Strathalbyn & District Aged Care Facility

Performance Report

14 Alfred Place
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Phone number: 08 8536 2426

**Commission ID:** 6181

**Provider name:** Barossa Hills Fleurieu Local Health Network Incorporated

**Review Audit date:** 12 October 2021 to 15 October 2021

**Date of Performance Report:** 26 November 2021

# Performance report prepared by

Alice Redden, 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

|  |  |
| --- | --- |
| **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** | **Non-compliant** |
| Requirement 2(3)(a) |  Non-compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **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) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Non-compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | 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) | Non-compliant |
| Requirement 7(3)(e) | 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 Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

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

* the Assessment Team’s report for the Review Audit; the Review Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved Provider’s response to the Review Audit report received 10 November 2021
* the Assessment Team report, Performance report and Re-accreditation decision for Site Audit conducted on 12 to 14 April 2021.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

The Non-compliance is in relation to Requirement (3)(e) as the service could not demonstrate information is provided to each consumer in a clear, accurate or timely manner to enable consumers or their representatives to exercise choice and decision making in relation to care and service delivery. I have provided reasons for my decision below in the relevant Requirement.

Consumers and their representatives interviewed confirmed consumers are treated with dignity and respect, can maintain their identity and culture, and live the life they chose. Consumers described staff as kind, caring and respectful. Representatives and consumers confirmed the service works with them to provide support to consumer in line with the consumers’ individual and unique needs.

Staff were observed to be respectful of consumers’ privacy and were observed to interact respectfully and considerately to each individual consumer. Staff described what was important to each consumer and how they support each consumer’s choices and support consumers to maintain personal relationships.

The service has systems to identify and assess consumers’ unique histories, cultural preferences and personal needs. Policies and procedures support culturally safe care and support consumers to make choices, including where risk is involved to continue living the life they chose.

## 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.*

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

*Care and services are culturally safe.*

### 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.*

### 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.*

The Assessment Team found the service did not demonstrate each consumer is provided information which is clear and easy to understand to enable the consumer to exercise choice. Relevant evidence included:

* One consumer’s representative was not satisfied staff communicate appropriately with the consumer who has verbal communication impairment to ensure the consumer understands and exercises choice. Staff were observed not communicating with the consumer during care interactions.
* One consumer with a hearing deficit did not have appropriate communication strategies in place to ensure information, particularly around diet choices, communicated effectively. The service had not identified the deficit or implemented strategies until following the Assessment Team raising the issue when the service implemented a communication book.
* One representative was not satisfied they were provided information from the service in a timely manner to assist in decision making and care of the consumer.
* Three consumer representatives were not satisfied with the information and communication in relation to a recent infection outbreak.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include creation of a site-specific contact list for consumer representatives for more timely communication and information sharing and review of individual consumer’s strategies and care plans for improved communication and information sharing to support choice and decision making.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate each consumer and consumer representatives were provided information in a timely manner or information communicated in a way to support consumers to exercise choice. The service had not identified the issues through their own assessment, feedback or monitoring processes to ensure ongoing improvement or to demonstrate an effective application and knowledge of this Requirement.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Non-compliance is in relation to Requirements (3)(a) and (3)(e) as the service could not demonstrate assessment and planning was reflective of consumers’ needs to inform the delivery of safe and effective care and services or was reviewed effectively following changes and incidents. I have provided reasons for my decision below in the relevant Requirement.

Consumers and consumer representatives interviewed confirmed they are partnered in the ongoing assessment and planning of consumers’ care and services. Consumers confirmed they have a say in the way care and services are delivered. Consumers and their representatives provided examples of being involved and informed of assessments, care plans and care plan review processes. Representatives confirmed they are informed when a consumer’s condition changes and are aware of the care plans.

