Palm Lake Care Deception Bay

Performance Report

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**Commission ID:** 5747

**Provider name:** Palm Lake Care Operations Pty Ltd

**Site Audit date:** 6 July 2021 to 9 July 2021

**Date of Performance Report:** 18 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) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Non-compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | 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** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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

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

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

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

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Consumers and representatives said consumers independence is encouraged and staff understand consumers needs and preferences, including what is important to them. They said the service supports consumers to maintain connections with friends and family members, both inside and outside the service.

Consumers and representatives said consumers are supported to take risks to enable them to live the best life they can. Most consumers and representatives said the service provides information to assist them in making choices about consumers care and daily activities, including meal selections and service events.

Consumers and representatives said staff maintain consumers privacy, including preferences in relation to the sharing of information and during interactions. For example, consumers said staff knock on the door prior to entry and are respectful of privacy when delivering care and services.

Staff described how the service supports consumers who choose to take risks. For example, staff described how they support one named consumer who chooses to smoke by storing cigarettes and lighter at the staff workstation and providing these at times as identified in the care and services plan. The risks had been explained to both the consumer and their representative.

Staff described the services processes for identifying consumer’s individual preferences, on entry to the service and as part of the ongoing assessment processes. Staff provided examples of the various ways’ information is provided to consumers such as through noticeboards, verbal and written communication.

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

## Assessment of Standard 1 Requirements

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

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

Consumers and representatives said staff generally treat them with dignity and respect, and know what is important to them in relation to culture, identity and diversity.

Staff demonstrated an understanding of individual consumers’ backgrounds of consumers and described how this influenced the day-to-day delivery of care and services.

However, the Assessment Team provided information in relation to observations made in one area of the service including a consumer wearing clothing inside out, consumers wearing non-slip socks as footwear, a television at high volume in an area where consumers care was provided; and a named consumer sitting in a public area of the service in chairs positioned to make a temporary bed.

The Approved Provider in its response dated 3 August 2021, stated that feedback from consumers and representatives identified that staff treated consumers with dignity and respect; and the Assessment Team’s observations reflected throughout the Site Audit report noted staff interactions to be respectful and understanding of consumer’s needs.

The Approved Provider in their response has provided information evidencing documentation for named consumers including:

* Information to guide staff in care delivery for the named consumer who was observed to be wearing clothes inside out. The named consumer is resistive to staff assistance and can remove clothing independently. Staff understand the consumers individual needs and staff do not attempt to provide care that is not in accordance with the consumers preference. The Approved Provider stated, that when appropriate staff do assist the consumer to change their attire which is reflective of maintaining consumer respect and dignity.
* Consumers in one area of the service who were observed to be wearing non-slip socks, the Approved Provider stated there is an assessed need for consumers to wear non-slip socks when they do not wish to wear shoes.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. While at the time of the Site Audit, the Assessment Team identified observations in one area of the service, it is my decision this has not reflected that consumers are not treated with dignity or respect. For the reasons detailed, this requirement is Compliant.

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

*Care and services are culturally safe.*

Consumers and representatives said staff knew about individual consumers’ backgrounds and what was important to them.

Staff demonstrated understanding of individual consumers and could describe how they supported consumers cultural safety. For example, the service holds religious services for consumers and there are also consumers who choose to practice their faith in their room.

Care documentation included assessments and care plans that referred to supporting each consumer’s cultural safety, and included life history, spiritual preferences, family and social networks and significant days and events.

However, the Assessment Team provided information in relation to observations of staff practices and language when speaking about consumers. Including:

* The Assessment Team observed a conversation between care and Registered staff who made racially insensitive remarks about another culture’s language. The conversation was in close proximity to four consumer’s room and the Assessment Team observed some consumers doors open.
* In the Assessment Team’s interview with a staff member, a reference was made to de-canting of consumers to other areas of the service; and in a second interview another staff member making a comment regarding a consumer’s manner of behaviour.

The Approved Provider in its response, stated that Management were advised on one conversation between staff that was overheard by the Assessment Team; and when asked to expand to the staff involved the Assessment Team would not divulge the nature of the conversation. Therefore, the service was unable to follow up with staff. The Approved Provider acknowledge that a staff member in one interview with the Assessment Team had used the word decant, however this was not reflective of the staff member or any staff respect to consumers at the service. In relation to a staff member making a comment regarding a consumer’s behaviour, the Approved Provider provided information that evidenced the staff member understood and respected the individual consumer.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. While at the time of the Site Audit, the Assessment Team identified two occasions when observation of staff practices and conversations where identified, overall consumers and representatives expressed satisfaction that the service understanding individual consumers background and includes this in the delivery of care and services. I am satisfied that the service is providing care and services that are culturally safe for consumers. For the reasons detailed, this requirement is Compliant.

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

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

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

Consumers said they are supported by the service to exercise choice and independence. For example, one named consumer who used an electric mobility scooter advised they liked to go outside of the service for trips to the local shopping centre.

Staff described how the service supported consumers to exercise choice, such as with meal services. They described how the menu offers two hot meals and a vegetarian option along with sandwiches or salad to suit consumers preference.

Staff described how consumers are supported to maintain friendships both inside and outside of the service. For example, consumer’s family and friends are encouraged to visit and have meals with consumers; the service had a mobile electronic device available for consumers to contact relatives and friends via videoconferencing.

However, the Assessment Team provided information that consumers expressed they were not always informed or offered an opportunity to make decision about their care and services. Including:

* Three consumers said they were not consulted about the new menu which recently commenced at the service and included meal options they disliked.
* Consumers advised they were not informed regarding the absence of activities during the week prior to the site audit commencing. On the first day of the Site Audit, the Assessment Team observed a bingo game in progress; one consumer was observed to be distressed and advised they had not been informed the activity was in progress.
* Consumers and representatives were not consulted or informed of the service’s planned refurbishment project for the memory support unit in May 2021.

The Approved Provider in its response, provided information in relation to the consultation undertaken with consumers and representatives for the refurbishment in the memory support unit. The Approved Provider acknowledged that the painting of the door to the memory support unit had been completed with only some consumers having choice into the colour of paint. Given it is a communal living space, the Approved Provider in its response acknowledged the difficulty in all consumers being in agreement with refurbishment. Therefore, the service encourages and supports all consumers to decorate their personal rooms as they desire.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, the mostly positive feedback from the 14 consumers and/or representatives during the Site Audit, and the written response from the Approved Provider, under this requirement and other requirements within this Standard.

I am satisfied that the service is supporting consumers to exercise choice and maintain their independence. For the reasons detailed, this requirement is Compliant.

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

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

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

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

Consumers said they are provided with information to assist them in making choices about the delivery of their care and services, including daily activities, meal selections and service events. However, consumers explained the information provided to them is not always consistent, clear or accurate. For example:

* Five consumers and representatives said they couldn’t understand the monthly menu design or the meal names; and consumers had difficulty remembering the week’s menu as staff took food orders two days in advance. Most of the consumers said they had difficulty knowing the meals on offer as the menu names were unfamiliar and no descriptions available. Consumers said when they asked staff who are taking the orders to explain the meals, they do not always know.
* Consumers were not aware of the activities on offer at the service or the changes in lifestyle staff. During the Site Audit, some consumers expressed confusion as the activities conducted during the week were not reflective of the activity calendar.

The Assessment Team provided evidence in relation to consumers not always being informed to the outcomes of assessments for social and medical needs. I have considered this under Standard 2.

