Wheatfields Incorporated

Performance Report

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**Commission ID:** 6841

**Provider name:** Wheatfields Incorporated

**Site Audit date:** 30 November 2021 to 2 December 2021

**Date of Performance Report:** 8 March 2022

# Performance report prepared by

Janine Renna, 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** | **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) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | 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) | Compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Non-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** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | 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) | 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) | 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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Site Audit report received 4 January 2022.

# STANDARD 1 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 compliant as six of the six specific Requirements have been assessed as compliant.

Overall, consumers considered they are treated with dignity and respect, can maintain their identity and live the life they choose. Consumers said they are supported and encouraged to do things for themselves and provided examples of how their privacy is maintained by staff, how their care and services is culturally safe and how they are supported to exercise choice, take risks and maintain relationships.

Staff spoke about consumers in a respectful manner, described their life history, background and preferences, and provided examples of how they ensure care and services are culturally safe. Staff explained how they maintain consumers’ privacy and support consumers to exercise choice and take risks.

Sampled care plans documented consumers’ cultural needs and preferences and were reflective of how they want their care to be delivered. Care plans provided strategies for staff to support consumers in taking risks.

Documentation, observations and interviews with consumers, representatives and staff, demonstrated consumers are provided information to assist in making choices regarding meals, activities and their personal and clinical care.

Based on this evidence, I find the service compliant with all Requirements in Standard 1 Consumer dignity and choice.

## 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) Compliant

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(b) and (3)(e) in Standard 2, as the service was unable to demonstrate:

* assessment and planning informs the delivery of safe and effective care;
* each consumer has their current needs, goals and preferences identified and documented; and
* consumers’ care is reviewed regularly for effectiveness and when circumstances change.

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

In relation to all other Requirements in this Standard, the Assessment Team found consumers confirmed they feel like partners in the ongoing assessment and planning of their care and services. Consumers and representatives said the service works with them to develop a safe and effective care plan and they are informed about the outcomes of assessment and planning.

Staff demonstrated an understanding of assessment and planning processes and provided examples of how assessment and planning outcomes are communicated to consumers, representatives and external providers of care.

Care planning documents were observed to be accessible to consumers, representatives and staff.

Based on this evidence, I find the service to be compliant with Requirements (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

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

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

The Assessment Team was not satisfied the service demonstrated 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. While the Assessment Team found the service has policies and procedures to guide staff in undertaking charting and assessments to identify risk, they were found to be ineffective, as risks to sampled consumers’ health and well-being had not been identified, assessed, documented and used to inform the delivery of care and services. The Assessment Team provided the following evidence relevant to my finding:

Pain management

* Documentation demonstrated Consumer A experienced four episodes of pain in the four weeks preceding the Site Audit, however, a pain assessment and pain management plan had not been undertaken and documented since the consumer entered the service six months prior.
	+ Monitoring process, such as consumer of the day reviews, did not identify the lack of assessment and pain management plan, despite the consumer being noted to have pain in their leg and shoulder.

Infection status

* Two staff informed the Assessment Team that Consumer D was being treated for a viral infection.
	+ Two progress note entries demonstrate staff requested confirmation of the status of infection, however, care planning documentation did not communicate whether the consumer had an infection, associated risks or how care should be delivered.
	+ Staff were unable to describe management strategies for the infection or confirm whether it was still active.

Diabetes management

* While Consumers D and E had diabetic management plans, the plans did not detail the frequency of blood glucose level (BGL) monitoring, range for BGL parameters or action to take if BGLs are outside parameters.
	+ Consumer D had their BGL range documented in charting, however, Consumer E did not.
	+ This gap in relation to Consumer E was self-identified, however, at the time of the Site Audit the consumer’s diabetic management plan had not been updated to include their BGL range.
	+ Two staff could not relay Consumer E’s BGL range and reported they would refer to their diabetic management plan and charting for this information.
	+ The service does not have a policy or procedure in relation to diabetes management.

Continence management

* Care planning documentation for Consumer F identifies their urinary incontinence and includes strategies to manage the risk. The most recent continence assessment for Consumer F was undertaken as part of entry processes.
* For a 29 day period sampled, documentation demonstrated the consumer required an additional continence aid on 16 occasions, however, additional continence assessments were not initiated.

Restrictive practices

* Assessment and planning processes did not document information required under the *Quality of Care Principles 2014* for three consumers observed to be restrained.
	+ Consumer B did not have a restraint authorisation form, risk assessment or behaviour support plan in relation to the use of bed rails.
	+ Risk assessments showed the risks of restraint had been communicated and informed consent obtained for the three types of restraint used in relation to Consumer C. However, assessment and planning processes did not document how the restrictive practices are to be used, their duration, frequency and monitoring requirements.
	+ Risk assessments for Consumer G did not detail monitoring requirements, however, documentation demonstrated staff were undertaking frequent two hourly checks on the consumer.
* Management reported behaviour support plans had not been completed for all consumers, as the designated staff member responsible for this task has been required to work on the floor due to staff shortages. Management were unable to provide a date for when the behaviour support plans were likely to be completed.

Inconsistent information

* Documentation for sampled consumers contained inconsistent information to guide staff practice in the delivery of care and services.
	+ Care planning documentation and handover information contained conflicting directions in relation to Consumer G’s mobility and transfer needs.
	+ Care planning documentation for consumer B contained conflicting information in relation to the amount of oxygen they are to receive and does not guide staff on the management of oxygen therapy. Additionally, the consumer’s risk assessment states they self‑administer medication, however, staff reported the consumer’s medication is administered by staff.

The provider did not agree with some aspects of the Assessment Team’s findings and maintains that 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 provider’s response includes information and evidence to refute assertions made by the Assessment Team.

Pain

The provider asserts there was an incorrect assumption that ‘consumer of the day’ was to review assessments and care plans. The provider’s response includes a template, which demonstrates consumers’ pain and interventions are reviewed as part of this process.

The provider’s response includes Consumer A’s Physiotherapy assessment/plan, which identifies the consumer’s pain, including leg and shoulder, and includes pain management strategies.

Infection status

The provider asserts that the Assessment Team has made an assumption in relation to Consumer D’s infection status. The provider’s response does not include evidence to address whether the consumer had a viral infection at the time of the Site Audit and if so, that assessment and planning processes were effective in informing the delivery of care.

Diabetes management

The provider’s response states that BGL reportable ranges for Consumer E were available to staff through progress notes and includes a copy of progress notes to support this claim.

The provider disagrees with the Assessment Team’s findings that Consumer D’s diabetic management plan did not contain a range for BGL monitoring. While the provider’s response includes a copy of Consumer D’s diabetic management plan to support this claim, the document provided was created after the Site Audit had concluded.