The service has an assessment and care planning process, including completing comprehensive assessments on entry to the service which are to be reviewed six monthly and when changes and incidents occur. Assessments viewed involved other specialists and medical officers where required. Staff and management described the assessment and review processes and acknowledged some deficits in assessments and care plans had been identified which they were working on. However, the service did not demonstrate each consumers assessments and care plans were reviewed for effectiveness following changes or incidents and assessments and care plans were not consistently completed to reflect consumers clinical care including risks.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team found the service did not demonstrate consumers’ assessments and care plans, including consideration of risks informed the safe and effective delivery of care. Relevant evidence included:

* One consumer receiving respite care at the service did not have assessments and care plans completed with sufficient information to inform care. Clinical care needs, including urinary catheter care and diabetic management had not been completed with sufficient details to inform staff in managing the consumer’s needs.
* One consumer who entered the service for respite care and then became permanent did not have assessments and care plans completed in line with the service’s assessment process to inform the delivery of safe and effective care. Some assessments were not completed for months following entry to the service.
* Evidence from Standard 2 Requirement (3)(e) is also relevant to this Requirement, including two consumers with multiple falls and known high falls risks did not have appropriate updates of falls risk strategies in their care plans to inform staff on managing the risks.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include; review of handover and incident review and monitoring systems, creation of a complex care needs register, consultation with care staff on consumers strategies, review of consumers care plans and creation of a falls review group.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate the assessment and planning processes were effectively followed for all consumers to ensure assessment and planning was completed or reflective of consumers needs, including complex clinical needs and risks. The services own monitoring processes had identified some deficits but had not identified or addressed the deficits identified by the Assessment Team and improvements and actions had not been taken to address the deficits at the time of the review audit.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

### 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) 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 service did not demonstrate care and services are reviewed regularly for effectiveness when incidents or change occur. Relevant evidence included:

* One consumer had approximately nine falls in three months, the final fall resulting in a fracture. The documented falls strategies had not been updated or modified following the incidents to prevent further incidents. However, care staff providing care for the consumer were able to describe additional strategies used which were not documented in the care plan.
* One consumer had approximately 10 falls in five months. The documented falls strategies had not been reviewed for effectiveness or updated and modified. The consumer had also had multiple falls from a chair which had not resulted in a review, assessment or documented strategies to manage.
* One consumer did not have communication and sensory assessments reviewed for effectiveness or updated to reflect changes in the consumers needs.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include; review of handover and incident review and monitoring systems, creation of a complex care needs register, consultation with care staff on consumers strategies, review of consumers care plans and creation of a falls review group.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate regular reviews and reviews undertaken following changes and incidents were effective at identifying and ensuring appropriate changes and strategies were documented in consumers assessments and care plans.

Based on the summarised evidence above, I find the service Non-compliant in 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 Quality Standard is assessed as Non-compliant as three of the seven specific Requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), (3)(b) and (3)(g) as the service could not demonstrate each consumer’s personal care and clinical care was delivered in line with best practice, had high impact risks managed effectively or had antibiotics used in line with antimicrobial stewardship. I have provided reasons for my decision below in the relevant Requirement.

Consumers and consumer representatives interviewed considered consumers received personal care and clinical care that is safe and right for them. Consumers were satisfied they are provided personal care in line with their needs. Consumers were satisfied their pain was managed effectively and staff responded and provided appropriate assistance following incidents. Consumers and their representatives confirmed consumers have access to medical officers and other allied health specialists when required.

Consumer files confirmed consumers’ clinical needs, such as pain, wounds and behaviours are assessed, and charts are in place to monitor. Documentation confirmed medical officers, specialists and allied health are involved in the review and development of consumers’ care and appropriate referrals are made when changes or deterioration occurs. Consumers with weight loss or swallowing risks were regularly reviewed, monitored, managed effectively and referred to specialists when changes occur. Consumers requiring end of life care have supports in place to ensure their personal care and clinical care needs are met and their dignity and comfort maintained. Staff confirmed processes for managing consumers’ personal and clinical care in line with individual consumers’ needs and preferences.