Staff described the service’s processes identifying consumer preferences on entry to the service and ongoing through the assessment and care planning process. Staff described various ways of how information is provided to consumers including through noticeboards, verbally and written communication.

The Chef Manager said that they provide information to care staff on the meal service, including what meals contain via a briefing session.

Lifestyle staff said the informed consumers of service activities by visiting each consumer’s room, however, acknowledged that with social distancing requirements, the service is limited to the number of consumers at each activity. As a result, they invited consumers who enjoy specific activities first based on knowledge of the individual consumer.

The Assessment Team observed activity calendars and daily menus in consumer’s rooms and communal areas of the service.

The Approved Provider in its response, stated they are happy to accept the Assessment Team’s feedback in relation to meal services and are working to improve the presentation of the menu and ensure consumers and representatives have a better understanding of their choices. In relation to information being provided to consumers about lifestyle activities at the service, the Approved Provider in its response said the consumers had been verbally advised that the service’s activity calendar was not available for the week of the Site Audit due to the unavailability of lifestyle staff.

I acknowledge the Approved Provider’s response to the findings at the site audit and the actions they have taken and are planning on taking to address the deficiencies identified. However, in reviewing the information contained above it is my decision that at the time of the site audit, each consumer was not provided with information that was clear and easy to understand to enable consumers to exercise choice. Therefore, it is my decision this Requirement is Non-compliant.

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

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

# STANDARD 2 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

Consumers and representatives considered they felt like partners in the ongoing assessment and planning of consumers care and services. Consumers and representatives provided positive feedback about how the service worked in partnership with them and expressed satisfaction with the information that was provided to them about care planning processes.

The Care Manager described the service’s assessment and care planning processes including a three-monthly review of consumer’s care plans; how the outcomes of care planning are communicated to the consumers and representatives; and referrals to other health professionals as appropriate. They described how the services process for assessing and planning considered consumers end of life wishes, including completion of an Advanced Health Directive on entry to the service and again care plan review case conferences. Staff demonstrated an understanding of individual consumers, their needs and preferences.

Review of consumers’ assessment and care planning documentation reflected partnership with consumers and others that the consumer wishes to be involved and demonstrate the involvement of other organisations and providers of care and services.

The service demonstrated the involvement of individuals and provider of other care and services in assessment and care planning including allied health services and external specialist services.

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

## Assessment of Standard 2 Requirements

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

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

Consumers and representative were generally satisfied with the consumer care, and said they were involved in the consumers initial and ongoing assessment and care planning processes.

The Care Manager described the services assessment and care planning processes which included a three monthly review of consumers care plans. At the time of the Site Audit, the Care Manager advised that due to a shortage of Registered Nurses, the majority of consumers’ care plans were overdue for review.

Care staff demonstrated an understanding of individual consumers needs and preferences, and any changes in the needs and preference of consumers would be communicated to the Registered Nurse.

The service had a suite of evidence based assessment tools available to staff via the electronic care documentation system.

The Assessment Team reviewed care documentation for five named consumers and provided information that ongoing assessment and care planning was not completed in accordance with the service’s three monthly review process. The Assessment Team identified deficiencies in risk consideration and/or assessment for wound assessments, skin care, pain charting, oxygen management, diabetes management and blood pressure management.

The Approved Provider in their response provided information evidencing that the assessment and care planning for the named consumers considered individual risks for the named consumers. Including:

* Current wounds assessments had been completed for the named consumer weekly in accordance with the documented Wound Assessment and Care Plan. Information was also provided evidencing the Medical Officer and Podiatrist had regularly reviewed the wounds.
* For the named consumer with identified skin care needs: Information was provided identifying the consumer had a below knee amputation several years ago. The Approved Providers response include a skin integrity assessment, validated 1 June 2021 and updated 24 July 2021; a wound assessment of a current wound, and a personal care plan to guide staff in care delivery to support and promote optimal skin care.
* For the named consumer requiring oxygen management and pain charting: Information was provided evidencing that the consumer was prescribed the identified medication for breathlessness associated with Chronic Obstructive Pulmonary Disease. Assessment and care planning information provided included the consideration of risks associated with oxygen therapy, and included strategies to direct care delivery including replacement of oxygen prongs, cleaning the oxygen concentrator air filter and changing oxygen cylinders. Information was also provided evidencing the Medical Officer had regularly reviewed the named consumer including management of prescribed medication.
* For the named consumer requiring diabetes management, information was provided identifying the consumer is non-compliant with recommended diabetic management strategies. The Approved Providers response included a Diabetic Management Care plan dated 27 July 2021 and strategies to manage the associated risks. For example, reporting and escalation when parameters are outside of Medical Officer directives.
* For the named consumer requiring daily monitoring of blood pressure. Information provided evidenced that the named consumer wished to cease currently prescribed medication to explore natural alternatives. The Approved Provider included blood pressure charting which identified for the period 4 June 2021 to 27 July 2021 the assessment of the consumers blood pressure was completed weekly in accordance with directive.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. I have considered the acknowledgement by the Care Manager at the time of the Site Audit that the majority of consumers care plans had not been reviewed in the last three months in accordance with the services assessment and care planning processes. It is my decision, that while the service had not followed its process of three-monthly care plan reviews, I am satisfied that the assessment and planning for the named consumer’s had identified individual risks to inform the delivery of safe and effective care and services. For the reasons detailed, this requirement is Compliant.

### Requirement 2(3)(b) 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.*

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

*The organisation demonstrates that assessment and planning:*

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

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

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

### Requirement 2(3)(e) 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.*

At the time of the Site Audit, the Care Manager advised that due to a shortage of Registered Nurses, the majority of consumers’ care plans were overdue for review. The Care Manager said care plans had been updated for consumers that had a change in clinical care needs or had returned form hospital.

Review of care documentation by the Assessment Team identified eight consumers had not had care plans reviewed within the last three months in accordance with the services processes. The Approved Provider acknowledged that the service was not currently completing consumer three monthly care plan reviews, and had identified this in the service’s plan for continuous improvement with immediate actions to focus on the review of consumers with a changed health status or returning from hospital.

The Approved Provider in their response provided information evidencing that while not all consumers care plans had been reviewed in the last three months as per the service processes; the care and services for the named consumers had been reviewed regularly for effectiveness including when there had been a change in consumers’ needs, goals or preferences.

The Assessment Team did not provided information in relation to consumer and representative feedback specific to this requirement. However, I have considered in my decision, information provided in the Site Audit report which identified consumers and representative said they were involved in the consumers ongoing assessment and care planning processes.

I have considered information in the site audit report and the Approved Providers response including the actions taken and/or planned by the Approved Provider. It is my decision the assessment and planning for the named consumer’s had been reviewed regularly for effectiveness, including when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. For the reasons detailed, this requirement is Compliant.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Consumers and representatives expressed satisfaction that consumers had access to Medical Officers and other health professionals if required, and consumers needs and preferences were effectively communicated between staff and other providers of care and services. Consumers and representative said the service had spoken with them about the consumers’ needs, goals and preferences in relation to end of life wishes.

Staff described the way care is delivered for consumers nearing end of life and provided examples of ways in which consumers’ comfort is maximised near the end of life.

The service demonstrated that a deterioration or change to a consumers’ health or well-being is recognised and responded to in timely manner; information related to consumers care needs and preferences is communicated within the organisation and where care is shared; and appropriate referrals occurred when needed and that the consumer had access to relevant health professions as required.