Continence management

The provider’s response states Consumer F’s continence care was effectively and appropriately managed and includes a continence assessment completed 45 days after entry and 5 days prior to the period sampled by the Assessment Team. This continence assessment details the consumer’s continence history, frequency, type of incontinence, relevant behaviours and management strategies.

Restrictive practices

The provider asserts a restraint authorisation form is not required for Consumer B, as their bed rails are to assist with movement and mobility. The provider’s response includes a risk assessment for the consumer’s bed rails, however, it is dated after completion of the Site Audit.

In relation to Consumer C, the provider disagrees with the Assessment Team’s findings and asserts the consumer’s risk assessment identifies the measures in place to support their decision to use restrictive practices. The provider’s response includes the consumer’s risk assessment and behaviour evaluation demonstrating restrictive practices have been documented.

Inconsistent information

The provider asserts Consumer G’s mobility information was communicated in numerous documents and due to the strong communication between staff, the consumer’s care was not compromised. The provider’s response does not include any evidence to refute the Assessment Team’s findings that documentation included different directives in relation to the consumer’s mobility and transfer needs.

The provider’s response states Consumer B’s care plan is consistent with handover documents, however, the evidence provided to support this claim was created after the Site Audit had concluded. The provider asserts the consumer self-administers medication that is prepared by staff, however, no evidence was provided to support this claim.

The provider’s response describes actions taken to address deficiencies identified by the Assessment Team, including but not limited to, updating policies and procedures, providing staff with appropriate training, and updating assessments and care planning documentation.

I acknowledge actions taken by the service to rectify issues identified by the Assessment Team, however, I find at the time of the Site Audit, assessment and planning did not consider risks to consumers’ health and well-being to inform the delivery of safe and effective care and services. In coming to my finding, I have considered the following information:

Pain

While Consumer A did not have a pain assessment or pain management plan completed from date of entry, documentation demonstrates the consumer’s pain was identified, assessed and planned for by the physiotherapist. There was no evidence indicating the consumer’s pain is unmanaged, as documentation suggests current pain management interventions were effective.

Infection status

At the time of the Site Audit, two staff reported Consumer D was being treated for a viral infection, which was not reflected in care planning documentation to communicate the risk and direct staff in the delivery of care. Staff were unable to describe management strategies for the infection or confirm whether it was still active.

Diabetes management

At the time of the Site Audit, two consumers’ diabetic management plans did not include the frequency of BGL monitoring, range for BGL parameters or action to take if BGLs are outside parameters.

While the medical officer recorded Consumer E’s BGL reportable ranges in the progress notes, their diabetic management plan was not subsequently updated to include medical officer directives. Additionally, staff reported they would refer to consumers’ diabetic management plan, not progress notes, to guide their delivery of care.

The Assessment Team’s report indicates the organisation does not have policies or procedures in relation to diabetes management. I have considered the evidence in my findings for Requirement (3)(e) in Standard 8 Organisational governance, as the core deficiency relates to the organisation’s clinical governance framework.

Continence management

Evidence included in the provider’s response indicates one consumer’s regular episodes of incontinence was known by staff and assessments were completed the day of and 45 days after entry. Despite the consumer requiring additional continence aids on 16 occasions, assessments were comprehensive and inclusive of information to guide staff in providing safe and effective care and services.

Restrictive practices

While the use of bed rails for Consumer B is used to assist with movement and mobility, and not to manage or influence the consumer’s behaviour, at the time of the Site Audit, a risk assessment had not been undertaken to evaluate the risk of bed rails and guide staff practice in providing safe and effective care.

In relation to Consumer C, while the service obtained informed consent for the use of restrictive practices, documentation showed the service did not document how the restrictive practices are to be used, their duration, frequency and monitoring requirements, as required under the *Quality of Care Principles*.

In relation to Consumer G, I acknowledge that risk assessments guide staff practice in relation to how restrictive practices are to be used, the risks of restraint, management strategies and review requirements, however, monitoring requirements were not detailed to ensure the consumer’s safety is maintained.

The Assessment Team’s report indicates behaviour support plans had not been completed for all consumers, due to staff shortages. I have considered the evidence in my findings for Requirement (3)(a) in Standard 7 Human resources and Requirement (3)(e) in Standard 8 Organisational governance, which reflect the core deficiencies.

Inconsistent information

While there was no evidence care had been compromised, documentation used to guide care and service delivery for two consumers was inconsistent and did not to ensure care and services is provided safely and in line with their needs and preferences.

Based on the evidence summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

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

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

The Assessment Team found some care plans were individualised and reflected the needs, goals and preferences of consumers, in relation to their personal and advance care. However, the Assessment Team was not satisfied assessment and planning identifies and addresses all consumers’ current needs, goals and preferences, including end of life planning. The Assessment Team provided the following evidence relevant to my finding:

End of life planning

* Documentation demonstrated the service’s processes had not been followed for three consumers nearing end of life. For example:
	+ While all three consumers had palliative care plans, they contained limited information in relation to goals of care and no information in relation to emotional, spiritual and clinical or personal needs. Only one of the three sampled consumers had end of life wishes documented.
	+ Management strategies were not included in palliative care plans and end of life pathways had not been completed for all sampled consumers.
	+ Management reported the end of life care pathway should have been completed for all three consumers and acknowledged this gap had not been identified via monitoring processes.
	+ The one representative reported satisfaction with the consumer’s care and confirmed end of life wishes had been discussed and addressed.
* A palliative care audit was conducted prior to the Site Audit and included a sample of 13 sampled consumers, none of whom were receiving palliative care. The palliative care audit returned a score of 86% and gaps identified were consistent with those identified by the Assessment Team in relation to the three sampled consumers.

Identified needs and preferences

* One consumer’s care plan directs staff to apply compression bandages each morning, however, the consumer and two staff confirmed they are refused.
	+ Management acknowledged the consumer’s care plan had not been updated.
* Incident reports for one consumer identified as a high risk of falls record they prefer to sleep in a recliner chair or lounge at night, however, this is not documented in their care plan.
	+ Two staff interviewed were knowledgeable of the consumer’s preferred sleeping habits.
	+ Management acknowledged the consumer’s preferences had not been captured in their care plan.

