Regis Cranbourne

Performance Report

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**Commission ID:** 3619

**Provider name:** Regis Aged Care Pty Ltd

**Assessment Contact - Site date:** 16 February 2022 to 17 February 2022

**Date of Performance Report:** 5 April 2022

# Performance report prepared by

S Byers delegate of the Aged Care Quality and Safety Commissioner.

# 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

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(c) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(d) | Non-Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site 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 Assessment Contact - Site report received 29 March 2022.

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Assessment Team assessed one of the five specific requirements under this Quality Standard and found the requirement Non-compliant. Therefore, the Quality Standard is found Non-compliant.

##  Assessment of Standard 2 Requirements

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

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

The Assessment Team found the approved provider did not demonstrate care and services are reviewed regularly for effectiveness, when circumstances change and/or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team’s evidence included:

* Care plans and documentation were not up-to-date and did not meet the consumer’s current needs, goals and preferences. For example:
	+ The specialised nursing care plan for a consumer who experienced deterioration between December 2021 to January 2022 in relation to sudden weight gain and leg swelling (refer to Standard 3 Requirement 3(3)(d)) had not been reviewed or updated since 5 October 2021.
	+ Care documentation including Falls Risk Assessment Tool (FRAT) and falls risk care plan was not reviewed or updated in relation to a consumer’s fall in February 2022. While I note the service updated the consumers care plan during the assessment contact in response to feedback from the Assessment Team, the consumer’s care plan had not been reviewed since December 2021
	+ Care documentation did not reflect a change in fluid preferences for a consumer with specific dietary needs. Staff advised the consumer has been receiving the change in fluid for over a year, however it was not in line with their care plan.

While the service provided an updated sleep plan to the Assessment Team during the assessment contact to reflect a consumer’s use of bed rails, the previous date of review for the care plan was November 2019. I acknowledge the consumer had in place a recently reviewed restraint care plan that documented the use of bed rails, however the Assessment Team identified a lack of continuity of information across the consumers care planning documents that demonstrated irregular review of the consumers care planning documentation.

The approved provider refutes some of the Assessment Team’s evidence. While the approved provider acknowledges some minor documentation deficits, they argue these errors were rectified immediately and do not impact on the care being delivered to consumers.

While I acknowledge the service rectified some of the documentation deficits, I consider the documentation deficits identified by the Assessment Team demonstrate that care planning documentation is not regularly reviewed by the service or when an incident or change in care needs occur. It is my view the service’s failure to regularly review and update care documentation to ensure it meets each consumer’s current needs, goals and preferences does impact consumer care as evidenced by the deficits in the delivery of care identified across Standard 3.

The Assessment Team found a consumer was not reviewed by a medical practitioner after a fall with head strike. The approved provider ‘s response outlines it is not standard organisational policy for a medical practitioner review after every fall. I am satisfied the supporting evidence submitted by the approved provider demonstrates the consumer was reviewed by Allied Health the same day and monitored by staff for deterioration post fall.

In making my decision I have considered the Assessment Team report and the approved provider’s response. Based on the evidence available to me I consider at the time of the visit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with this Requirement.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Assessment Team assessed four of the seven specific requirements under this Quality Standard and found all four requirements Non-compliant. Therefore, the Quality Standard is found Non-compliant.

### Assessment of Standard 3 Requirements

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

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

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

The Assessment Team found the service did not demonstrate that each consumer receives personal and clinical care that is effective, safe and optimises their health and well-being. The Assessment Team identified deficits in care across several clinical areas including restrictive practices, pain management, skin integrity and wound management. For example:

* Care documentation demonstrated clinical staff did not follow the services Pain Management Policy for a consumer using as required pain analgesia. The Assessment Team identified pain charting and monitoring were not recorded and staff did not make a referral to the consumer’s medical practitioner or physiotherapist to review and manage the consumer’s pain.
* The Assessment Team observed a lack of follow up by staff for a consumer experiencing pain. While clinical staff were notified of the consumer’s pain, review of progress notes did not demonstrate the consumer’s pain had been assessed or managed. Management acknowledged the lack of follow up by staff.
* Wound charting was not completed daily as required for a consumer with a pressure injury. While strategies to manage the consumer’s pressure injury were documented in the consumer’s care plan, staff interviewed were unable to describe the strategies in place to manage the consumers pressure injury. The Assessment Team observed strategies were not being followed in line with the consumer’s care plan. The Assessment Team noted the consumer’s wound had deteriorated and documentation did not reflect the deterioration. Further deficits in documentation were identified including inconsistencies in wound measurements and evaluations.