### 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 service was found Non-compliant in this Requirement following a site audit in April 2021. The service undertook improvements to address the deficits in. Improvements implemented were effective at addressing the deficits in relation to behaviours, falls and pain management. However, the improvements were not effective at ensuring each consumer received best practice clinical care in relation to restrictive practice, wound management and personal care.

The Assessment Team found the service did not demonstrate personal and clinical care was provided to each consumer in line with best practice or in line with consumers needs. Relevant evidence included:

* Three consumers with challenging behaviours where psychotropic medications where used to manage did not have documented consultation, the medication interventions used were not documented in behaviour support plans and the effectiveness of the use of medication was not documented in line with best practice.
	+ Management acknowledged the deficits and stated they were in the process of updating documentation, including behaviour support plans to reflect new legislation but had not completed this for all consumers.
* One consumer whose preference is for female only care staff to attend during personal care did not have this preference documented or supported and male care staff had attended the consumer.
	+ Management stated they were unaware of the consumer’s preference and would meet with the consumer and their representative to discuss.
* Two consumers did not have wounds managed in line with best practice as evaluation of the wounds were not consistently completed to ensure monitoring of the wound size and deterioration.
	+ Management acknowledged the wound evaluations completed should be more comprehensive.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include; an audit of all behaviour care plans has been undertaken and where required care plans updated to included pharmacological strategies, a review of all restrictive practice authorisations and consultation documentation and a review and update of wound evaluation processes.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate each consumer was receiving personal care and/or clinical care in line with best practice and which was tailored to the consumer’s needs. Consumers with challenging behaviours where medications were used to manage did not have appropriate documentation in place to support, direct or demonstrate consultation and monitoring of the use of the medication in line with best practice. Consumers with wounds, while being attended in line with wound management plans did not have consistent wound evaluations completed to monitor the wound progression or deterioration in line with best practice. One consumer was not being delivered personal care which was tailored to their needs. The service’s own monitoring processes had not identified the deficits and where the service was aware documentation required improvement actions had not been taken to address the deficit.

Based on the summarised evidence above, I find the service Non-compliant in 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 found the service did not demonstrate each consumer’s high impact risks associated with clinical care and oxygen therapy were effectively managed. Relevant evidence included:

* One consumer with known risks associated with chronic obstructive airway disease and who was prescribed and required oxygen therapy to manage, did not have oxygen administered when required.
	+ The consumer was observed to be out of breath and confirmed staff had not assisted to administer oxygen.
	+ Medication chart with oxygen prescribed showed staff had not administered the oxygen when required.
	+ Clinical staff interviewed were unaware of the prescription and specialist directives to administer oxygen when required.
	+ The service updated the handover sheet following the deficit being identified.
* One consumer with known risks associated with chronic lower respiratory diseases was being administered oxygen therapy without it being prescribed by a medical officer.
	+ Staff interviewed were unaware the oxygen was not on the medication chart or the oxygen management plan was not appropriately or adequately completed to direct oxygen therapy.
	+ Progress notes indicate oxygen was being administered continuously and increased when required without a medical officer prescription.
* Evidence from Standard 2 Requirements (3)(a) and (3)(e) is also relevant in the Requirement as two consumers with multiple falls with known high falls risks did not have new documented strategies implemented to inform all staff on how manage the risks, including how to reduce or prevent ongoing injuries or incidents of falls. One consumer had approximately nine falls in three months with the last fall resulting in a fracture.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include; the implementation of a high-risk register monitoring consumers on oxygen therapy, staff education on oxygen management and implementation of a falls group to review, monitor, action and discuss consumers falls.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate the high impact risks associated with consumers requiring oxygen therapy to manage a clinical care need were not being managed effectively. The service did not demonstrate effective management of two consumers with known risks of falls to ensure all staff were informed of strategies to manage and prevent and reduce the risks of falls. The service had not identified the deficits through their own monitoring processes to ensure clinical care was being administered and risks managed effectively. Staff administering and managing oxygen therapy for consumers at risk did not have the appropriate directives and guidance to support the management of the risk and to administer the oxygen appropriately.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

