St Paul's Lutheran Hostel

Performance Report

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**Commission ID:** 6157

**Provider name:** St Paul's Lutheran Homes Hahndorf

**Assessment Contact - Site date:** 13 July 2021 to 14 July 2021

**Date of Performance Report:** 16 September 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.

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| **Standard 1 Consumer dignity and choice** |  |
| Requirement 1(3)(a) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(b) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | 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 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 approved provider did not provide a response to the Assessment Team’s report
* the performance report following a Site Audit undertaken on 30 September 2020 to 2 October 2020.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Assessment Team assessed Requirement (3)(a) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The Assessment Team recommended the service meets Requirement (3)(a) in this Standard, as the service was able to demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(a). I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team were satisfied the service demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued. The Assessment Team provided the following evidence relevant to my finding:

* All consumers interviewed considered staff treat them with dignity and respect.
* Staff spoke about consumers’ life history, background, likes, dislikes and capabilities, and explained how this influences their day-to-day delivery of care. Staff were observed interacting with consumers in a calm and caring manner.
* Care planning documents show consumers’ social and emotional needs and preferences are recorded and used to inform lifestyle activities.
* Documentation and staff interviews demonstrated staff have undertaken training for dignity and respect, Aboriginal awareness, elder abuse and lesbian gay bisexual transgender and intersex (LGBTI).

Based on this evidence, I find the service to be compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as non-compliant as two Requirements have been assessed as non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(b) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

The Assessment Team recommended the service did not meet Requirements (3)(a) and (3)(b) in this Standard. In relation to Requirement (3)(a), the Assessment Team were not satisfied the service demonstrated safe and effective personal care is provided to each consumer, specifically with regard to the management of consumers’ diabetes, falls risks, nutrition and hydration, chemical restraint and bowel charting. In relation to Requirement (3)(b), the Assessment Team were not satisfied the service’s systems and processes ensured each consumer’s high impact risks were effectively managed, specifically in relation to post falls management and skin integrity.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service non-compliant with Requirements (3)(a) and (3)(b). I have provided reasons for my findings under the specific Requirements below.

### 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 were not satisfied the service demonstrated each consumer gets safe and effective personal and clinical care that is best practice, tailored to their needs and optimises their health and well-being. The Assessment Team provided the following evidence relevant to my finding:

Diabetic management

* Consumer A:
	+ Incident reports show the consumer did not receive their regular insulin on one occasion, as the service did not have stock of the required medication.
	+ The consumer reported staff do not know what to do when they have low blood glucose levels (BGLs) and there have been several instances when insulin was out of stock. The consumer reported following the most recent omission of their insulin, their diabetic regime was ‘disrupted for a couple of weeks, as they had to get back on track with their BGLs.’ The consumer confirmed they reported the issue to management.
	+ On the day of the incident, the consumer’s BGLs were monitored at 4:40pm and their 8:00pm regular insulin was not administered. The consumer’s BGLs were not monitored until the following morning.
	+ Management confirmed an investigation was initiated and the matter referred to the Australian Health Practitioner Regulation Agency (APHRA). Management stated they did have stock of the consumer’s regular insulin and the consumer has received an apology.
	+ The consumer’s diabetic management plan indicates their BGL reportable range is between 3mmol/L to 25mmol/L and BGL monitoring is to occur four times a day, however, the consumer’s medication chart stated their BGL reportable range is 3mmol/L to 30mmol/L and BGL monitoring is to occur three times a day.
* Consumer B:
	+ As a result of a medical officer (MO) review, the consumer’s insulin has been altered from regular to sliding scale. Documentation showed staff are not consistently recording the units of insulin administered to the consumer.

Falls management

* One consumer had two witnessed and one unwitnessed falls over a 30-day period in May and June 2021. Two of the falls resulted in skin tears.
* The consumer’s falls risk assessment tool (FRAT) and neurological observations documentation showed the service did not comply with it’s falls policy:
	+ The consumer’s FRAT was not updated following the last fall.
	+ Documentation showed for two of the three falls, neurological observations did not commence until one hour after the fall occurred. Documentation for one of the three falls was not provided to the Assessment Team.
* Care planning documentation showed the consumer was not reviewed by a physiotherapist after their increase in falls.

Nutrition and hydration

* The service commenced monitoring processes in response to one consumer’s decrease in food and fluid intake. For the 27-day period of food and fluid intake charting, the chart was only completed on 11 days and most of these entries only recorded one meal.

Restraint

* One consumer was prescribed an as required (PRN) antipsychotic medication to manage their agitation and aggression. At the time of the Assessment Contact, the medication had not been administered to the consumer.
* Documentation showed the service informed the representative that the consumer had been prescribed an antipsychotic medication, however, the service could not demonstrate the representative had an understanding of chemical restraint.
* Documentation did not show that non-pharmacological interventions were trialled prior to the medication being prescribed.