The provider did not agree with the Assessment Team’s findings and maintains that assessment and planning captures the needs and preferences of consumers. In relation to end of life planning, the provider asserts end of life pathways were commenced where necessary, the sampled consumers’ needs, goals and preferences were known and there was no adverse outcome for any consumers. The provider’s response includes the following evidence to refute the Assessment Team’s assertions:

* End of life pathways for two of the three sampled consumers to support they had been completed when palliating.
* A medical officer’s progress note dated five days prior to the Site Audit to support the consumer was ‘not quite palliative’ and as a result, did not require an end of life pathway.
* Spiritual and cultural needs assessments for the three sampled consumers, demonstrating their needs and preferences had been captured.
* Palliative care symptom form for one of three sampled consumers to demonstrate care need requirements were identified and documented.
* In relation to the consumer who refuses compression stockings, a behaviour evaluation to demonstrate their refusal of care is documented and strategies implemented. The provider’s response states that the consumer’s care plan will remain unchanged, as it is an identified clinical need.
* A behaviour management plan to demonstrate one consumer’s preference to sleep on a recliner was known and documented.

The provider’s response includes a copy of the service’s Continuous improvement plan to demonstrate some of the deficiencies identified by the Assessment Team have either been addressed or are part of the plan. These actions include, but are not limited to, staff training, reviewing audit processes and updating consumer information.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and provider’s response, I find at the time of the Site Audit, assessment and planning did not identify and address all consumers’ current needs, goals and preferences, including end of life planning.

In coming to my finding, I have considered that an end of life pathway for one of three consumers had not been completed in line with the organisation’s policy. While the provider’s response included evidence that the consumer was ‘not quite palliative’ five days prior to the Site Audit, there is no evidence demonstrating the consumer had not deteriorated from that time until commencement of the Site Audit.

I have also considered that while three consumers had palliative care plans, they contained limited or no information and strategies to guide staff in addressing consumers’ needs goals and preferences in relation to their emotional and spiritual, clinical and personal care. The provider’s asserts the consumers’ spiritual and cultural needs had been captured, however, the evidence provided is generic and does not address those needs and preferences specific to end of life care.

In relation to the consumer who refuses compression stockings, while their refusal of care is documented in their behaviour evaluation, it relates to generic refusal of care and there is not specific information to guide staff in relation to the refusal of compression stockings.

With regard to the consumer who prefers to sleep on their recliner chair or lounge at night, I have considered that this information is documented in the consumer’s behaviour management plan, staff know about it and there is no evidence indicating the consumer is not receiving care in line with their preferences.

Based on the evidence summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

### 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 was not satisfied the service demonstrated care and services are reviewed regularly for effectiveness or in a timely manner following changes in circumstances or incidents which impact the needs, goals and preferences of consumers. Specifically, the Assessment Team found care plan evaluations were not up-to-date and care and services had not consistently been reviewed following identification of wounds. The Assessment Team provided the following evidence relevant to my finding:

* The organisation’s policies and procedures in relation to assessment and planning requires care plans to be reviewed every six months or within 24 hours of an incident.
	+ Management reported the service was behind on its care plan evaluation schedule and was unable to provide detail on how many care plan reviews were overdue.
	+ Management reported care plan evaluations were on hold and due to recommence in 2022, as the care plan review process was being reviewed. Management reported it was self-identified that care plans did not contain sufficient information.
	+ An assessment and planning audit undertaken in October 2021 identified care plans and assessments had not been reviewed and updated for four of 13 sampled consumers. The audit also identified that eight of 11 sampled consumers who experienced an incident had not had care plans reviewed within 24 hours of an incident.

Commentary to the audit acknowledged care plans were overdue and did not detail action that would be taken. There was no evidence of a corrective action plan to address deficiencies identified.

* The organisation has policies that require staff to complete an incident report and commence a wound management plan following identification of skin tears, wounds and pressure injuries. The organisation’s policies also require staff to conduct a full skin assessment as required by the consumer’s condition or change in needs and on return from hospital or extended leave. Staff are to monitor the effectiveness of prevention and management strategies and update the skin care plan as part of the ongoing assessment and care planning process. Documentation and interviews with management showed these policies had not always been followed for three sampled consumers:
	+ Skin assessments for Consumers B, C and H were not reviewed or updated following identification of wounds.
	+ A wound management plan was not commenced, management strategies were not documented and an incident report was not completed following identification of Consumer B’s pressure injury.
	+ A wound management plan was not commenced for Consumer C until nine and 10 days after one blister and two wounds were identified on their toes respectively.

Following identification of these wounds, the consumer’s care plan was not reviewed to include current wounds and management strategies.

The consumer and representative reported current wound management strategies are not effective, as friction is still experienced on the consumer’s toes.

* + Consumer C’s care plan was not reviewed to include management strategies for pain associated with their wound.

The consumer reported they are in pain most of the time, particularly when dressings are being changed, and staff do not offer pain relief prior to undertaking this task.

* + The effectiveness of care and services for Consumer H was not reviewed, despite having a wound that had been ongoing for more than 13 months.
	+ Management reported the effectiveness of care and services for wound care is reviewed and evaluated via multiple methods, including at each dressing change, fortnightly wound nurse reviews, monthly clinical indicator reports, clinical audits and consumer of the day reviews.

Of two sampled consumers, documentation showed their wounds were reviewed as part of consumer of the day processes, however, no analysis of the effectiveness of care and services was undertaken.

Evidence of wound management audits was unable to be provided.

One clinical statistics report reviewed identified new pressure injuries, however, did not comment on the effectiveness of care and services for those that were pre-existing.

While some deficits identified by the Assessment Team are acknowledged, the provider maintains the service is compliant with this Requirement as there has been no negative outcome for consumers. The provider’s response also describes actions taken in response to some of the deficiencies identified. The response included:

* A nurse consultant has been engaged to provide education in relation to improving care plan evaluations. This has been scheduled for January 2022.
* Throughout the implementation of assessment and planning improvements, assessments continued to be reviewed and updated to reflect changing needs of consumers.
* Acknowledgement that a wound management plan and skin assessment were not initiated in line with the organisation’s policy following identification of Consumer B’s pressure injury. The provider states that the respective staff member has been performance managed and maintains the consumer is satisfied with the management of their wound.
* Acknowledgement that care planning documentation for Consumer C had not been updated to signify current injuries and did not include strategies to inform care and services.
* Progress notes to demonstrate Consumer C’s pain is overseen by a medical officer and pain relief is administered to minimise their pain.
* Consumer H’s skin assessment does not require updating, as it is current to their care needs.
	+ The skin assessment provided in support of this claim was dated after the Site Audit had concluded.

I acknowledge the provider’s response and associated documentation provided, however, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, care and services were not reviewed regularly for effectiveness, and when circumstances change, or when incidents impact the needs, goals or preferences of consumers.

In coming to my finding, I acknowledge that consumers’ care plan evaluations had not been reviewed and updated as the assessment and planning processes were under review, however, care planning documentation had not been maintained and updated to ensure information that guides staff practice was reflective of consumers’ current needs, goals and preferences.