### 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) Non-compliant

*Minimisation of infection related risks through implementing:*

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

The Assessment Team found the service did not demonstrate practices to promote appropriate antibiotic use for consumers with urinary infections. Relevant evidence included:

* Five consumers with urinary infections were prescribed and administered antibiotics not in line with the policy and procedure and not in line with promoting appropriate antibiotic use.
* All five consumers were commenced on antibiotic without waiting for results of pathology.
* Three of the five consumers did not have a specimen sent to pathology for testing prior to the commencement of antibiotics.
* Two of the five consumers did not show any signs of infection, however, were commenced on antibiotics.
* Clinical staff interviewed were unable to demonstrate a knowledge or application of alternative strategies and practice in line with appropriate antibiotic prescribing and antimicrobial stewardship.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include a review and update of the urinary infection management policy in alignment with antimicrobial stewardship and plan to educate staff on the updated policy once approved.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate an understanding or application of appropriate antibiotic use in line with antimicrobial stewardship. Staff practice was not in line with best practice or policies when considering antibiotic use to treat infections. Five consumers were commenced on antibiotics prior to pathology results being obtained, three did not have pathology tested and two consumers did not have symptoms of an infection. The service has reviewed and updated the policy, however, monitoring and evaluation will be required to ensure staff practice aligns.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

Consumers and consumer representatives interviewed confirmed consumers get the services and supports for daily living that are important for their health and well-being and enable them to do the thing they want. Consumers confirmed they enjoy attending a range of activities of their choice and are supported by staff to attend. Consumers confirmed staff support them to remain independent and support them in maintaining connections with their families, friends and community. All consumers interviewed were satisfied with the quality and variety of meals provided at the service.

The service has an effective system to assess and identify consumers’ emotional, psychological and social needs and preferences and has plans in place to support consumers in living the life they choose. An activities program with individual and group activities is in place to support consumers in attending a variety of activities of interest to them. Staff interviewed described individual consumers’ social and emotional needs and preferences and provided examples of how they support consumers where required.

Meal service observed, showed a calm environment with consumers enjoying their meals which were served in line with consumers preferences and dietary needs.

The service was found non-compliant in relation to Standard 4 Requirement (3)(b) following a site audit conducted in April 2021. The service demonstrated appropriate actions and improvements have been implemented to address the deficiencies and the service demonstrated they are now compliant with this Requirement. Further reasons are provided below in the relevant Requirement.

## 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.*

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

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

The service was found Non-compliant in this Requirement following a site audit in April 2021 as the service did not demonstrate appropriate supports for daily living to promote each consumer’s spiritual and religious needs.

The service demonstrated they have implemented the following improvements to address the deficits:

* A new role was created to support consumers’ spiritual and religious needs.
* A review and audit of consumers’ care plans and assessments was undertaken to ensure all consumers’ spiritual, religious, cultural and social needs were identified and captured.
* A new tool was implemented to consult and identify consumers’ needs and preferences.
* Education was provided to staff and activity instructions were developed and used to assist staff and volunteers in supporting activities.
* Care evaluations identified consumers requiring additional one-to-one supports which were implemented.
* Increased religious services and supports have been provided based on consumers’ needs and strategies are in place to support religious services during periods of lockdown.

Consumers and their representatives interviewed confirmed the improvements implemented and are satisfied the service supports consumers’ emotional, spiritual and psychological well-being.

Staff interviewed confirmed the improvements and provided examples of how they support individual consumers in line with new processes.

Based on the summarised evidence above, I find the service Compliant with this Requirement.

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Non-compliance is in relation to Requirement (3)(c) as the service could not demonstrate all furniture, fittings and equipment is safe and well maintained and suitable for consumers. I have provided reasons for my decision below in the relevant Requirement.