The service had a suite of policies and procedures to guide staff in care delivery including in relation to end of life care, and a restraint management policy.

However, consumers and representatives consistently described the high level of agency registered staff utilised by the service impacted in the delivery of safe and effective clinical care including medication management. The service was unable to demonstrate effective management and monitoring of high impact and high prevalence risks for consumers, including in relation to diabetes management, wound care and weight loss and nutrition.

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

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team provided information that not all consumers and representatives are satisfied that consumers received the care they needed. For example:

* The representative for one named consumer said they visited the service daily, and reported that the service currently used a large number of agency staff who did not have experience supporting people living with dementia. They expressed concern for consumers safety in the memory support unit and provided an example of the consumer experiencing a fall when staff in the unit were unable to provided one-to-one care due to other staff being on meal breaks.
* On the first day of the Site Audit, a second named consumer advised the Assessment Team that had been waiting for wound dressings since early in the morning. The consumer expressed their preference for retiring to bed early, and said they regularly had to ask for evening medications which are often late.
* The representative for a third named consumer confirmed due to the large number of agency nursing staff consumer’s medication is often late and this further increases the consumer’s anxiety. The representative reported the consumer had recency received a double dose of anti-anxiety medication.

Care staff generally described the care needs of individual consumers and how these were managed in line with their care plan. For example, for the named consumer who experienced a fall staff described strategies to support care such and the consumer requiring one-to-one support when walking around the service.

A number of care staff reported the high use of agency registered staff is impacting on the care of the consumers, due to their lack of familiarity with consumer care needs.

Review of documentation provided to the Assessment Team identified the service was not consistently monitoring some consumers with personal and clinical care needs in relation to restraint and wound management. Including:

* Inconsistent information in relation to the number of consumers prescribed a psychotropic medication that was considered a chemical restraint. One report provided to the Assessment Team identified 14 consumers subject to a chemical restraint; and the service’s Clinical Indicator’s report identified 24 consumers.
* In relation to chemical restraint: incomplete or inconsistent completion of restrictive practice authorisations, including risk assessments, discussion of associated risks with the consumer and/or representative and review of prescribed psychotropic medications.
* For two named consumers, wound care documentation identified inconsistent review and monitoring of wounds and one wound had deteriorated.

The Approved Provider in its response stated that since earlier this year not all consumer medication reviews have been accompanied by a re-signing of the restrictive practice authorisation. The Approved Provider’s response provided information to clarify the inconsistent information in relation to the number of consumers who are considered to be subject to chemical restraint, identifying the service considers any consumers prescribed psychotropics without a diagnosis as subject to chemical restraint until the Medical Officer confirms the consumer’s diagnosis. In relation to the two named consumers with wounds, the Approved Providers response provided information evidencing that a review of one of the named consumers wound management was undertaken. For the second name consumer, no further information was provided.

In response to the consumer feedback identified to the team, the Approved Providers response included:

* Clarification that the named consumer who experienced a fall was not being provided one-to-one nursing care. Information including a falls risk assessment, falls care plan and progress note was also provided and evidenced strategies to guide staff in the consumer’s individualised care delivery.
* For the second named consumer, information was provided that the service is engaging with the consumer in relation to times for wound management and medication administration. A copy of the consumer’s wound care plan was provided, however I was unable to ascertain from the information provided how the service monitored and managed the wound as information in detailed comments was not expanded; and the dressing and review schedule during this period was not identified.
* For the third named consumer, the Approved Provider’s response included information that the service had undertaken and investigation into the medication incident. The service is also planning to undertake a review of medication round times and is implementing an electronic medication management system by the end of 2021.

The Approved Provider in its response identified a number of improvement initiatives including a dedicated Quality and Compliance Officer; oversight by senior organisational staff to undertake audits and support the service to implement improvements including outcomes for consumers; and review of the clinical roster to support improved clinical outcomes for consumers.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the immediate and planned actions undertaken and committed to by the Approved Provider, at the time of the site audit, the service did not consistently demonstrate that all consumers receive individualised care that is safe, effective and tailored to specific consumer needs and preferences. I am concerned that consumers and representatives provided feedback that care delivery for consumers was negatively impacted by a lack of staff. Therefore, it is my decision this requirement is Non-Compliant.

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

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

The service has not demonstrated it consistently and effectively managed the risk related to the personal and clinical care of each consumer in the areas of diabetes, medication and falls management, and nutrition. Including:

* One named consumer’s diabetic management plan included staff directives to measure blood glucose levels four times daily, and insulin to be administered when blood glucose levels are outside parameters nominated by the Medical Officer. For the period 29 June to 6 July 2021, charting did not identify the consumer’s blood glucose levels where consistently recorded four times per day.
* Two named consumers who choose to self-medicate did not have completed or contemporaneous assessments to identify strategies to minimise associated risks. The Assessment Team identified one of the consumers had a documented cognitive impairment.
* Two named consumers risk for malnutrition had been identified, however the service was unable to demonstrate effective ongoing management and one consumer continued to experience ongoing weight loss.
* Inconsistent information for one consumer who required restriction of fluid intake. The Assessment Team identified the consumer’s care plan documented a 1.5 litre restriction; and fluid charting and progress notes record 1 litre fluid restriction. Review of progress notes identified the consumer regularly exceeded the fluid restriction.
* One named consumer was identified as a high risk for falling in care planning documentation, however the Assessment Team provided information which evidenced the consumer experienced nine falls in June 2021. On two occasions the consumer was not reviewed by the physiotherapist, or a risk assessment completed in line with the organisation’s falls management policy.

The Assessment Team’s Site Audit report included feedback from consumers and/or representatives expressing concern in relation to consumer’s medication management. Including consumers not receiving medications on time and receiving a double dose of medication; and a consumer not receiving required medications; and a consumer self-medicating without appropriate self-administration assessments completed.

A review of care planning documentation identified that staff were not ensuring or monitoring that consumers were receiving nutritional supplements as prescribed by the Dietitian; or monitoring of fluid intake for a named consumer requiring a fluid restriction. The documentation established that fluid and food intake for the three named consumers, was not adequately charted to enable effective clinical monitoring.

The Approved Provider in its response provided information identifying for some of the named consumer’s identified in the Assessment Team’s Site Audit report. The consumer:

* Requiring diabetic management had a history of non-compliance with recommended diabetic management strategies. The Approved Providers response under other requirements included a Diabetic Management Care plan with documented strategies to manage the associated risks.
* Not receiving a medication, evidence was provided to confirm all medications where administered on 7July 2021, excluding eyedrops which were refused by the consumer.
* Experiencing significant weight loss is in the terminal phase of illness. The consumer was reviewed by the Dietitian on 10 July 2021 and nutritional supplements and food and fluid charting commenced.
* Experiencing nine falls in June 2021, was reviewed by the Medical Officer or Physiotherapist. In addition, a urinalysis test was completed which reported no abnormalities.
* Self-medicating without appropriate assessments. The Approved Provider’s response state the consumer makes their own decisions, and wishes to continue to self-medicate some medications. Nursing staff confirm with the consumer at medication rounds that the consumer has self-medicated.