I have considered that the organisation’s policies in relation to assessment and management of wounds had not been followed for three sampled consumers. Specifically, skin assessments were not undertaken following identification of wounds, wound management plans were not commenced for each consumer and care planning documentation was not updated to reflect consumers’ change in condition. While the service has processes in place to monitor wounds, they do not evaluate the effectiveness of current strategies.

In relation to Consumer C’s pain, I acknowledge that it was known and being managed by a medical officer, however, care planning documentation had not been updated to reflect the consumer’s changing needs and provide staff with strategies to minimise the consumer’s pain.

Based on the evidence summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# 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 Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 3, as the service was unable to demonstrate:

* each consumer gets safe and effective personal care and clinical care;
* effective management of high impact and high prevalence risks;
* significant deterioration is recognised and responded to in a timely manner;
* information about consumers’ condition, needs and preferences is documented and communicated within the organisation and with others where responsibility for care is shared; and
* minimisation of infection related risks through implementing effective standard and transmission based precautions and practices to promote appropriate antibiotic prescribing and use.

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

In relation to all other Requirements in this Standard, consumers and representatives reported consumers have access to relevant specialists and health professionals when needed. One representative confirmed their loved one’s end of life needs, goals and preferences were recognised and addressed.

Staff described how care and service delivery changes for consumers nearing end of life and provided examples of how input is sought from other health professionals to meet consumers’ needs.

Care plans demonstrated timely and appropriate referrals made to relevant individuals, organisations and providers of other care and services where necessary.

Based on this evidence, I find the service compliant with Requirements (3)(c) and (3)(f) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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 was not satisfied each consumer gets safe and effective care that is best practice tailored to their needs and optimises their health and well-being. Consumers and representatives reported satisfaction with the personal and clinical care consumers receive and evidence demonstrated safe and effective care in relation to restrictive practices and pain management. However, the Assessment Team was not satisfied best practice care was provided in relation to wound care and bowel management strategies for one consumer had not been adhered to. The Assessment Team provided the following evidence relevant to my finding:

Wound care

* Care planning documentation for three sampled consumers with pressure injuries demonstrated wound progress was not consistently recorded.
* Policies and procedures in relation to skin integrity are in place, however, they do not contain information to guide staff in documenting, photographing and measuring the wound.
* Four staff and management provided inconsistent information in relation to documentation requirements for wound care.
* Three staff reported they had not received wound management training for at least two years. The Assessment Team noted the wound nurse had not received training in wound management.
* Management reported progress note reviews, wound reports, consumer of the day reviews, clinical audits and monthly clinical indicator reports are used to ensure care is safe, effective and best practice.

Bowel management

* A bowel management plan was implemented for one consumer experiencing constipation, which included a comprehensive daily plan for instances when bowels had not been opened for six days.
* Documentation demonstrates the consumer’s bowel movements were charted daily, with bowel movements occurring approximately every two to three days as per the consumer’s goal.
* The consumer alleged staff administered an enema against their wishes on one occasion. In response to this allegation, a report was made as required under the Serious Incident Response Scheme (SIRS).
* Documentation demonstrated the enema was administered on day five of bowels not opening, not day six as per the consumer’s bowel management plan. Management conceded the consumer should not have been administered an enema at the time.
* Staff interviewed were knowledgeable about the consumer’s bowel management plan.
* Following the incident, measures were implemented to enable greater transparency. The consumer reported satisfaction with the current arrangements.

The Assessment Team provided the following evidence demonstrating how the service understands and applies this Requirement:

* For three sampled consumers with mechanical and chemical restraints, consumers and representatives confirmed the risk had been discussed, the restraint is used minimally and in the least restrictive form and in accordance with consumers’ wishes.
* Three of four consumers confirmed their pain was appropriately managed and considered staff to be responsive to their needs.
* All clinical and care staff demonstrated knowledge of each sampled consumers’ personal and clinical care needs and could describe how care is tailored to their needs and optimises their health and well-being.
* Management described how staff keep up-to-date with best practice guidelines and information.

While some deficits identified by the Assessment Team are acknowledged, the provider maintains the service is compliant with this Requirement. The provider’s response also describes actions taken in response to some of the deficiencies identified. The response included:

* Wound management policies and processes have been implemented to guide staff in wound documentation and measurement.
* Consumer H’s wound was known to the medical officer and representative, measurement of the wound did occur and the wound did not fluctuate in size. A copy of a feedback form from the consumer’s representative was provided demonstrating satisfaction with management of the consumer’s wound.
	+ The response did not include evidence to demonstrate that the consumer’s wound had been measured by staff.
* Commentary from staff in relation to documentation requirements for wound care is not valid, as the wound nurse was not present during the Site Audit.
* The Assessment Team’s statement that the wound nurse has not received wound care training is concerning, as the staff member is a registered nurse and continues to self-educate with best practice in wound care.
* A statement from the wound nurse to demonstrate wound training they had undertaken in the previous two years.

I acknowledge the provider’s response an associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates the service is compliant with this Requirement.

In relation to wound management, while the progress of wound status was not consistently recorded, the deficiencies stem from insufficient policies and procedures to guide staff practice and ineffective processes in relation to monitoring and management of high impact or high prevalence risk. I have considered the evidence presented by the Assessment Team in my findings for other Requirements which reflect the core deficiency, including Requirement (3)(b) in this Standard and Requirement (3)(e) in Standard 8 Organisational governance.

While two staff reported they had not received wound management training in two years, there was no evidence corroborating these statements, and information submitted by the provider demonstrates the wound nurse had undertaken multiple wound management training programs in two years prior to the Site Audit.

In relation to bowel management, I have considered the evidence does not indicate a systemic issue. While the consumer received an enema that was not in line with their bowel management plan, the service reported the incident and implemented measures to enable greater transparency. The consumer reported satisfaction with current arrangements and staff had adhered to the bowel management plan for another sampled consumer.

I have also considered evidence in the Assessment Team’s report indicates best practice care and services is provided to consumers in relation to restrictive practices and pain management. Additionally, consumers and representatives reported satisfaction with the personal and clinical care consumers receive and provided examples of how care and services are tailored to their needs. Staff were knowledgeable about sampled consumers’ needs and the service demonstrated how they keep up-to-date with best practice requirements and disseminate that information to staff.