Consumers and consumer representatives interviewed confirmed consumers feel they belong and are at home in the service and feel safe and comfortable in the service environment. Consumers and their representatives confirmed consumers’ rooms and the service environment is clean and maintained. Consumers confirmed they have access to indoor and outdoor living environments.

The service has preventative and reactive cleaning and maintenance programs, including safety and clinical equipment checks conducted by external contractors. Documentation confirmed maintenance and environmental monitoring is completed and actions taken where required. Staff confirmed maintenance processes and provided examples of reporting maintenance issues.

## 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) Non-compliant

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

The Assessment Team found the service did not demonstrate it had systems in place for ensuring equipment used for the provision of care and services, including equipment owned by consumers was safe and well maintained. Relevant evidence included:

* Not all equipment used by consumers is routinely monitored or maintained for safety and suitability of use, including shower chairs and comfort chairs and walking frames owned by the consumer.
* One consumer was not assessed appropriately for safe equipment and chair use until following an incident.
* One consumer’s representative is not satisfied with the maintenance processes for addressing identified issues with consumer equipment.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include reviewing the preventative maintenance schedule, including all shower chairs, comfort chairs and other equipment and an audit of all furniture and equipment has now occurred.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate it had an effective process to ensure all furniture and equipment used by consumers was safe, suitable and well maintained.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

# STANDARD 6 COMPLIANT 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

The Quality Standard is assessed as Compliant as four of the four specific Requirements have been assessed as Compliant.

Consumers and consumer representatives interviewed confirmed they are encouraged, supported and feel comfortable providing feedback and making complaints. Consumers confirmed they would speak to staff if they had issues and are confident staff listen to them and help. Consumers and their representatives confirmed they can raise complaints and feedback verbally, through forms and through meetings. Consumers and their representatives are satisfied appropriate actions are taken when feedback and complaints are made.

The service has an effective complaints and feedback system, including policies and procedures to guide stakeholders on making, managing and monitoring complaints. The service maintains a complaint register to record and resolve complaints. Meeting minutes confirm complaints are raised, documented and actioned and where trends are identified improvements occur. Staff confirmed feedback mechanisms and support they provided to consumers in managing and resolving feedback and complaints.

## 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) Compliant

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

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Non-compliance is in relation to Requirements (3)(a) and (3)(d) as the service could not demonstrate sufficient staff numbers are deployed to enable the delivery of safe and quality care to consumers or that staff are all appropriately trained. I have provided reasons for my decision below in the relevant Requirements.

Consumers and consumer representatives interviewed confirmed consumers receive care and services from staff who are knowledgeable, capable and caring. Consumers described staff as kind, caring and respectful and are like family. Consumers confirmed staff are aware of their individual preferences and support their choices and treat them with respect. However, consumers and their representatives confirmed staff are very busy and there was not always enough staff resulting in consumers having to wait for assistance and care.

Staff were observed to interact respectfully with each consumer and treat consumers with dignity. Staff interviewed confirmed training and recruitment processes and that they are able to provide feedback and participate in performance reviews. However, majority of staff interviewed confirmed they do not always have sufficient staff or time to perform their roles.

The service has systems to recruit, train and monitor the performance and competence of staff. The service has a scheduled roster which includes appropriate skill mix of management, clinical, care, allied health, lifestyle and hospitality staff. However, review of the rosters and allocations shows vacant shifts are not always filled resulting in not enough staff to provide care and services to consumers.

## Assessment of Standard 7 Requirements

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

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

The service was found Non-compliant in this Requirement following a site audit in April 2021. The service undertook improvements to address the deficits in staffing including recruitment of additional clinical, care and lifestyle staff. However, the improvements have not been effective at ensuring there are sufficient staff to provide appropriate and timely care to consumers.