While the service demonstrated it identified and monitored consumers subject to chemical restraint, it did not identify and monitor a consumer subject to mechanical restraint:

* The service did not identify that a consumer with a low low bed was subject to mechanical restraint. Documentation review demonstrated informed consent had not been obtained and this was supported by feedback from the consumers representative who was not aware of the mechanical restraint. Staff interviewed confirmed the consumer had a low-low bed, however management was not aware. The Assessment Team found documentation did not demonstrate the restraint was assessed or regularly reviewed.

The Assessment Team observed multiple consumers did not have their call bells within reach to call for assistance.

The approved provider did not dispute the Assessment Team’s findings under this requirement. In its response the approved provider included actions taken since the assessment contact which include:

* review of consumers’ assessment and care plans
* memos have been issued to clinical staff regarding the services Pain Management Policy and Falls Management Policy.
* education and training for clinical staff in restrictive practices, pain charting, neurological observations and documentation, including 1:1 training.
* falls prevention and restrictive practices training is scheduled to be delivered to all staff.

In making my decision I have considered the Assessment Team report and the approved provider’s response. Based on the evidence available to me I consider at the time of the visit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with this Requirement

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

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

While the service demonstrated it manages the risks relating to weight loss, diabetes and catheter management effectively, the Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with falls and behaviour management. The Assessment Team found deficits in the way these aspects of consumers’ care is delivered. For example:

* While strategies were documented in a consumer’s behaviour support care plan to manage self-harm behaviours, staff interviewed were unable to describe the strategies in place to manage the consumers behaviours. The consumer required half-hourly monitoring and staff were unable to demonstrate where monitoring is recorded. The Assessment Team observed strategies were not being followed in line with the consumer’s behaviour support care plan.
* For a consumer identified as a high falls risk (who had experienced several falls over the previous three months) the Assessment Team found documentation did not demonstrate contributing factors were effectively reviewed or trending of falls was undertaken. For example, regular and as-required psychotropic medication prescribed to the consumer were not recorded in the consumer’s documentation. While the consumer was reviewed by clinical staff and a physiotherapist after each fall, care plan reviews did not demonstrate consideration or trial of new strategies and guidance for staff to reduce the likelihood of falls in the future. The consumer’s care plan stipulated strategies to manage the consumer’s falls, including hip protectors and bed sensor. Staff interviewed were unable to describe the preventative strategies in place to manage the consumer’s falls. Representative feedback and observations by the Assessment Team confirmed strategies were not being followed in line with the consumers care plan.
* Neurological observations post fall were not completed in line with the service’s Falls Management Policy. Staff interviewed were unable to demonstrate understanding and application of the policy.

The Assessment Team’s review of documentation identified further deficits. For example, Falls Risk Assessment Tools and neurological observations were not correctly completed for all consumers sampled.

The approved provider did not dispute the Assessment Team’s findings under this requirement. In its response the approved provider included actions taken since the assessment contact which include:

* review of consumers’ assessment and care plans
* memos have been issued to clinical staff regarding the services Pain management Policy and Falls Management Policy.
* education and training for clinical staff in restrictive practices, pain charting, neurological observations and documentation, including 1:1 training.
* falls prevention and restrictive practices training is scheduled to be delivered to all staff.

In making my decision I have considered the Assessment Team report and the approved provider’s response. While I acknowledge the actions taken by the approved provider, I consider at the time of the assessment contact the approved provider did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. I am not satisfied the approved provider demonstrated that risks relating to falls and behaviours had been managed effectively. I find the service is Non-compliant with this Requirement.

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

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

The Assessment Team found consumer care documentation does not always reflect the identification of, and timely response to, changes in health status. For example, the Assessment Team identified the service did not identify and respond promptly to a change in physical function for a consumer who experienced sudden weight gain and leg swelling.

While the consumer was reviewed by their medical practitioner, documentation review did not demonstrate that further monitoring occurred such as weekly weights and fluid balance charting prior to the consumer’s transfer to hospital. Upon the consumers return from hospital, documentation review did not identify follow up or review by staff for nearly a month in response to the consumer’s leg swelling.

Review of the consumer’s care plan and representative feedback both identified the consumer experiences leg swelling. The Assessment Team noted the consumer’s care plan had not been reviewed in four months, however stipulated the consumer is to wear compression stockings daily to manage leg swelling. The Assessment Team observed the consumer was not wearing the compression stockings during the assessment contact.

Staff interviewed did not demonstrate an understanding of the consumers change in physical condition. While staff could describe how they would record the consumers fluid restriction, they were unable to locate the consumers fluid balance charting.