The Approved Provider in its response also identified a number of improvement initiatives including a dedicated Quality and Compliance Officer; oversight by senior organisational staff to undertake audits and support the service to implement improvements including outcomes for consumers; and review of the clinical roster to support improved clinical outcomes for consumers.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the immediate and planned actions undertaken and committed to by the Approved Provider, at the time of the site audit, high-impact or high prevalence risks for consumers were not effectively being managed. Therefore, it is my decision this requirement is Non-Compliant.

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

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

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

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

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

The Assessment Team provided information that two consumer representatives expressed dissatisfaction in relation to COVID-19 visitor restrictions; including that the service continued to isolate consumers even after a COVID-19 test result had returned negative.

Staff demonstrated an understanding of the principles of anti-microbial stewardship, including practices implemented to support optimal consumer care such as encourage fluid intake for consumers and collection of pathology samples and confirmation of results prior to the prescription of antibiotics.

The service had a nominated Infection Prevention and Control lead who had completed the required training from the Department of Health. At the time of the Site Audit the Infection Prevention and Control lead did not demonstrate an effective understanding of the responsibilities of the role including when the service’s Outbreak Management Plan had been reviewed. However, the service’s Clinical Manager is currently undertaking the required training and will be the service’s appointed Infection Prevention and Control lead. The Assessment Team reviewed the service’s Infection Control Policy and identified there was no reference made to COVID-19 or the requirement for an Infection Prevention and Control lead at the service.

Over the Site Audit, the Assessment Team observed staff not consistently wearing face masks appropriately and a number of staff were observed to be wearing fabric masks. The Assessment Team provided feedback to Management who said staff are provided the choice to wear either single use or fabric face masks.

The service had a single point of entry and screening where screening was completed. 100% of service staff had received influenza vaccination; and Management said staff are being contacted via the organisation’s corporate office to notify of the requirement to have their first COVID-19 vaccination.

The Approved Provider in its response provided information, including care planning documentation for named consumers to evidence that the service had recently experienced a rhinovirus outbreak in an area of the service, and as a result the local Public Health Unit directed no visitors were permitted at the service. Once advised by the local Public Health Unit, the first named consumer’s representatives was contacted and advised support visits could recommence. For the second name consumer, the Approved Provider provided information which evidenced that once the consumer’s COVID-19 test was confirmed the service removed the consumer from isolation.

The service’s Outbreak Management plan has been reviewed and updated in June and July 2021 in response to the deficiencies identified by the Assessment Team. The Approved Provider’s response included information evidencing:

* The training and responsibilities of the service’s appointed Infection Prevention and Control lead at documented in the organisation’s Infection Prevention and Control Lead Policy.
* The service completes regular Infection Control audits annually, and corrective actions from the March 2021 audit were added to the service’s Plan for Continuous Improvement.
* The Approved Provider clarified at the time of the Site Audit the service was not in lockdown and staff and visitors where wearing face masks as a precaution. I note reference to the **Queensland Health’s Residential Aged Care Facility and Disability Accommodation PPE Guidance; and Residential Aged Care Direction at the time of the Site Audit required staff who work only in a single facility and care of non-COVID-19 consumers to be required to practice standard precautions.**

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider. While at the time of the Site Audit, the Assessment Team identified some deficiencies, I am satisfied that the service has evidenced actions have been taken to address these and current infection control auditing processes continue to monitor these. For the reasons detailed, this requirement is Compliant.

# 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

Consumers and representatives considered consumers are encouraged and supported by the service to participate in local community events of interest and supported to maintain contact with those important to them.

Care planning documentation included information about consumers activities of interest, information about relationships consumers wish to maintain; personal background, family, preferences, spiritual and emotional needs; and referrals to other organisations as appropriate. Individual consumer’s dietary needs and preferences were reflected in care documentation.

Staff said they had access to the equipment they needed and the equipment was maintained. Review of maintenance documentation provided to the Assessment Team identified scheduled preventative and reactive maintenance, which includes equipment maintenance, had been completed.

However, some consumers expressed dissatisfaction with the service’s delivery of activities. Most consumers and representatives were not satisfied with both the quality and quantity of the food at the service.

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

## Assessment of Standard 4 Requirements

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

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

The Assessment Team provided information that not all consumers and representatives were satisfied with the service’s delivery of activities. At the time of the Site Audit, the service had been in recent restricted lockdown and consumers said they relied on the service to provide social support. Consumers were not aware of the activities on offer at the service or the changes in lifestyle staff. During the Site Audit, some consumers expressed confusion as the activities conducted during the week were not reflective of the activity calendar. Consumers and representatives said the service did not run scheduled activities the week prior to the Site Audit due to insufficient lifestyle staff.

Lifestyle staff described the services monthly calendar of events and how the service engages consumers during events, consumer meetings, and the lifestyle care plan reviews. Lifestyle staff described how the services lifestyle events and activities meets the needs and preferences of consumers, including consumers with varying levels of ability.

Lifestyle staff confirmed that for the two week period prior to the Site Audit, the number of lifestyle staff at the service had been impacted due to unplanned leave. Lifestyle staff were not aware of what activities had occurred during this two week period. Management said that whilst lifestyle staff were absent from the service, consumers had access to boardgames, puzzles and other activities in the service. Lifestyle and care staff said that when the service is not in lockdown, activities do not consistently run effectively due to the rostering of lifestyle staff.

Following feedback by the Assessment Team at the time of the Site Audit, Management said, the service would utilise additional lifestyle staff from another site within the organisation and a dedicated care staff member would be rostered to provide lifestyle support.

However, on day four of the Site Audit, the Assessment Team observed no activities being conducted in the service. Over the course of the four day Site Audit, activities conducted were not reflective of those listed in the activity calendar; and activities were not consistently scheduled or observed in the service’s memory support unit.

The Approved Provider in its response acknowledged that lifestyle staff had required unexpected leave in the two weeks prior to the Site Audit; however, the service had provided activities in small groups or individually to consumers. Information in relation to lifestyle activities during this two week period had been communicated verbally to consumers. The Approved Providers response included information to evidence the engagement of consumers in the services lifestyle program, including documented Lifestyle Participation charts for the named consumers. The service has also provided all consumers at the service the full Lifestyle Program to ensure activities being offered are communicated.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. I have considered the feedback provided by some consumers identified dissatisfaction with the lifestyle program for a two week period, it is my decision this has not reflected that supports for daily living had not been provided to consumers for a prolonged period. The Approved Provider has evidenced immediate and planned actions in response to the identified deficiencies, including that lifestyle activities are now occurring at the service. For the reasons detailed, this requirement is Compliant.

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

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

Some consumers provided examples of how the service supports them in the event they are feeling low, for example one named consumer said staff always have a joke and this helped their mood; a second named consumer said they are supported by a psychologist and this was beneficial.

However, the Assessment Team provided information which identified the recent lack of lifestyle activities at the service had impacted on some consumers emotional wellbeing. For example, one consumer said without lifestyle staff they had no one to talk to; a second named consumer said the services insufficient lifestyle staff had resulted in activities not being held at the service that week.

Lifestyle staff described how the service supports church services of three denominations and offer consumers pastoral visits if requested. Lifestyle staff described how they undertook wellness checks with consumers on a regular basis and consumers experiencing low mood are provided one-on-one emotional support.

Review of consumer care documentation reflected information in relation to consumers spiritual, psychological and emotional wellbeing including detailed information about consumers background, family, preferences and spiritual and emotional support needs.

On the fourth day of the Site Audit, the Assessment Team identified a Catholic Mass was scheduled to be televised for consumers to participate in however this did not occur.