The Assessment Team found the service did not demonstrate the sufficient numbers of workforce are deployed to enable the delivery of safe and quality care and services to consumers. Relevant evidence included:

* Thirteen of the 23 consumers and/or their representatives interviewed were not satisfied there were sufficient staff to provide appropriate and timely care for consumers.
* Four consumers provided examples of not having their needs met in a timely manner, including:
	+ One consumer being incontinent due to waiting for the toilet.
	+ One consumer not being provided timely medication for pain relief.
	+ One consumer not being provided timely medication for shortness of breath.
	+ One consumer not having enough support for activities.
* Nine representatives provided examples of not being satisfied there were sufficient staff resulting in representatives being required to provide care, including personal care, toileting, supervision and assistance with meals.
* Seven of 13 staff interviewed confirmed staffing numbers are inadequate to ensure consumers are provided with appropriate care and services.
* Reviews of rosters and staff attendance records show vacant staff shifts are not always filled resulting in insufficient staff to provide personal care and clinical care.
	+ There were 68 unfilled shifts and 21 partially unfilled shifts on the morning shift in five weeks preceding the review audit.
	+ There were 63 unfilled shifts and 19 partially unfilled shifts on the afternoon shift in the five weeks preceding the review audit.
	+ There were four unfilled night shifts in the five weeks preceding the review audit.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced and continued actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include ongoing continuous recruitment for clinical care and lifestyle staff and weekly tracking of rosters and vacant shifts to monitor improvements and ongoing needs for recruitment.

The service has appropriate plans and actions in place to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate sufficient numbers of staff were consistently deployed to ensure consumers received appropriate and timely care and services. The service has had ongoing Non-compliance in this Requirement since April 2021 and improvements undertaken have not effectively addressed all deficits. Improvements in the response times to consumers needs and in the support of consumers lifestyle and activity needs have occurred. However, there are ongoing deficits in the provision of timely and appropriate personal and clinical care. Majority of consumers and their representatives interviewed were not satisfied there were sufficient staff to provide care to consumers. Staff interviewed and deficits in the filling of vacant shifts confirmed the ongoing issue of insufficient staff.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

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

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

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

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

The Assessment Team found the service did not demonstrate the workforce is appropriately trained to deliver the outcomes required by these standards. Relevant evidence included:

* Training records show mandatory and identified training is not completed by staff as required.
	+ Clinical and care staff had not completed falls prevention and medication management training as required.
	+ Clinical and care staff had not completed restrictive practices training as required.
* Two consumers representatives stated dissatisfaction with the skills of staff.
* One staff was dissatisfied with the training during onboarding.
* Monitoring of training attendance is not effective at ensuring staff complete mandatory and additional identified training, including through updating and review of training attendance records and review and updating of individual staff training and evaluation records.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include ongoing training of all staff and management conducting training on site to improve the attendance and completion rates of required training.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate all staff had received training as required. The deficits in staff training relate directly to other deficits identified in Non-compliant requirements demonstrating staff do not have the training to perform their roles, specifically in relation to falls, medications and restrictive practices. Monitoring systems were not effective or maintained to ensure education and staff training was effective at ensuring staff had the training required to deliver the outcomes required by these Standards

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

### Requirement 7(3)(e) Compliant

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

# 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 two of the five specific Requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(c) and (3)(e) as the service could not demonstrate effective organisational governance systems in relation to regulatory compliance and clinical governance in relation to antimicrobial stewardship. I have provided reasons for my decision below in the relevant Requirement.

Consumers and their representatives interviewed consider the organisation to be well run and the organisation partners the consumers in the delivery of care services and improvements. Consumers confirmed they feel safe and are provided opportunities for feedback in relation to how the service is run. Consumers and their representatives confirmed they are satisfied with the management of consumers risks and incidents.

The service has organisational governance systems which are overseen by the Board who are accountable for the delivery of care and services. The service has effective information systems, financial governance and risk management systems. The service has systems to report and prevent elder abuse and has a clinical governance framework to direct and guide the delivery of care. However, not all governance systems are implemented effectively by the service. Regulatory compliance systems are not effective when new legislation is implemented at the service. Continuous improvement and workforce governance systems have not been effective at addressing the ongoing Non-compliance identified at the site audit in April 2021.

