provider must demonstrate:

* Staff are educated and competent with regards effective management of high impact and high prevalence risks to consumers in areas such as responsive behaviours and restraint, pain, wounds, weight loss, palliative care, falls and infection control.
* Communicate the importance of safe infection control practices to consumers and their families.
* Staff are educated in reporting requirements for SIRS

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

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

The approved provider must demonstrate:

* Education is provided to staff to address shortfalls in key areas of care and service delivery, including key areas of clinical risk such as behaviour, weight and falls management, and the accuracy and completeness of care planning and assessment.

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

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

The approved provider must demonstrate:

* Regular assessment and monitoring of staff performance is conducted to address deficiencies in care planning and in areas of high impact/high prevalence risk.
* Clinical oversight and education are conducted with all staff.

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

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

The approved provider must demonstrate:

* That it sufficiently engages consumers in the development, delivery and evaluation of care and services, and supports them in that engagement.
* There is support for consumers with cognitive/communication challenges, to provide feedback on care and services.

### 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 approved provider must demonstrate:

* Clinical indicator trends are analysed with actions addressed to minimise risk.
* Organisational governance oversees identification and evaluation of individual consumer and organisational mitigation strategies to ensure consumers are receiving care and services that are safe, effective, integrated, high-quality and continuously improving.

### 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 approved provider must demonstrate:

* Effective organisation-wide governance systems to ensure safe, effective and quality care and services for consumers.
* Critical incident, complaint and feedback data are drivers for planned improvements to regulatory compliance and quality care delivery.
* Review and update all behaviour management plans to make them more individualised.
* Face to face education is conducted with staff on complaints management and open disclosure

### 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 approved provider must demonstrate:

* Risk management is addressed in relation to care documentation, incident management and prevention practices, clinical indicator and training records and reports, and gaps in identification of, responding to and reporting abuse and neglect of consumers.
* Incident management and quality indicator reports contain rigorous investigation and analysis to identify contributing factors.
* Comprehensive strategies and interventions are identified, implemented and evaluated at individual and organisational levels to successfully prevent and/or reduce future incidents and negative clinical trends in relation to falls, behaviours and weight loss.
* SIRS incidents are reported within timeframes.

### 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 approved provider must demonstrate:

* Gaps in clinical oversight are addressed.
* Restraint and restrictive practices are used as last resort, with appropriate consent, and restraint monitoring and review requirements.