The Approved Provider in its response stated the service currently schedules and holds a Lifestyle Programme over six days of the week and advised in line with the workforce review the Lifestyle Programme will extended to seven days a week. The Programme includes various group and individual activities for consumers. The Approved Provider said it was not always possible for Lifestyle staff to be available for one-to-one individual support to consumers at their preferred times, however, all staff, not only Lifestyle staff provided wellness checks to support consumers emotional and spiritual wellbeing. Consumers are encouraged to decorate their rooms as their wish, including the display of religious or spiritual pictures and/or ornaments.

In addition, the Approved Provider’s response included clarification of the Assessment Teams observation in relation to the Catholic Mass. The Catholic Mass was scheduled, however due to visitor restrictions in place the Catholic Pastoral team were unable to visit the service in person. The Catholic Mass was never intended to be a televised activity.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. I have considered the positive feedback provided by consumers, as well as some consumers who identified the recent lack of lifestyle activities for a two week at the service had impacted on their emotional wellbeing. I am satisfied that the service does provide Services and supports for daily living that promote each consumer’s emotional, spiritual and psychological well-being. For the reasons detailed, this requirement is Compliant.

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

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

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

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

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

The Assessment Team provided information that accurate information about consumer’s condition, needs and preferences is not communicated within the organisation. For example, one named consumer preferred to have cereal for dinner however staff served a hot meal; a second named consumer who is diabetic and experienced difficulty swallowing bread said the service advised everything on the menu is suitable for a diabetic diet. During the Site Audit, the Assessment Team observed catering staff offering the consumer cake, biscuits and cordial, however the consumer requested a cup of tea and fruit, which was provided.

Staff described how information is communicated in relation to any changes to consumer needs or preferences including via handover documentation, advice received from Registered staff, care documentation and lifestyle participation records. Information in relation to consumer dietary changes is shared via update by the clinical to the consumer nutritional profiles in the kitchen. The Chef Manager utilised consumer nutritional profiles to generate meal choices forms, which care staff used to collect consumers meal preferences. Care staff said information about changes in consumers preferences is communication via conversations with staff and due to an increased use of agency staff this can be missed. I have considered this information under Requirement 7(3)(a).

Review of information provided to the Assessment Team identified:

* Staff meeting minutes for 7 May 2021 identified staff were not completing the documentation on consumer meal tray lists fully.
* Consumer meal choice forms and identified consumer meal information was not consistent with consumers needs or preference. For example, forms did not reflect, for one named consumer their preference for cereal for dinner; a second named consumer their requirement for a diabetic diet; and for a third consumer their requirement for a lactose free diet.
* The lifestyle plans of consumers reflected their individual lifestyle needs, activity preferences, identified consumer goals and detailed shared responsibilities for these.

The Approved Provider in its response has provided information evidencing:

* The first named consumer is diabetic; however, wished to monitor their weight and preferred to eat cereal for breakfast and dinner and staff would offer a hot meal at dinner to encourage a balanced diet across the day. The consumers dietary care plan has been reviewed and update by the Clinical Manager in partnership with the consumer and representative, reflecting individual preferences.
* The Approved Provider advised, the second named consumer is not consistently compliant with their diabetic diet and the consumer has been reviewed by the Dietitian and Speech Pathologist. The Chef Manager consulted the consumer and confirmed that items on the menu being offered to the consumer are suitable for a diabetic diet.
* The consumer meal choice forms records the consumers selection of meal. Individual consumers had dietary profiles and these are utilised by the kitchen when preparing and serving meals. Evidence was provided that the three named consumers dietary profiles evidenced their individual preferences and needs.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team including under other Requirements where overall consumers and representatives expressed satisfaction that consumers needs and preferences are effectively communicated between staff; and the written response from the Approved Provider. While the Assessment Team identified some deficiencies in the documentation of information relating to three consumers dietary preferences, the Approved Provider in their response evidenced communication mechanisms are in place within the service and where care is shared. I am satisfied that the service does communicate information about the consumer’s condition, needs and preferences within the service, and with others where responsibility for care is shared. For the reasons detailed, this requirement is Compliant.

### 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.*

Most consumers and representatives were not satisfied with both the quality and quantity of food at the service and provided examples including one named consumer who preferred fruit was being offered cakes; a second named consumer who had been at the service four weeks did not like the taste or texture of the hot meals; and a third named consumer who disliked onions but was offered stir-fry’s and dislikes the meal alternative so has to settle for sandwiches. The representative for one consumer had met with the Chef Manager about the meal quality but expressed things had not improved and meals were being served cold.

Overall, consumers and representatives said the quality of the food was impacted as food is served late and cold, making it unappetising.

Consumers had access to sandwiches and snacks between meals, and received morning and afternoon tea. The service had a summer and winter menu in place.

Individual consumer’s dietary needs and preferences were reflected in care documentation.

The Chef Manager described the meal preference process, which included consumers meal requests taken by care staff two days in advance and documented on the meal options form.

Management and the Chef Manager demonstrated aware of the ongoing complaints regarding food quality and advised the service would be reviewing food complaints. I have considered this information in my decision for Requirements under Standard 6.

Review of information provided to the Assessment Team identified consumer meeting minutes reflected ongoing issues with food quality and variety.

The Assessment Team observed the services kitchen clean and tidy and staff demonstrating general food safety practices.

On one occasion during the Site Audit, the Assessment Team observed a lunch meal service and identified meals served up to 20 minutes late; 12 of 25 plates returned to the kitchen with at least half the meal not eaten; and a discussion between consumers who said they disliked the spices on the vegetables.

The Approved Provider in its response has acknowledged that at one lunch service during the Site Audit the meal service was delayed. The service has implemented a number of actions in response to the Site Audit report including the addition of a description to the menu of each meal item to support staff explanation to consumers about ingredients and descriptions of meals. The Approved Provider advised all consumers had a choice of two hot options, salad or sandwiches at meal services; and in relation to the spiced vegetables the service now offers vegetables both with and without spices.

The service is planning to re-establish the monthly consumer Food Focus Group meeting to support feedback from consumers and make improvement to the meal service.

The Clinical Manager reports monthly on unexpected consumer weight loss or gain, and the Approved Providers response included information for the period January to June 2021 which evidenced a downward trend in unexpected consumer weight loss.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team including under other Requirements; and the written response from the Approved Provider. While I acknowledge the Approved Provider’s response to the findings at the site audit and the actions they have taken and are planning on taking to address the deficiencies identified. In reviewing the information contained above it is my decision that at the time of the Site Audit, meals provided at the service were not of suitable quality. Therefore, it is my decision this requirement is Non-Compliant.

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall consumers and representatives considered consumers felt safe and comfortable in the service environment. They said they felt a sense of belonging.

Consumers and representatives expressed satisfaction with the environmental services provided, such as cleaning and laundry services. They identified no concerns in relation to maintenance services, and expressed satisfaction with the cleanliness of consumers’ rooms and the quality of furnishings. Consumers and representatives said the environment encouraged consumers to maintain their independence.

Management said the service had a reactive and preventative maintenance schedule and maintenance logs are checked daily by maintenance staff. Maintenance staff work Monday to Friday, however, remain on call for matters requiring immediate attention over the weekend.