The service was found Non-compliant in relation to Standard 8 Requirement (3)(d) following a site audit conducted in April 2021. The service demonstrated appropriate actions and improvements have been implemented to address the deficiencies and the service demonstrated they are now compliant with this Requirement. Further reasons are provided below in the relevant Requirement.

## 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.*

### 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.*

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

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

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

The service was found Non-compliant in this Requirement following a site audit in April 2021. The service undertook improvements to address the deficits in regulatory compliance in relation to the mandatory reporting of incidents, serious incidents and minimising restraint. Improvements implemented were effective at addressing the deficits in relation to reporting of serious incidents, however they were not effective at ensuring the service was complying with legislation in relation to restrictive practices.

The Assessment Team found the service did not demonstrate effective organisational governance systems in relation to regulatory compliance, specifically in relation to implementation of new legislation for management of restrictive practices. Relevance evidence includes:

* Three consumers sampled who are administered chemical restraint, medication for the management of behaviours, did not have behaviour plans reflective of legislative requirements, including no evidence of informed consent, no documented strategies of hen to use the medication and no monitoring of the use of the medication.
* Not all staff have attended or completed required training in relation to restrictive practices and the legislative changes.

The Assessment Team recommended the service had effective organisational governance systems in relation to continuous improvement and workforce governance. However, based on evidence throughout the report I find the service did not demonstrate effective governance systems to ensure ongoing continuous improvement or effective workforce governance. Relevant evidence includes:

* Evidence and outcomes in Standard 7 demonstrate the service does not have an effective workforce governance system. While the service has a system to recruit, plan, roster and train staff, sufficient staff are not deployed to ensure all shifts are filled to provide care and services required for consumers. Systems are not effective at monitoring and ensuring all staff attend required training where additional training needs are identified.
* Evidence throughout the report, specifically in relation to the Requirements found Non-compliant and particularly Standard 3 Requirement (3)(a) and Standard 7 Requirement (3)(a) where the Non-compliance is ongoing since April 2021, demonstrate the service does not have an effective continuous improvement system. The service has a system which records improvements, and consumer feedback is considered in improvement activities. However, the service’s monitoring systems are not effective at identifying deficits requiring ongoing and continuous improvement. Improvements implemented following deficits identified by an Assessment Team at a site audit in April 2021 have not been effectively implemented or evaluated to ensure the improvements are imbedded and effective at addressing the deficits and ensuring the service complies with the Quality Standards. The service has implemented a new auditing and monitoring system to identify improvements, while some improvements have been identified, other deficits were not identified, and the service has not evaluated the effectiveness of the new system.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include; a review of all behaviour support plans, all consumers behaviour support plans have been updated, education for staff on following up medication use and processes to ensure all incidents are reviewed within seven days.

The service has appropriate plans and actions in place to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate organisational governance systems were effective, specifically in relation to regulatory compliance, workforce governance and continuous improvement. While the service has systems in place in relation to regulatory compliance, they are not implemented effectively, and staff practice is not in line with the policies and procedures. Deficits were identified in the implementation of a new legislative requirement in April 2021 in relation to the reporting of serious incidents. Deficits again were identified in the implementation of new legislative requirements at the review audit in October 2021, in relation to restrictive practices. The service’s monitoring and implementation of continuous improvements to address previous non-compliance has not been consistently effective ensure the service returns to compliance against the Quality Standards. The service’s monitoring and governance of the workforce has not been effective at ensuring sufficient staff or in addressing the deficits in filling vacant shifts. While the service has demonstrated a commitment in reviewing, improving and addressing the deficits, the systemic issues have not been addressed resulting in ongoing deficits occurring in the implementation of systems at the service.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

### 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.*

The service was found Non-compliant in this Requirement following a site audit in April 2021 as the service did not demonstrate effective risk management systems in relation to managing high impact or high prevalence risks and managing and preventing incidents, including the use of an incident management system.