While the approved provider’s response did not specifically respond to the Assessment Team’s evidence under this Requirement it included action taken since the assessment contact including review of consumers assessment and care plans and the delivery of education and training to staff.

In making my decision I have considered the Assessment Team report and the approved provider’s response. Based on the evidence available to me I consider at the time of the visit the service did not demonstrate it effectively recognises and responds to the deterioration or change in a consumer’s health capacity or condition in a timely manner. I find the service is Non-compliant with this Requirement.

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

*Minimisation of infection related risks through implementing:*

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

While the Assessment Team found the service identifies and manages consumers infections and antibiotic prescriptions are minimised, the service did not demonstrate that standard and transmission based precautions to prevent and control infection are followed by staff to minimise infection related risks.

The Assessment Team observed poor infection minimisation practices during the assessment contact. On the first day of the visit the Assessment Team observed staff were not adhering to droplet precaution measures and wearing appropriate Personal Protective Equipment (PPE) when engaging with a consumer in isolation post exposure to COVID-19. Signage on the consumers door stated droplet precaution measures were in place and stipulated specific PPE requirements. The Assessment Team observed the consumers bedroom door open, ceiling fan on and several staff enter the consumers room without donning appropriate PPE. The Assessment Team raised their observations with management who addressed the concerns immediately and closed the bedroom door and turned off the fan. Management also issued communication to staff reminding of precaution and isolation requirements. Later during the assessment contact the Assessment Team observed the door was open again.

While most staff could describe infection control practices to minimise the transmission of infections, some staff did not demonstrate an understanding of the need for precautionary measures to minimise infection related risks, like those in place for the consumer in isolation.

Staff advised they had attended training in infection control and PPE. Review of training records aligned with staff feedback.

Clinical staff described strategies in place to minimise the risk of increasing resistance to antibiotics. Antimicrobial medication is monitored and tracked monthly. Care documentation identified consumers at risk of infections or those with infections. Medical practitioners are contacted and review consumers where an infection is suspected.

The service has an infection control policy and framework, COVID-19 outbreak management plan and antimicrobial stewardship (AMS) plan in place to guide staff practice.

The approved provider provided a response that included actions taken since the assessment contact including education and training delivered to staff.

In making my decision I have considered the Assessment Team report and the approved providers response. While I acknowledge the actions taken by management during the assessment contact to address the deficits, I consider the risk to consumers observed by the Assessment Team and supported by staff interviews at the time of the assessment contact is sufficient reason to consider the approved provider has not demonstrated compliance with the requirement. I therefore find this Requirement Non-compliant.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

An overall rating for this Quality Standard is not given as only one of the five specific requirements have been assessed.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(c) Compliant

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

The Assessment Team found consumers and representatives were satisfied appropriate action is taken in response to feedback and complaints. Representatives provided examples where the service addressed and resolved issues in an open and transparent way.

Management and staff demonstrated an understanding of open disclosure that was supported by examples where open disclosure principles were applied to manage recent complaints.

The Assessment Team reviewed resident and relative meeting minutes and a feedback and complaints quality audit report that aligned with consumer, representative and staff feedback.

The service has complaint handling and open disclosure policies in place to guide staff practice.

In making my decision I have considered the Assessment Team report. Based on the evidence provided I consider the approved provider has demonstrated compliance with this requirement. I therefore find this Requirement 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

The Assessment Team assessed two of the five specific requirements under this Quality Standard and found them compliant.

Based on the available evidence including the Assessment Team report and approved provider response, the delegate has found an additional requirement not assessed by the Assessment Team during the assessment contact Non-Complaint. Therefore, the Quality Standard is found Non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

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

The Assessment Team found the service at the time of the assessment contact was not adequately staffed to deliver and manage safe and quality care and services.

Mixed feedback was received from consumers and representatives about staff numbers at the service. Negative feedback primarily related to cleaning and use of agency staff. Two representatives provided feedback indicating their consumer’s care was adversely impacted by insufficient staffing numbers.

The Assessment Team identified several unfilled shifts from the service’s roster documentation for clinical, care and cleaning staff.

I note that both representatives who provided negative feedback relating to care as a result of staffing numbers, had also provided the feedback to management and were satisfied the service had addressed their concerns appropriately.

The approved provider refutes the Assessment Team’s findings. The approved provider submitted a comprehensive response that included clarifying information to the Assessment Team report as well additional materials including roster documentation, education for cleaning staff, consumer feedback forms, cleaning audits and correspondence confirming the booking of agency cleaning staff.