Based on the evidence summarised above, I find the service compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### 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 was not satisfied high impact or high prevalence risks associated with the care of each consumer was effectively managed. While some high impact and high prevalence risks were managed in line with consumers’ needs and preferences and staff were knowledgeable about risks associated with the care of sampled consumers, the Assessment Team found ineffective management of consumers’ pressure injuries and medication. The Assessment Team provided the following evidence relevant to my finding:

Pressure injury management

* Consumer B
	+ A wound management plan and skin assessment had not been undertaken following identification of a pressure injury on the consumer’s sacrum.
	+ Staff and management could not detail the wound status or describe wound management strategies.
	+ From the time of identification until commencement of the Site Audit (13 days), the consumer’s pressure injury had not been documented, including wound chart, photograph, staging or measurements.
* Consumer C
	+ Care planning documentation showed the consumer had been assessed as at risk of pressure injuries and following implementation of prevention strategies; three pressure injures developed on their right foot.
	+ Documentation demonstrated no action was taken following identification of a blister on the consumer’s right foot. The representative stated they informed staff about the blister on the consumer’s toe and was told it was fine.
	+ Nine days after the blister was identified, a wound management plan was commenced for a stage two pressure injury to the same toe. While the wound was staged and described, sizing and photographs were not documented.
	+ Documentation showed that despite staff attending to their foot every two to three days to dress the existing pressure injury, the consumer subsequently developed two further pressure injuries on the right foot and wound management plans did not commence until the wounds were stage two.
	+ Interviews with the consumer and representative, and documentation showed recommendations made by the vascular team were not always implemented, as the consumer’s footwear applied pressure to their toes and the cradle used did not relieve pressure.
	+ Documentation demonstrated the consumer’s dressing regime was not always followed.
* Consumer H
	+ Documentation showed the consumer’s pressure injury was not identified until it had developed to a stage two.
	+ There was no evidence indicating specialist input was sought, despite the wound having been ongoing for more than 13 months.
	+ The Assessment Team could not ascertain the status of the wound, as the size has not been documented since identification and only two photographs had been taken. Staff and management were unable to confirm the staging or status of the wound.
* Of three staff interviewed, one believed they had received training in wound care in the past year and two reported they had not received training since they commenced working at the service.
* The organisation’s procedures do not guide staff in wound management, rather, where wounds are identified or suspected, the procedure states, ‘manage wound’ and refers staff to the wound management plan. No sampled consumers had a wound management plan.

Medication management

* Documentation demonstrated two consumers’ time sensitive medication was not consistently administered at the scheduled time.
	+ Medication records for an eight day sampled period demonstrated one consumer’s medication was administered more than 30 minutes late on 22 of 56 occasions, including more than 60 minutes late on 10 occasions. At least four of these occasions were, however, signed for by staff when the consumer returned from an outing.

The consumer reported their medication is frequently administered late, which makes them feel anxious.

* + Medication records for a 14 day period demonstrated one consumer’s medication was administered more than 30 minutes late on 12 occasions, including more than 60 minutes late on one occasion.

The consumer reported delayed administration of their medication results in less control of their mobility and shaking, which they find unpleasant and frustrating.

* + Three staff interviewed were familiar with the timing of sampled consumers’ time sensitive medication and reported medication is frequently administered late due to staff shortages.
* One representative reported staff had, on at least three occasions, administered two doses of medication which resulted in the consumer feeling drowsy. The representative reported this to management, however, further instances had occurred.
* Medication records demonstrated staff had administered medication to one consumer within 80 minutes of the last dose. The Assessment Team noted that the medication is time sensitive and administration within two hours of the last dose can cause an overdose.
* The organisation does not have a policy or procedure specific to medication management and while the clinical policy provides some guidance in relation to medication administration, it does not guide staff in relation to instances when medication administration is delayed.
* Documentation and interviews with management demonstrated monitoring processes for medication management were ineffective and did not detect gaps identified by the Assessment Team.

The provider did not agree with the Assessment Team’s findings and maintains high impact or high prevalence risks associated with the care of each consumer is effectively managed. The provider’s response included evidence to refute assertions made by the Assessment Team. The response also included a Continuous improvement plan to demonstrate some of the deficiencies have either been addressed or are part of the plan. The response included:

* Consumer B’s wound has healed and is being monitored for potential breakdown. The consumer is satisfied with the care they are receiving.
* For the two consumers requiring time sensitive medication, a spot check was conducted for a period following the Site Audit, which identified their medication was administered within the therapeutic range on 49 of 56 and 33 of 35 occasions respectively. These errors have been discussed with relevant staff.
* In relation to the consumer who received two doses of medication on at least three occasions, this has not occurred in the last 12 months.
* The organisation’s medication management procedure, which states that staff are to complete an incident form when medication incidents occur.
* Improvements implemented include, but are not limited to, staff education and training, policy and procedure updates, and completion of internal audits.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, high impact or high prevalence risks associated with the care of each consumer were not effectively managed.

In coming to my finding, I have considered that early identification of skin breakdown did not always occur to prevent further deterioration and staff were not documenting wound size and stage to monitor the effectiveness of management strategies. For two of three consumers, staff and management could not detail the status of their wounds or describe management strategies. I have also considered that dressing regimes were not always followed and all specialist recommendations were not implemented to ensure the best outcome for consumers. In relation to one consumer, specialist input was not sought despite their wound being ongoing for at least 13 months.

In relation to medication management, I have considered that while two consumers’ time sensitive medications were frequently administered late, the core deficiency relates to insufficient staffing numbers and ineffective monitoring processes. I have considered the evidence presented by the Assessment Team in my findings for other Requirements which reflect the core deficiency, including Requirement (3)(a) in Standard 7 Human resources and Requirement (3)(d) in Standard 8 Organisational governance.

Based on the evidence summarised above, I find the service non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### 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) Non-compliant

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

The Assessment Team was not satisfied deterioration or a change to a consumer’s physical condition had consistently been responded to in a timely manner. While the Assessment Team observed staff recognised a change in health status for two sampled consumers, the severity and time critical nature of one consumer’s condition was not recognised and responded to on two occasions. The Assessment Team provided the following evidence relevant to my finding:

* Episode one:
	+ Following signs and symptoms of a cardiac event, staff did not arrange immediate medical assistance, rather, contacted the consumer’s next of kin and waited for their arrival.
	+ Management reported it was concerning that hospital transfer was not immediately arranged.
	+ Initial observations were undertaken during the morning when the consumer’s change in condition was identified. With the exception of one respiratory measurement, documentation shows no further observations were obtained until the next day.
	+ A retrospective note was entered documenting the consumer had been transferred to hospital on the day their change in condition had been identified. The consumer returned to the service on the same day.
	+ Vital sign observations indicate the consumer experienced a further change in physical condition the day after signs and symptoms of cardiac event had occurred, however, there was limited commentary to indicate the consumer’s condition.
* Episode two:
	+ Following signs and symptoms of a stroke, initial observations were undertaken and the next of kin informed.
	+ One staff reported the medical officer was contacted, however, in consultation with the representative it was decided not to send the consumer to hospital as it would be too stressful. The staff member conceded this had not been documented.
	+ No further action was documented and further observations were not obtained until two days after the signs and symptoms of stroke were initially observed.
	+ Documentation demonstrated the consumer remained unwell, with ongoing changes in their physical function. While some investigations were arranged and medical officer contacted, they were not undertaken in a timely manner.