Bowel management

* Documentation showed the service responded and escalated care for a consumer showing signs of deterioration, however, there were three instances of inconsistencies in the consumer’s bowel charting. These included two occasions where no time was recorded, and one entry was incorrectly dated.

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 30 September 2020 to 2 October 2020, where it was found each consumer did not get safe and effective personal and clinical care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to diabetic management plans. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Procedures relating to hypoglycaemia management, continence care, wounds and restraint minimisation and management have been updated to guide staff practice.
* Diabetic management plans have been reviewed a MO.
* Twelve clinical staff have attended diabetic management training.
* Complex health folders have been updated to contain diabetic management plans for all consumers.

The provider did not submit a response to the findings and evidence documented in the Assessment Team’s report.

In coming to my finding, I have relied upon documentary evidence which demonstrates at the time of the Assessment Contact, the service did not ensure each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being.

I have considered that one consumer did not receive their regular insulin on at least one occasion, and the consumer’s BGLs were not monitored until the following morning after the incident had occurred. Additionally, the consumer’s BGL reportable range was inconsistently recorded in two documents used to guide staff practice. I have also considered that the units of insulin administered to one consumer on a sliding scale were not consistently recorded.

With regard to one consumer that had several falls, the service did not comply with it’s falls policy, as the consumer’s FRAT was not updated following the most recent fall and neurological observations did not always occur within the specified time frames.

I have also considered that bowel, and food and fluid charting was not consistently completed. With regard to one consumer’s decrease in food and fluid intake, the chart was only completed for 11 of the 27 days, with most days only recording one meal.

Regarding the consumer prescribed a PRN antipsychotic, while the medication had not been administered to the consumer, the service could not demonstrate the consent was informed and non-pharmacological interventions were trialled prior to the medication being prescribed.

Based on this evidence, I find the service 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.*

The Assessment Team were not satisfied the service demonstrated high impact or high prevalence risks associated with the care of each consumer were effectively managed, specifically in relation to skin integrity and post falls management. The Assessment Team provided the following evidence relevant to my finding:

Falls management

Evidence shows one consumer’s falls risk was not effectively managed, as falls strategies and interventions were not implemented until after the consumer had six falls, and neurological observations were not undertaken in line with the service’s procedure:

* Documentation showed the consumer had one witnessed and five unwitnessed falls over a three-day period. Of these six falls, four occurred within an eight-hour time frame. The consumer hit their head on the last fall and was subsequently transferred to hospital.
* For three of the six falls, documentation showed the frequency of neurological observations were not undertaken in line with the service’s procedure.
* Staff were unable to demonstrate that additional falls strategies or interventions were put in place following or during the eight-hour period that the consumer had four falls. The only strategy staff reported was ensuring the consumer had their call bell within reach.
* When the consumer returned from hospital, a physiotherapist assessment was undertaken, and strategies were implemented to mitigate the consumer’s risk of falls.

Skin integrity

Evidence shows one consumer’s pressure injuries were not managed in line with their care plan and the service’s procedures:

* Documentation showed at the time of the Assessment Contact, the consumer had four wounds, including one ongoing surgical wound, one unstageable pressure injury to their left heel and two stage two pressure injuries on their sacrum. All pressure injuries developed subsequent to the consumer commencing palliative care.
* The consumer’s palliative care plan states they are to be repositioned two-hourly during the day and overnight, or when observed to be in an uncomfortable position. For the 28-day period sampled, repositioning charts demonstrated repositioning did not occur in line with the consumer’s assessed needs on eight days. Of the eight days, the consumer was repositioned one time on one day, two times on one day, three times on four days, four times on one day and six times on one day.
* Documentation showed after this 28-day sample period, two stage two pressure injures were identified on the consumer’s sacrum.
* Two staff interviewed were aware the consumer was on a repositioning chart but were unable to demonstrate knowledge of repositioning times.
* Wound charting showed the service did not comply with it’s wound management procedure. For example:
	+ The consumer’s unstageable pressure injury to their left heel did not include sizing of the wound.
	+ Wound charting for the consumer’s sacral pressure injuries were recorded on the one chart. While some photographs of the wound included a ruler, the length of the wound was unclear and there was no ruler that measured the width.

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 30 September 2020 to 2 October 2020, where it was found high impact or high prevalence risks associated with the care of each consumer were not effectively managed, specifically in relation to psychotropic medication, fluid restrictions for medical conditions, weight loss or post falls management. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implementation of a weekly clinical team handover meeting to discuss high risk consumers and care plan changes.
* Removal of all bed rails.
* Ascertaining environmental restraint authorisations and undertaking assessments for consumers in one area of the service.
* Implementing a clinical risk register and online psychotropic medication spreadsheet to enable effective monitoring of high risk consumers.