While I acknowledge that some consumers and representatives were not satisfied with staffing numbers, on balance I am satisfied the response from the approved provider addresses the concerns raised in the Assessment Teams report.

Evidence provided by the approved provider included:

* Roster documentation that demonstrates the service has established processes in place to effectively plan and manage workforce and replace shifts.
* Internal review of the service’s cleaning roster prior to the assessment contact that identified improvements including recruitment of additional cleaning staff, education and training for cleaning staff and interim engagement of agency cleaning staff.

The approved provider also provided evidence to demonstrate that agency cleaners were engaged and on site for the dates of the unfilled cleaning shifts identified by the Assessment Team.

Call bell documentation reviewed by the Assessment Team and referred to in the approved provider’s response demonstrated most call bells are responded to in a timely manner.

In making my decision I have considered the Assessment Team report and the response from the approved provider. On the balance of the evidence available to me, I consider the approved provider has demonstrated compliance with this requirement. I therefore find this Requirement Compliant.

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

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

The Assessment Team found consumers and representatives were satisfied that staff are kind, caring and respectful. Consumer feedback included examples where staff respect their culture and identity. The Assessment Team’s observations of staff interaction with consumers throughout the assessment contact aligned with consumer and representative feedback.

The service has in place polices on culture, diversity and respect to guide staff practice.

In making my decision I have considered the Assessment Team report. Based on the evidence provided I consider the approved provider has demonstrated compliance with this requirement. I therefore find this Requirement Compliant.

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

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

The approved provider has been found non-compliant with Standards 2 and 3 with deficits identified in staff competency to deliver safe and quality outcomes under the Quality Standards. For example, care documentation and review systems, falls prevention and management, behaviour management, pain management, skin integrity and wound management, infection control protocols, identifying and monitoring deterioration in a timely manner and understanding and identification of mechanical restraint.

The Assessment Team also identified that staff did not have current knowledge or could describe how they provide care in line with service policy. For example, Falls Management Policy and Pain Management Policy (See Standard 3 Requirements 3(3)(a) and 3(3)(b))

On several occasions the Assessment Team observed that delivery of care and services provided by members of the workforce was not consistent with consumers assessed needs, goals and preferences and risks associated with the care and service.

While the approved provider’s response to the Assessment Team’s report included evidence that did not directly address the Assessment Team’s findings under Standard 3 it did identify several areas where education will be delivered to support staff to competently perform their roles and improve the care outcomes for consumers. The areas of education include restrictive practices, pain management, falls prevention and neurological observations.

The Assessment Team identified deficits in the delivery of safe and effective clinical care across Standard 3. In its response the approved provider argues the deficits do not relate to workforce management but are better addressed by education and training of clinical staff. I agree with the approved provider’s position and consider the deficits in care identified by the Assessment Team are a result of staff capability.

In making my decision I have considered the Assessment Team report and the approved providers response. I consider at the time of the visit the approved provider did not demonstrate the workforce is appropriately trained and equipped to deliver the outcomes required by the Quality Standards. I consider the risk to consumers observed by the Assessment Team and supported by staff interviews where lack of knowledge about the delivery of care was demonstrated is sufficient reason to consider the approved provider has not demonstrated compliance with the requirement. I therefore find this Requirement 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.

**Standard 2, Requirement 2(3)(e)**

* Implement effective processes to ensure care planning documents are reviewed when circumstances change or when incidents occur.
* Establish and implement monitoring processes to ensure deficits in documentation are identified and addressed to ensure all information remains current and relevant and the requirements of Standard 2 are complied with on an ongoing basis.

**Standard 3 Requirements 3(3)(a), 3(3)(b), 3(3)(d) & 3(3)(g)**

* Ensure planned care that is tailored to each consumer’s needs is consistently delivered and best practice clinical principles applied for all consumers, specifically the management of restrictive practices, pain, skin integrity and wounds.
* Ensure effective identification and management of high impact and high prevalence risks associated with falls and behaviour management.
* Ensure staff have the skills and knowledge to manage high impact and high prevalent risks relevant to consumers living at the service.
* Ensure the service’s processes enable deterioration or change to be responded to in a timely manner.
* Ensure staff have the knowledge and skills to support processes relating to management of restrictive practices, pain, skin integrity and wounds, falls and behaviours.
* Implement and monitor effective infection control and minimisation practices.
* Educate and monitor staff to ensure adherence with infection control protocols.

**Standard 7 Requirement 7(3)(d)**

* Ensure staff are recruited, trained, equipped and supported to deliver safe and quality outcomes under the Quality Standards