The provider did not agree with the Assessment Team’s findings and maintains the consumer’s change in condition was identified and responded to in a timely manner. The provider’s response states clinical staff followed appropriate nursing protocol in relation to episode one, as resources at hand were used to review and manage the consumer’s decline in physical function. The response also states appropriate follow up was undertaken and the consumer’s symptoms had resolved. The response does not include evidence to demonstrate how the consumer’s decline was managed and monitored following identification.

In relation to both episodes, the provider raised concerns with the assumed diagnosis that the consumer was displaying signs and symptoms of a cardiac event and stroke. The provider asserts none of these had occurred and provided a progress note from the medical officer to support this claim in relation to episode one.

The provider also questions the validity of statements made by staff to the Assessment Team, as follow up conversations held with staff following the Site Audit yielded different results.

I acknowledge the provider’s response and associated documentation provided. However, I find that information and evidence in the Assessment Team’s report and provider’s response demonstrates deterioration or change of one consumer’s physical condition was not responded to in a timely manner on two occasions.

In coming to my finding, I have considered that while the consumer did not experience a cardiac event and may not have had a stroke, the signs and symptoms displayed by the consumer were indicative of these acute conditions and appropriate monitoring and action should have occurred.

In relation to episode one, I have considered that despite showing signs and symptoms of a cardiac event, immediate medical assistance was not requested. While the consumer was subsequently transferred to hospital, this did not occur in a timely manner and there was no evidence demonstrating the consumer’s deterioration was monitored and reviewed following identification.

In relation to episode two, I have considered that despite showing signs and symptoms of a stroke, there is no evidence demonstrating the consumer was monitored for two days after symptom onset. While staff reported the consumer was reviewed by a medical officer on the day symptoms presented, this is not supported by evidence and documentation indicates the consumer was not reviewed until after four days.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

### 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.*

The Assessment Team was not satisfied the service demonstrated 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. While consumers, representatives and most staff expressed satisfaction with the service’s communication processes, staff had not consistently documented consumers’ needs or changing condition to inform those providing care and services. The Assessment Team provided the following evidence relevant to my finding:

* Documentation demonstrates the organisation’s clinical documentation procedure was not consistently followed by staff. For example:
	+ The infection status for two consumers with current infections was not documented.
	+ The diabetic management plan for two consumers did not contain management strategies, such as actions to take if outside normal parameters, and for one of the two consumers, no BGL range was documented in the management plan or clinical monitoring chart.
	+ Consumers’ wound size had not been documented and staged to enable monitoring of wound status.
	+ The use of mechanical restraint for Consumer B had not been identified in care plans, risk assessment, progress notes or restraint monitoring forms.
	+ The Assessment Team were unable to ascertain from progress notes when two consumers were transferred to and discharged from hospital.
	+ Clear commentary was not documented for one consumer experiencing two episodes of acute deterioration.
* All consumers, representatives and most staff were satisfied with communication processes.
	+ One staff reported information is not effectively communicated to staff, as they are required to scroll through progress notes.
	+ Most staff reported changes in consumers’ care and services are communicated through various channels and considered the current processes were sufficient.
	+ Staff provided examples of how changes to consumers’ dietary needs and preferences are communicated.
* Staff described processes for sharing information with other providers of care and services. Documentation demonstrated recommendations from the multidisciplinary team had been incorporated into care planning documentation.
* Management reported monitoring processes are in place to ensure effective communication, including verbal handover, progress note reviews and clinical audits.
* The care planning audit conducted during October 2021 self-identified some deficiencies, such as communication with consumers and representatives not being documented. Documentation demonstrated some action plans in response to findings were documented but had not been followed up or embedded into practice.

The provider did not agree with the Assessment Team’s findings and maintains that the service is compliant with this Requirement. The provider’s response states that only one staff interviewed by the Assessment Team reported improvements could be made to communication processes, which was as a result of clinical management being unavailable during the Site Audit, as they were assisting the Assessment Team. The provider asserts that conversations with clinical staff following the Site Audit identified this was an isolated occurrence.

The response addresses the Assessment Team’s findings that actions taken by the service in response to the care planning audit had not been followed up or embedded into practice. The provider asserts the action plan requires a suitable amount of time for actioning to occur and as such, this was in progress at the time of the Site Audit.

The response includes the service’s Continuous improvement plan to demonstrate deficiencies identified by the Assessment Team have either been addressed or included in the plan. These actions include, but are not limited to, staff education and training, review and implementation of policies and procedures, conduct of internal audits and implementing monitoring processes.

I acknowledge the provider’s response and the associated documentation provided.

In coming to my finding, I have considered evidence in the Assessment Team’s report and provider’s response, which demonstrates there are areas for improvement to ensure information about the consumer’s condition, needs and preferences are documented and communicated within the organisation and with others for which responsibility for care is shared. However, I find the core deficiencies do not relate to this Requirement.

In relation to the inadequate documentation of infection status, use of mechanical restraint and diabetic management, I have considered the evidence presented by the Assessment Team in my findings for Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

I have considered the evidence presented by the Assessment Team in relation to inadequate documentation and measurement of wounds in my findings for Requirement (3)(b) in this Standard.

In relation to the inadequate documentation of hospital transfers and action taken in response to deterioration, I have considered the evidence presented by the Assessment Team in my findings for Requirement (3)(d) in this Standard.

Based on the information summarised above, I find the service compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

### 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 was not satisfied the service demonstrated minimisation of infection related risks through implementing infection prevention and control precautions and practices to promote appropriate antibiotic prescribing and use. While the Assessment Team found staff were knowledgeable of infection control practices, evidence demonstrated the infection status of two consumers was not effectively communicated to enable optimal infection control. The Assessment Team also found the service did not demonstrate practices to promote antibiotic prescribing were consistently applied, nor were recurrent use of antibiotics identified and responded to. The Assessment Team provided the following evidence relevant to my finding:

Infection status

* The organisation’s policy in relation to minimising risk of infection requires staff to complete an infection report upon identification, including the type of infection, swab results and prescribed medication.
* Documentation, and interviews with staff and management demonstrate the organisation’s policy was not followed for two sampled consumers. For example:
	+ Consumer F:

Care documentation contained minimal information to determine if the consumer has or had a virus and the associated infection control management strategies.