The service demonstrated they have implemented the following improvements to address the deficits:

* A new clinical risk management procedure was developed and implemented.
* Training and support was provided to clinical and care staff in relation to the new risk management procedure and in relation to managing behaviour risks and incidents.
* Appropriately qualified clinical staff were recruited and commenced in senior roles, including in the monitoring and management of incidents and behavioural risks.
* A process for the delegation and facilitation of leadership to strengthen clinical governance oversight and management of risks was implemented.

Documentation, including incident registers, incident reports and meeting minutes, demonstrated the service is effectively managing, monitoring, recording, reporting and responding to risks and incidents in line with the reviewed processes and improvements implemented.

Staff interviewed confirmed the improvements and provided examples of managing risks, incidents and reporting incidents in line with the service’s processes and risk management framework.

Based on the summarised evidence above, I find the service Compliant with this Requirement.

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

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

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

The Assessment Team found the service did not demonstrate effective clinical governance frameworks in relation to antimicrobial stewardship. Relevant evidence included:

* Practices to promote appropriate prescribing and use of antibiotics were not in line with the antimicrobial stewardship principles.
	+ Five consumers were commenced on antibiotics not in line with antimicrobial stewardship, including not being symptomatic and not having pathology tests or pathology results.
* The service’s policy and procedure did not provide sufficient information to guide staff practice in relation to antimicrobial stewardship, specifically in relation to urinary tract infections.
* The service’s infection report and analysis identified increase and predominance of urinary infections with antibiotic use. However, they have not been effective at identifying the deficits in practice to ensure the issue is addressed.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and have commenced actions to address the deficits and have committed to continuous improvement to return to compliance. Improvements undertaken include updating the urinary tract infection management policy to align with antimicrobial stewardship and provide staff relevant training.

The service has taken appropriate actions to address the deficits identified by the Assessment Team at the review audit. However, at the time of the review audit the service did not demonstrate the clinical governance system was effective at ensuring staff practice and knowledge aligned with antimicrobial stewardship or that effective procedures were in place to support staff or monitor staff practice.

Based on the summarised evidence above, I find the service Non-compliant in this Requirement.

# 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 1 Requirement (3)(e): Ensure information is communicated to consumers and their representatives in a clear, appropriate and timely manner to support consumers to exercise choice.
* Standard 2 Requirement (3)(a): Ensure assessment and planning is completed in line with the assessment and planning processes to inform the delivery of care, including consumers on entry or respite to the service have completed and comprehensive assessments.
* Standard 2 Requirement (3)(e): Ensure assessments and care plan strategies are reviewed for effectiveness and updated when changes or incidents occur and impact consumers’ needs.
* Standard 3 Requirement (3)(a): Ensure personal care and clinical care is delivered in line with best practice and is tailored to consumers needs, including in relation to restrictive practices medications and wound management.
* Standard 3 Requirement (3)(b): Ensure high impact and high prevalence risks associated with the care of consumers is identified, assessed and has documented strategies to guide staff in effectively managing the risks, including in relation to oxygen management and falls.
* Standard 3 Requirement (3)(g): Ensure staff practice in relation to the management of consumers with infections and their antibiotic use is in line with antimicrobial stewardship.
* Standard 5 Requirement (3)(c): Ensure all furniture and equipment used by consumers is monitored and maintained and suitable for consumer use.
* Standard 7 Requirement (3)(a): Ensure there are sufficient numbers of staff deployed to provide safe and quality care and services to consumers and ensure there is sufficient processes in place to fill vacant staff shifts.
* Standard 7 Requirement (3)(d): Ensure all staff complete mandatory and additional identified training as required and training attendance is monitored.
* Standard 8 Requirement (3)(c): Ensure changes to legislative requirements are implemented effectively, including in relation to restrictive practices. Ensure continuous improvement and workforce governance systems are monitored for effectiveness.
* Standard 8 Requirement (3)(e): Ensure policies, procedures and staff practice are aligned and support antimicrobial stewardship.