Maintenance staff provided examples of when maintenance was required and described the response time and actions taken. Staff described the services processes for reporting maintenance issues and lodging maintenance requests. They said that any identified hazards or risks to consumers or staff are immediately reported to registered staff who escalate to the maintenance team if required. Cleaning staff said the service had a cleaning schedule that included the completion of cleaning logs. They described how the cleaning schedule incorporated the individual consumer requests.

Review of information provided to the Assessment Team identified, regular maintenance of the service environment and timely response to equipment maintenance requests. The service had a program of monthly scheduled maintenance and included inspections and any maintenance as directed by the manufacturer. Maintenance documentation identified the service had completed maintenance in accordance with the monthly schedules, including detailing actions taken. There were no outstanding maintenance requirements at the service at the time of the Site Audit. Meeting minutes confirmed maintenance issues are discussed with consumers and staff.

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

## Assessment of Standard 5 Requirements

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

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

### 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.*

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

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

# 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

Overall consumers and representatives considered they are encouraged and supported to give feedback and make complaints. Consumers and representatives said they felt comfortable raising concerns and providing feedback either through direct communication with management and staff, or use of the service’s feedback forms. Consumers and representatives were aware of external feedback mechanisms including advocacy organisations and described how the service informs them of feedback channels.

Staff described the service’s feedback mechanisms for consumers and representatives to provide feedback or make a complaint. Staff said, if they could not resolve complaints within their scope of practice, they would inform senior staff or Management.

However, the service could not adequately demonstrate the collection and ongoing analysis of consumer feedback or that consistent and appropriate actions are taken to address complaints raised. The service did not adequately demonstrate how feedback and complaints are used to improve the quality of care and services.

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

## Assessment of Standard 6 Requirements

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

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

### 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 provided information that some consumers and/or representatives said complaints are not consistently responded to or action taken by the service in response to feedback. For example, the representative for one named consumer said they had raised a complaint with the service in March 2021 in relation to management of the consumer’s medications and had not received a response from the service.

The Assessment Team found that the documentation provided by the service in relation to complaints was incomplete, however the service did demonstrate an open disclosure process was utilised in managing the initial stages of a complaint. Management, at the time of the Site Audit confirmed that the service acknowledged actions taken in response to consumers’ feedback where not consistently completed.

The Approved Provider in its response stated that they do not dispute the comments that the service’s response to some feedback is neither timely nor comprehensive. The Approved Provider’s response included information that evidenced the initial response provided to the named consumer’s representative addressing concerns raised. Information was also provided evidencing that consumer and/or representative complaints received by the organisation’s central office are respond to in a timely manner.

The Approved Providers response also included actions the service planned to include support for the service Management by the organisation’s Operations Manager to ensure timely and consistent response to consumer feedback.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the Approved Provider’s response including planned actions, at the time of the site audit, the service did not demonstrate that appropriate action is taken in response to complaints. Therefore, it is my decision this requirement is Non-Compliant.

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

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

Feedback and complaints from staff have not been used to improve the quality of care and services. The Assessment Team provided information that identified consumers and representatives were not aware of any improvements made in response to their complaints or feedback. Consumer concerns relating to the meal service, staff sufficiency and communication and care consultation were not addressed to improve the quality of care.

Management and staff interviewed were unable to demonstrate a shared understanding of how consumer feedback is used to improve care and services. Management acknowledge the service did not consistently review all complaints to address the cause and take actions to improve consumer care and services.

The organisation did not have a complaints management policy to guide staff, however information was documented in the consumer handbook and service improvement guide.

The Approved Provider in its response provided information in relation to complaints escalated through the organisation’s central office which evidenced improvements made at the service as a result of consumer feedback. For example, two representatives raised a concern in relation to the overgrown state of some external pathways. As a result of this feedback, an external maintenance provider was engaged and a contract established for the ongoing maintenance of the service’s external areas. In addition, the Approved Provider’s response included information in relation to a further three representative complaints that had been actioned via the organisation’s central office.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. While I acknowledge the organisation has taken some actions in response to consumer feedback; I am not satisfied that the service adequately demonstrated that feedback and complaints are reviewed and used to improve the quality of care and services. Therefore, it is my decision this requirement is Non-Compliant.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall, consumers and representatives expressed confidence in the ability of staff, and considered that consumers receive care and services from staff who are knowledgeable, capable and caring. However, most consumers and representatives said that there are not enough staff to deliver timely care and services, and expressed concern in relation to the high number of agency staff and delays in responding to consumers requests for assistance.

The service demonstrated it had process for ensuring staff are competent, and had the qualifications and knowledge to effectively perform their roles. The service monitors staffs records in relation to national criminal history checks and professional registration requirements.

While the organisational had processes to ensure that the workforce is adequately trained, recruited and competent and supported in their roles, the service was unable to demonstrate the workforce is planned and sufficient to enable the delivery and management of safe and quality care; and that staff performance is regularly assessed, monitored and reviewed.

Review of information provided to the Assessment Team identified a large number of agency registered staff in use across the service, personnel records demonstrate regular performance appraisals are not completed and conversations regarding performances issue were not documented.

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

## Assessment of Standard 7 Requirements

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

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

Consumers and representatives said staff are mostly diligent and supportive in consumer care and service delivery. However, consumers and representatives expressed concern regarding adequacy of staff, including the extensive use of agency staff and delays in responding to consumers call bells. For example, one named consumer said they often had to wait for staff including, on the first day of the Site Audit when the consumer advised the Assessment Team, they had been waiting an extended time for wound care.

Care staff said the service experiences a high turnover of care staff due to the high workloads. Care staff expressed concern in relation to agency staff’s knowledge of individual consumer care needs and preferences, and provided examples of how this impacted on consumers care and services such as medications not being administered in a timely manner.

Management described the services roster plan which included five Registered Nurses rostered in each 24 hour period; two Registered Nurses each morning, two Registered Nurses each afternoon and one Registered Nurse overnight. Management advised the service had five fulltime Registered Nurses and an additional four Registered Nurses employed part-time or casually. As a result, the service had needed to utilise clinical management staff at the service or agency staff to replace unplanned leave.

Following feedback by the Assessment Team at the time of the Site Audit, Management said:

* The service is planning on implementing an electronic medication management system to support improved accuracy and reduction in medication errors.
* In relation to call bell response times, Management said the service monitored call bell response times, and reviewed at a service level monthly.

Review of roster allocation for the period 21 June 2021 to 4 July 2021, the Assessment Team identified:

* Five care shifts had not been replaced and seventeen care shifts were filled by agency staff.
* Three registered staff shifts had not been replaced and 46 shifts were filled by agency staff.
* Nine shifts were filled by the Management staff, thereby impacting on their ability to perform their own roles including providing clinical oversight.

The Approved Provider in its response stated that the service had been experiencing difficulty in recruitment of suitable Registered and care staff; and identified that the service utilises agency staff only when a shift cannot be filled by the services own staff. They advised that since the Site Audit, the service had successfully recruited four graduate Registered Nurses who will undertake a service graduate entry programme. The four graduate nurses commenced at the service on 2 August 2021.

The Approved Provider’s response included evidence of initiatives being taken in response to the deficiencies identified by the Assessment Team at the time of the Site Audit including:

* Improving the clinical roster
* Upgrade of the nurse call system to include recording the length of time calls bells are activated.
* When call bells are activated over seven minutes a notification is sent to the Service Manager.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the Approved Provider’s response including immediate and planned actions, at the time of the site audit, the service was not planned to ensure the delivery and management of safe and quality care. Therefore, it is my decision this requirement is Non-Compliant.