Progress notes for a 10 day period record a request for blood tests to ascertain the status of the virus, however, there is no further commentary on the status of infection. Management acknowledged this should have been actioned.

Three staff interviewed provided different information in relation to the status of infection. Management could not confirm the status of the infection.

An infection report was not completed.

* + Consumer C:

Following identification of a bacterial infection and commencement of antibiotics, an infection report was not completed and strategies for treatment of the wound were not documented.

* Documentation and interviews with staff demonstrate competency assessments on hand hygiene had not been completed in over 12 months.

Antibiotic use

* The organisation’s policy in relation to antimicrobial stewardship requires staff to undertake three day behaviour charting and obtain a urinalysis prior to commencing antibiotics. The organisation has other policies requiring staff to complete infection reports for each infection identified, undertake clinical audits and complete pharmacy reports to understand the prevalence of infection, staff practice and monitor effectiveness of treatment.
* Documentation demonstrated staff practice was not always undertaken in line with the organisation’s policy and reflective of best practice. For example:
	+ Consumer F:

Documentation demonstrated the consumer has received three courses of antibiotics for a recurrent infection and staff are routinely performing a urinalysis each month regardless of symptoms.

Staff reported monitoring will occur if the urinalysis returns a positive result, however, antibiotics will only be prescribed if the consumer is symptomatic.

Documentation demonstrated three day behaviour charting had occurred prior to administering antibiotics on only one of three occasions.

Documentation demonstrated staff conducted post treatment urinalysis on one occasion, however, this is not in line with best practice guidelines.

The recurrent use of antibiotics for Consumer F was not identified through monitoring processes.

* + Consumer C:

Following identification of a bacterial infection, the consumer was commenced on antibiotics.

Documentation demonstrated the consumer was receiving antibiotics for the same infection four months post identification and the wound had not yet healed.

* Staff reported they have not received training in antimicrobial stewardship since 2019.

The provider did not agree with the Assessment Team’s findings and asserts the organisation’s infection management policies were followed by staff appropriately. The provider’s response includes a copy of Consumer C’s infection report, which was created after the Site Audit had concluded. The response did not include evidence of infection reports completed for any other consumers highlighted in the Assessment Team’s report.

The provider also asserts staff training had been provided in relation to hand hygiene and the response included evidence demonstrating infection control and antimicrobial stewardship is included in the 2022 education plan. The response includes evidence staff had received hand hygiene and antimicrobial stewardship training in 2018, however, the Quality audit report shows staff were observed in hand hygiene during October and November 2021 and all were noted to demonstrate best practice.

The response includes the service’s Continuous improvement plan to demonstrate deficiencies identified by the Assessment Team have either been addressed or are included in the plan. These actions include, but are not limited to, updating policies and procedures, and staff education and training.

I acknowledge the provider’s response and associated documentation provided. However, based on the Assessment Team’s report and provider’s response, I find at the time of the Site Audit, processes in place to minimise infection related risks were not consistently followed by staff.

In coming to my finding, I have considered that staff did not consistently complete infection reports in line with the organisation’s policy and two consumers’ infection status had not been documented to enable effective treatment and management.

I have also considered that while the service has systems and processes for promoting antimicrobial stewardship, they were not consistently followed by staff. In relation to Consumer F, evidence demonstrates antibiotics were prescribed on two of three occasions without prior behaviour charting to determine if the consumer was symptomatic.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# STANDARD 4 COMPLIANTServices 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.

Overall, consumers and representatives consider the service supports consumers to do the things they want to do, and which are important for their health and well-being. For example:

* Consumers said they have a choice in activities for daily living and reported staff talk with them about their interests to ensure their needs are met.
* Consumers provided examples of the support they receive to promote their emotional and spiritual well-being.
* Consumers provided examples of the support they receive to maintain social and personal relationships, participate in the community and do things of interest to them.
* Consumers and representatives stated the service ensures consumers’ condition, needs and preferences are communicated within the organisation, and with others where responsibility is shared.
* Consumers were satisfied with the quality and variety of meals provided.
* Consumers reported equipment used to manage their safety and comfort is clean and in good condition.

Staff provided examples of how services are tailored to consumers’ individual needs, how consumers are supported to engage in activities and strategies used to promote consumers’ emotional, spiritual and psychological well‑being.

The following observations were made:

* On each day of the Site Audit, consumers were participating in a range of activities.
* Meals were nicely presented and were delivered to consumers who did not wish to dine in the communal dining area.
* The kitchen appeared clean and tidy, with staff practicing general food safety protocols.

Care plans were found to document information about consumers’ emotional, spiritual and psychological well-being, in addition to their needs and preferences, things of importance to them and dietary requirements. Consumer files showed timely and appropriate referrals to individuals, organisations and providers of other care and services for the provision of lifestyle support.

Lifestyle documentation showed group activities are diverse and individualised activity options are available.

Based on the above evidence, I find the service compliant with all Requirements in Standard 4 Services and supports for daily living.

## 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.*

### 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 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 compliant as three of the three specific Requirements have been assessed as compliant.

Consumers feel they belong and feel safe and comfortable in the service environment. Consumers and representatives reported the environment is clean and well‑maintained, and they enjoy the external communal areas. Consumers also confirmed the furniture and equipment they use is clean, well-maintained and suitable for their needs.

Staff demonstrated how they ensure the service environment is safe, including the process for actioning and prioritising maintenance.

The environment was observed to be clean and inclusive of shared areas to enable interaction. Consumers’ rooms were personalised and reflected their identity.

Consumers were observed moving freely throughout the environment and furniture, fittings and equipment appeared to be safe, clean, well maintained and suitable for consumers.

Based on the above evidence, I find the service compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

Consumers consider they are encouraged and supported to give feedback and make complaints, and appropriate action is taken to address feedback and complaints. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* They feel supported to provide feedback and complaints about consumers’ care and services and are comfortable doing so.
* They can provide feedback and complaints in various ways and their feedback and complaints have resulted in satisfactory changes.

Staff demonstrated an awareness of the range of feedback mechanisms and described how they assist consumers in making a complaint and providing feedback, including those who have difficulty communicating. Staff described principles of open disclosure and provided examples of improvements that have been made in response to complaints and feedback made by consumers.

Information relating to internal and external complaints processes, open disclosure, advocacy services and the Charter of Aged Care Rights was observed in communal areas.

Documentation showed feedback and complaints are recorded and analysed to implement improvements for any trends identified.