The provider did not submit a response to the findings and evidence documented in the Assessment Team’s report.

In coming to my finding, I have relied upon documentary evidence which demonstrates at the time of the Assessment Contact, the service did not ensure high impact or high prevalence risks associated with the care of each consumer were effectively managed. I have considered that despite one consumer falling on five occasions over a three-day period, strategies or interventions to mitigate the risk of falling had not been reviewed or implemented. As a result, the consumer fell a sixth time and was subsequently transferred to hospital. I have also considered that a consumer was not being repositioned in line with their assessed needs, resulting in the development of two pressure injuries on their sacrum. Additionally, the service did not effectively monitor the consumer’s pressure injuries, as they were not measured and recorded in line with the service’s procedures.

Based on the above evidence, I find the service non-compliant with this Requirement.

# STANDARD 7 Human 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 Requirement (3)(b) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The Assessment Team recommended the service meets Requirement (3)(b) in this Standard, as the service was able to demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(b). I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 7 Requirements

### 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 were satisfied the service demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identify, culture and diversity. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives interviewed considered staff provide care and services to consumers in a respectful, kind and sensitive manner. One consumer and two representatives provided examples of how staff ensure consumers’ needs are met.
* Staff were observed interacting with consumers in a kind, calm, respectful, patient and caring manner. Staff did not appear rushed when providing care to consumers.
* Staff reported they always knock before entering consumers’ rooms to ensure their dignity is maintained when providing personal care.
* Complaints data showed two complaints about staff that were escalated and reviewed, with actions implemented to improve care and services.

Based on this evidence, I find the service to be compliant with Requirement (3)(b) in Standard 7 Human resources.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as non-compliant as one Requirement has been assessed as non-compliant. The Assessment Team assessed Requirements (3)(d) and (3)(e) in this Standard. All other Requirements in the Standard were not assessed at the Assessment Contact.

The Assessment Team recommended the service did not meet Requirement (3)(d) in this Standard, as the service did not demonstrate effective risk management systems and practices are in place to manage high impact or high prevalence risks associated with the care of consumers.

The Assessment Team recommended the service meets Requirement (3)(e), as the service demonstrated it’s clinical governance framework is effective in managing and controlling infections and antimicrobial resistance, minimising the use of restraint and practicing open disclosure.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service non-compliant with Requirement (3)(d) and compliant with Requirement (3)(e). I have provided reasons for my findings under the specific Requirements below.

## Assessment of Standard 8 Requirements

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

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

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

The Assessment Team were not satisfied the service demonstrated risk management systems and practices were effective in managing high impact or high prevalence risks associated with the care of consumers. The Assessment Team provided the following evidence relevant to my finding:

* The service’s risk management systems and practices were ineffective in the management of diabetes:
	+ The service’s policy does not support staff practice in effective monitoring for hyperglycaemia or general diabetic management.
	+ Staff and management did not demonstrate an understanding of the service’s policy for BGL monitoring and recording, as their explanation of how they record BGLs was inconsistent with the policy.
	+ The diabetic management care plan and medication chart for one consumer had conflicting BGL monitoring instructions.
	+ BGL ranges in the care plans of three consumers were not consistent with MO directives.
* While the service completed neurological observations following falls for two consumers, documentation was inconsistent, and the service’s policy was not followed.
* Documentation showed individual consumer details are not discussed in detail at the service’s high risk consumer meetings.
* Documentation showed the service undertakes clinical review and auditing of wounds, however, the review process failed to identify inadequacies in documentation and inconsistencies with the service’s policy.
* At the time of the Assessment Contact, the Assessment Team requested documentation to demonstrate how high impact or high prevalence risks associated with care of consumers is managed, however, none were provided.
* Management reported high impact or high prevalence risks associated with the care of consumers is managed through daily progress note and file reviews, weekly clinical handover meetings, clinical audits and psychotropic medication reviews.
* Management reported areas of risk are trended, reviewed and reported to the service’s risk management committee and governing body and include, medication, hospitalisations, wounds, psychotropic medication use, restraint, pressure area care, falls, infections, incidents, complaints, complex health risk management, care plan reviews, weight and consumer movements.

The service was found non-compliant with Requirement (3)(d) following a Site Audit conducted on 30 September 2020 to 2 October 2020, where it was found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of consumers. Staff practice was found to be ineffective in several high risk clinical areas, indicating a systemic issue and the service’s risk management framework had not identified these risks. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Management reported training has been provided to staff regarding high impact or high prevalence risks, however, no training records were provided.
* A dignity of choice policy and procedure has been developed.
* Documentation showed all staff have received a factsheet and training for the Serious Incident Response Scheme (SIRS).
* Documentation showed most staff have received dignity and respect training.