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

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

Overall consumers and representatives said staff were kind and caring in their interactions. However, some consumers said that staff are often rushed, work short or agency staff are employed who don’t know consumers or their care needs.

At the time of the Site Audit, the Assessment Team observed staff being kind and respectful in their interactions with consumers. However, the Assessment Team provided information in relation to observations of staff practices and language when speaking about consumers. Including:

The Assessment Team observed a conversation between care and Registered staff who made racially insensitive remarks about another culture’s language. The conversation was in close proximity to four consumer’s room and the Assessment Team observed some consumers doors open.

In the Assessment Team’s interview with a staff member, a reference was made to de-canting of consumers to other areas of the service; and in a second interview another staff member making a comment regarding a consumer’s manner of behaviour.

The Approved Provider in its response, stated that Management were advised on one conversation between staff that was overheard by the Assessment Team; and when asked to expand to the staff involved the Assessment Team would not divulge the nature of the conversation. Therefore, the service was unable to follow up with staff. The Approved Provider acknowledge that a staff member in one interview with the Assessment Team had used the word decant, however this was not reflective of the staff member or any staff respect to consumers at the service. In relation to a staff member making a comment regarding a consumer’s behaviour, the Approved Provider provided information that evidenced the staff member understood and respected the individual consumer.

While at the time of the Site Audit, the Assessment Team identified three occasions when observation of staff practices and conversations where observed, I note consumers and representatives said that staff at the service where kind and caring and the Assessment Team observed kind and respectful interactions. I have considered information in the site audit report and the Approved Provider’s response and I am satisfied that the workforce are kind, caring and respectful of each consumer’s identity, culture and diversity. For the reasons detailed, this requirement is Compliant.

### Requirement 7(3)(c) Compliant

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

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

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

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard.

Two consumers and/or representatives interviewed identified some staff could improve their interactions with consumers; and specifically, for consumers living in the memory support unit, agency staff do not always know how to support consumers living with dementia. They provided examples of how this impacted consumers such as medication errors and delays in meal service.

The service had a nominated Infection Prevention and Control Leads who had completed training as required by the Department of Health.

Management said the organisation’s central office monitored the completion of staff mandatory training, including sending of reminders three months ahead of the time to staff who are due for annual mandatory training. For agency staff, Management said the completion of mandatory training is required as part of the contractual arrangement.

Management said for staff who had not completed mandatory training or provided current police checks, were stood down from employment until the training was complete. The Assessment Team confirmed this on review of the services Heads of Department meeting minutes.

One agency Enrolled Nurse confirmed they had completed the mandatory competencies as a requirement of employment.

One care staff member who worked in the service’s memory support unit said they had attended dementia training in 2020, and to date no further training had been provided in dementia care.

Review of the service’s Plan for Continuous improvement identified a number of staff training areas, including responsive behaviours training, consumer care documentation and end of life are planning documentation. However, the Assessment Team identified at the time of the Site Audit inconsistent or incompletion documentation of actions undertaken by the service in these improvement areas.

The Approved Provider in its response stated there were some items in the Plan for Continuous Improvement had not yet been closed out for accuracy. The Approved Provider provided information to evidence the service provided training to staff to support the delivery of outcomes required by the Standards, such as Kind, Caring and Respectful Care; and education provided through the Preceptored Training Programme.

The Assessment Team provided information under Requirement 7(3)(c) that evidence the service had processes and was able to demonstrate member of the workforce had the qualifications and knowledge to effectively perform their roles. I have considered information provided under this requirement in my decision.

For the reasons detailed, this requirement is Compliant.

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

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

The Assessment Team provided information that identified the service did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

Management said that approximately 50% of staff were overdue for completion of annual performance appraisals. Management provided an example of recent performance discussions and incidents in relating to staff performance, including:

A performance discussion with a care staff member following identified issues in relation to equipment management.

A staff member involved in an incident reported under the Serious Incident Response Scheme who was required to complete elder abuse training as part of the investigation and action plan.

However, at the time of the Site Audit the service was unable to provide evidence of the performance discussion or that required training being completed.

Review of documentation provided to the Assessment Team identified performance appraisal, including probationary reviews are not regularly being completed.

The Approved Provider in its response stated that the service acknowledges that performance appraisals for staff are not all current and this was a deficiency not included in the service’s Plan for Continuous Improvement at the time of the Site Audit. In addition, the Approved Provider’s response included clarification of the training completed by the staff member as part of the Serious Incident Response Scheme incident investigation and action plan.

The Approved Provider’s response included evidence of initiatives being taken in response to the deficiencies identified by the Assessment Team, including implementation of a Preceptored Program and staff training modules.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, and the written response from the Approved Provider, under this requirement and other requirements within this Standard. While I acknowledge the Approved Provider’s response, at the time of the Site Audit, the service was unable to demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Therefore, it is my decision this requirement is Non-Compliant.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Consumers and representatives confirmed they engaged with management and staff during consumer meetings regarding their experience at the service. However, consumers and representatives were not able to provide examples of how they are involved in the development, delivery and evaluation of services. Consumers and representatives expressed that issues raised had not consistently been follow up by service Management.

The service reports monthly to the Board, who review and monitor organisational risks; however, the service’s governance systems were ineffective in addressing concerns around information management, continuous improvement, feedback and complaints and workforce governance.

The service had risk management practices to ensure the identification and response to allegations of elder abuse, mandatory reporting under the Serious Incident Response Scheme legislation and supporting consumers to live the best life they can.

The organisation had policies for antimicrobial stewardship, minimising the use of restraint and open disclosure to guide staff practice. However, the service could not demonstrate it had an effective clinical governance framework that monitored clinical care delivery or demonstrate consistent applying of open disclosure in the complaint’s management process.

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

## Assessment of Standard 8 Requirements

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

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

Consumers and representatives said they engage with the service’s Management and staff during consumer meetings. During the Site Audit the Assessment Team observed a poster requesting expressions of interest from consumers to be involved in the development, improvement and delivery of care and services.

However, the Assessment Team provided information from interviews with Management who at the time of the Site Audit where unable to demonstrate how the service communicates and collaborates with consumers and representatives in the development and evaluation of services. Management acknowledged the service did not consistently review all complaints and take actions to improve consumer care and services. I have considered this information under Requirement 6 (3)(d). Some consumers and representatives were not consulted about the service’s new menu; or consulted or informed of the service’s planned refurbishment project for the memory support unit in May 2021.

The Approved Provider in its response, provided information which evidences the consultation undertaken with consumers and representatives for the refurbishment in the memory support unit. In addition, the Approved Provider provided evidence of consumer and representative engagement and partnership, for example the purchase of a pool table in January 2021; the replacement of carpet in the memory support unit as a result of consumer and representative; and the refurbishment of a consumers room to support their individual care needs. In relation to consumer engagement and feedback with the service’s new menu, I have considered this under Requirement 4(3)(f).

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, the written response from the Approved Provider, under this requirement and other requirements and the mostly positive feedback from the 14 consumers and/or representatives during the Site Audit. I am satisfied that the service supports and engages consumers in the development, delivery and evaluation of care and services. For the reasons detailed, this requirement is Compliant.

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

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

The service provides monthly reports to the Board from the Clinical Governance team which included clinical indicators, incidents and complaints from external agencies.

The Board monitored the services clinical and care performance via service reports, attendance at the service’s leadership meeting, and walk through the service to meet with consumers and representatives. Service management described how the Board recently requested more detailed information from the service to enable comparison of clinical and other information provided.

However, while the reports are provided to the Board the Assessment Team provided information which identified some inconsistent data specifically in relation to the number of consumers who are prescribed a psychotropic which is considered as a chemical restrictive practice. The service manages consumer and representative complaints at a service level and escalated to senior management as required.

The Approved Provider in its response, provided information which evidences the organisation governing body promotes safe, inclusive and quality care through a number of initiatives including through ensuring a safe, well maintained service environment; provision of specialised clinical equipment; and specifically in the recent COVID-19 pandemic the establishment of service agreements to ensure staff and consumers have personal protective equipment available. In relation to the clinical data provide by the service to the Board, the Approved Provider in its response acknowledge that the service identified overreporting of consumers who are considered subject to chemical restrictive practice. I have considered the Approved Provider’s response under Requirement 3(3)(a) which provided information to clarify the inconsistent information in relation to the number of consumers who are considered to be subject to chemical restraint, identifying the service considers any consumers prescribed psychotropics without a diagnosis as subject to chemical restraint until the Medical Officer confirms the consumer’s diagnosis. Information was provided that evidenced internal and external complaints are escalated to the governing body as appropriate.

In coming to a decision on compliance for this requirement, I have considered the information brought forward by the Assessment Team, the written response from the Approved Provider, under this requirement and other requirements. I am satisfied that organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. For the reasons detailed, this requirement is Compliant.

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

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

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

While the service was able to demonstrate effective governance processes relating to financial governance and regulatory compliance; systems and process relating to information management, continuous improvement, feedback and complaints and workforce governance were not ineffective.

The organisation’s information processes have been effective in some areas such as communication of information about consumer’s condition, needs and preferences; however, the service did not demonstrate effectively that information provided to consumers was clear and easy to understand to enable consumers to exercise choice. The Assessment Team identified some inconsistencies in recording of consumer’s nutrition and hydration charting; inconsistent information reported specifically in relation to the number of consumers who are prescribed a psychotropic which is considered as a chemical restrictive practice.

The service’s continuous improvement processes had failed to identify and effectively action the deficits that had been identified by the Assessment Team at the time of the site audit. Auditing processes where inconsistent and the service did not provide information evidencing audits in relation to consumer care and services to ensure areas of improvement are identified. I note in the Approved Provider’s response for other Requirements acknowledgement was made there were some items in the service’s Plan for Continuous Improvement had not yet been closed out for accuracy.

Complaints and feedback processes have not effectively ensured the services took timely an appropriate action in response to complaints received, including utilising consumer feedback to improve service delivery as a result of feedback received.

Workforce governance processes have not effectively ensured that there are consistently sufficient staff at the service and this has resulted in negative outcomes for consumers including in the monitoring and delivery of personal and clinical care and services. The service acknowledged that performance appraisals for staff are not all current.

The Approved Provider in its response acknowledged the inconsistent data being reported in relation to chemically restrictive practice; and the service has implemented immediate action by confirming consumer diagnosis to ensure accurate reporting. The service utilises information from the service’s electronic care documentation system which provides information in relation to consumer’s meal preferences.

In relation to continuous improvement, the Approved Provider acknowledged a number of continuous improvement activities which have been ongoing and that the service’s plan for continuous improvement did not consistently identify how the initiative was identified. The Approved Provider in its response included a copy of the service’s Plan for Continuous Improvement which links improvements to the Quality Standards and identified the source of the improvement initiative, planned actions, evidence and outcomes. I note the service’s Plan for Continuous Improvement includes actions to address the deficiencies identified through the Site Audit.

The Approved Provider was unable to respond to information in the Site Audit report relating to cleaning audits as they were unable to determine the documents being specified.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the immediate and planned actions undertaken and committed to by the Approved provider, at the time of the site audit, the organisation did not demonstrate effective governance systems were in place in relation to information management, continuous improvement, workforce governance or feedback and complaints. Therefore, it is my decision this requirement is Non-Compliant.

### Requirement 8(3)(d) Compliant

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

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

### 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 organisation had policies for antimicrobial stewardship, minimising the use of restraint; and open disclosure. Staff demonstrated an awareness of how they support antimicrobial stewardship and minimising the use of restraint as part of consumer’s care and service delivery. The service had a nominated Infection Prevention and Control Leads who had completed training as required by the Department of Health. Practices were in place that demonstrated that the service had planned and is prepared for a potential outbreak.

The Assessment Team provided information with identified deficiencies in:

The monitoring and review of psychotropic medication, diabetes management, effective medication management; and the effective monitoring of consumer’s nutritional and hydration needs.

And while the service demonstrated an open disclosure process was utilised in managing the initial stages of a complaint; Management acknowledged the service did not consistently review all complaints to address the cause and take actions to improve consumer care and services.

The service has an inconsistent review processes and could not demonstrate investigative analysis regarding excessive call bell delays.

The Approved Provider’s response under this and other requirements, identified:

* The service had a governing Quality Framework that includes consumer feedback and engagement; safety; systems, standards and policies; safety culture; care innovation and workforce capability.
* Information provided included evidence that the service monitors call bell response times, and further actions committed to include the three month trial of a software program to support ongoing improvement of response times to call bells.
* The Approved Provider acknowledged there had been inconsistent data being reported in relation to chemically restrictive practice; and the service has implemented immediate action by confirming consumer diagnosis to ensure accurate reporting. Further actions taken by the service included a dedicated Quality and Compliance Officer has been assigned to the service to monitor clinical performance and provide guidance to the Clinical Manager to identify deficiencies and implement actions to address.
* The Approved Provider in its response stated that they do not dispute the comments that the service’s response to some feedback is neither timely nor comprehensive. The Approved Providers response also included actions the service planned to include support for the service Management by the organisation’s Operations Manager to ensure timely and consistent response to consumer feedback.

I have considered information in the site audit report and the Approved Provider’s response. While I acknowledge the immediate and planned actions undertaken and committed to by the Approved provider, at the time of the site audit, the lack of effective clinical monitoring and an inconsistent open disclosure processes, demonstrated the service did not have an effective clinical governance framework that monitored clinical care delivery. Therefore, it is my decision this requirement is Non-Compliant.

# Areas for improvement

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

* Requirement 1(3)(e) – Ensure each consumer is provided information to each consumer that is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.
* Requirement 3(3)(a) – Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; is tailored to their needs; and optimises their health and well-being.
* Requirement 3(3)(b) – Ensure the service effectively manages high impact or high prevalence risks associated with the care of each consumer.
* Requirement 4(3)(f) – Ensure consumers are receiving meals that are varied and of suitable quality and quantity.
* Requirement 6(3)(c) – Ensure the service takes appropriate action in response to consumer complaints, and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d) – Ensure the service reviews consumer feedback and complaints to improve the quality of care and services.
* Requirement 7(3)(a) – Ensure the service’s workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Requirement 7(3)(e) – Ensure the service has effective processes to ensure regular assessment, monitoring and review of the performance of each member of the workforce.
* Requirement 8(3)(c) – Ensure the service has an effective organisation wide governance system relating to information management, workforce governance, consumer feedback and continuous improvement.
* Requirement 8(3)(e) – Ensure the service works within a clinical governance framework that includes open disclosure and antimicrobial stewardship.