The provider did not submit a response to the findings and evidence documented in the Assessment Team’s report.

In coming to my finding, I have relied upon documentary evidence which demonstrates at the time of the Assessment Contact, the service’s risk management systems were not effective in managing high impact or high prevalence risks associated with the care of consumers. Specifically, the service failed to identify inadequacies in documentation and inconsistencies with implementation of the service’s policies, resulting in the ineffective management of consumers’ diabetes, falls and wounds.

Based on the above evidence, I find the service non-compliant with this Requirement.

### Requirement 8(3)(e) Compliant

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

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

The Assessment Team were satisfied the service demonstrated it’s clinical governance framework is effective in managing and controlling infections and antimicrobial resistance, minimising the use of restraint and practicing open disclosure. The Assessment Team provided the following evidence relevant to my finding:

Clinical governance

* Incident and risk management processes are guided by the service’s clinical care policy, clinical quality and risk management policy and procedure, governance framework procedure and a policy and procedures framework, and ensures quality care and services is provided and appropriate to consumer needs and preferences.

Antimicrobial stewardship

* The service’s antimicrobial and prescribing usage minimisation policy identifies the risk of antimicrobial overuse, actions and recommendations for staff.
* Three staff explained practical measures to reduce reliance on antibiotics and demonstrated an awareness of the risk of antibiotic resistance.
* Documentation showed staff have completed training for antimicrobial stewardship and representatives have been informed of the service’s policies and processes for the responsible use of antibiotics.

Open disclosure

* The service’s open disclosure policy and procedures provides instruction on open disclosure principals, responsibilities and processes.
* Three staff discussed how they respond to feedback or concerns in line with the open disclosure policy.
* Two consumers described the service’s approach to open disclosure and process when things go wrong.
* Documentation demonstrated an open disclosure process has been used to in response to complaints.

Minimising the use of restraint

* The service has a restraint policy and restraint minimisation and management procedure to guide staff practice in minimising the use of restraint.
* Staff demonstrated an understanding of how the service manages consumers that are environmentally restrained. Documentation showed the risks of environmental restraint had been discussed with consumers and representatives.
* Documentation showed the service regularly contacts representatives to discuss the use of psychotropic medication. The service did not have documentation signed by representatives acknowledging receipt and understanding of information, however, progress notes demonstrate that conversations were undertaken with representatives and an open disclosure information for medication management letter was supplied.
* While there was no evidence indicating non-pharmacological interventions were trialled prior to the prescription of PRN psychotropic medication to one consumer, there was no evidence to indicate the medication had been administered.

The service was found non-compliant with Requirement (3)(d) following a Site Audit conducted on 30 September 2020 to 2 October 2020, where it was found the service was unable to demonstrate an effective clinical governance framework, specifically in relation to deficiencies associated with understanding of antimicrobial stewardship, minimising the use of restraint and open disclosure. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implementation of a monthly review and analysis of infections.
* The service’s antimicrobial policy has been sent to general practitioners working with the service.
* Implementation of a self assessment tool for recording consumers receiving psychotropic medication. This tool is reviewed and reported monthly.
* An internal audit and review schedule has been introduced, with a focus on medication management, restraint and risk forms, psychotropic medication use and care plan review.
* While there was no evidence indicating non-pharmacological interventions were trialled prior to the prescription of PRN psychotropic medication to one consumer, there was no evidence to indicate the medication had been administered.

Based on this evidence, I find the service to be compliant with Requirement (3)(e) in Standard 8 Clinical governance.

# 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 3 Requirement (3)(a)

* Ensure effective processes are in place to ensure medication supply levels are sufficient to meet consumers’ needs.
* Ensure staff have the skills and knowledge to:
	+ appropriately monitor consumers under observation and ensure results are consistently recorded.
	+ report and document medication administered to consumers.
	+ recognise and minimise chemical restraint.
* Ensure records are accurate and reflective of each consumer’s care and service needs.
* Ensure policies, procedures and guidelines in relation to falls are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to falls.

Standard 3 Requirement (3)(b)

* Ensure staff have the skills and knowledge to:
	+ undertake effective post falls management, including assessment, review and monitoring of affected consumers.
	+ implement appropriate falls management strategies to minimise the risk of injury for consumers.
	+ recognise changes to consumers’ skin integrity, implement appropriate management strategies and initiate referrals to relevant health professionals.
	+ implement appropriate strategies and monitor effectiveness of strategies relating to wound management.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, including falls and wounds are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, including falls and wounds.

Standard 8 Requirement (3)(d)

* Ensure risk management systems and practices are effective in the management of diabetes, including hyperglycaemia and general diabetic management.
* Ensure risk management systems and practices effectively identify inadequacies in documentation and inconsistencies in policies and procedures.