Management described quality improvement activities that have resulted from consumer feedback.

Based on the evidence above, I find the service compliant with all Requirements in Standard 6 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 one of the five specific Requirements have been assessed as non-compliant.

The Assessment Team recommended the service does not meet Requirements (3)(a) and (3)(e) in Standard 7, as the service did not demonstrate:

* adequate numbers and mix of staff are maintained to deliver safe and quality care and services; and
* systems to monitor and review the performance of each member of the workforce are consistently effective.

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

In relation to all other Requirements in this Standard, consumers consider they get quality care and services when they need them, from people who are knowledgeable, capable and caring. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* staff are kind, respectful, gentle and caring when providing care and attending to consumers’ needs; and
* staff know how to deliver care and services according to consumers’ individual preferences and are well trained and competent to perform their roles.

Overall, staff reported they have been provided adequate training and can access a variety of courses relevant to their role when needed. Staff demonstrated knowledge of consumers’ likes and dislikes and described how they respect their history, culture and diversity.

Interviews with staff and management, and documentation showed competencies and training are monitored. While documentation demonstrated all staff have not completed mandatory training in line with the service’s schedule, there were no deficits found in the respective areas.

Based on the above evidence, I find the service compliant with Requirements (3)(b), (3)(c) and (3)(d) in Standard 7 Human resources.

## 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 Assessment Team was not satisfied the service demonstrated the number and members of the workforce is effectively planned and deployed to enable the delivery and management of safe and quality care and services. While most consumers, representatives and staff expressed satisfaction with the number and mix of staff, evidence demonstrated demand on clinical staff has attributed to delays in time-sensitive medication, care plan evaluations and behaviour support plans. The Assessment Team provided the following evidence relevant to my finding:

* Seven consumers and representatives were satisfied with the numbers and mix of staff and reported that while staff were busy, consumers’ needs were met. However, two consumers reported staff are busy and as a result, time-sensitive medication is administered late, particularly at 11:00 am.
	+ Over an eight day period sampled, documentation demonstrated one consumer’s medication was administered late on 22 of 56 occasions, including more than 60 minutes late on 10 occasions, of which seven were more than 90 minutes late.

Management reported on at least four occasions, the consumer’s medication was signed for upon return from an outing.

The Assessment Team noted the consumer’s 8:00 am and 11:00 am doses were more than 30 minutes late on seven and five of the eight days respectively.

The consumer reported they often have to find staff and request their medication, which makes them anxious.

* + Over a 14 day sampled period, another consumer’s medication was administered more than 30 minutes late on 12 occasions, including more than 60 minutes late on one occasion.

The Assessment Team noted the consumer’s 8:00 am dose was more than 30 minutes late on 11 of 14 sampled days.

The consumer reported delays in medication results in decreased mobility and less control of their function, which is frustrating and unpleasant.

* + Two staff reported they are unable to consistently administer medication on time due to staff shortages and stated it is particularly difficult at 11:00 am. Both staff reported they have raised their concerns with management on multiple occasions, however, no improvement has been observed.
	+ Management reported they had not received feedback from consumers in relation to delayed medication.
* Four of five clinical staff and one of nine care staff interviewed reported inadequate staffing levels. Of the five staff interviewed:
	+ One reported there has been a few occasions when a newly qualified nurse has been left in charge. They reported they felt uncomfortable with this and raised it with management, however, the issue has not been rectified.
	+ Two reported there are not enough staff and as a result, medication is regularly being administered late, medication errors are occurring and they cannot attend to consumers’ needs in a timely manner.
	+ One said they are working double shifts to cover absent staff and another said they need to work extra hard to ensure there is no impact to consumers’ care and services.
* Management reported care plan evaluations were behind schedule and behaviour support plans had not been implemented for most consumers due to staff shortages. Management stated senior clinical staff are required to complete this work on ‘dedicated office days’, however, these office days have been relinquished as they have been required on the floor.
	+ The Assessment Team noted this statement from management was corroborated by one staff.
* Management reported they are aware there is a need for more staff and are actively recruiting to address the issue.
* Call bell data indicates only two of approximately 1500 call bells over a two week sampled period exceeded 20 minutes. For the two occasions, documentation did not demonstrate any adverse impact to consumers’ care.

The provider did not agree with the Assessment Team’s findings and disputes the claim that care plan evaluations and behaviour support plans have not been completed due to staff shortages. The provider’s response did not include further information to address why these deficiencies occurred.

In the response to findings and evidence presented under Standard 3 Requirement (3)(b), the provider states they cannot provide commentary in relation to medication delays for two consumers, as the sample period is unknown, however, a spot check was conducted and identified their medication was administered within the therapeutic range on 49 of 56 and 33 of 35 occasions respectively. These errors have been discussed with relevant staff.

The response acknowledges recruitment has been difficult given the current industry shortfalls, however, recruitment of staff has occurred through various resources.

The provider asserts that rosters are managed to ensure care needs are met and there is no evidence suggesting consumers’ 11:00 am medication is delayed due to staff shortages. The provider maintains that consumers are satisfied with staffing levels and their care needs are met.

I acknowledge the provider’s response and associated documentation provided. However, based on the Assessment Team’s report and provider’s response, I find at the time of the Site Audit, the workforce was not planned to enable, and the number and mix of the workforce deployed enables, the delivery and management of safe and effective care and services. While evidence indicates the number of care staff were sufficient to meet consumers’ needs, interviews with staff and management demonstrate clinical staff are required to work on the floor to cover shifts and as a result, are unable to undertake other tasks that inform the delivery of safe and effective care and services, such as completion of care plan evaluations and behaviour support plans. Documentation and interviews with staff and consumers also demonstrates low clinical staffing numbers has attributed to time-sensitive medication often being administered late, which causes anxiety and loss of function to those impacted.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(a) in Standard 7 Human resources.

### 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) Compliant

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

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

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

The Assessment Team was not satisfied the service demonstrated each member of the workforces’ performance is regularly assessed, monitored and reviewed. While the Assessment Team identified the service has assessment, monitoring, appraisal and development processes, they were found to be ineffective as performance appraisals had not been undertaken in line with the schedule and incorrect staff practices were not identified. The Assessment Team provided the following evidence relevant to my finding:

* Three staff reported they had not undertaken a performance appraisal during 2021. Management explained performance appraisals were up-to-date as of December 2020 and none had been undertaken since June 2021.
	+ Management reported a three month plan has been created to undertake those outstanding, however, it had not yet commenced. Documentation shows staff were scheduled to undertake their performance appraisals during December 2021 and throughout 2022.
* Management reported staff performance is measured by observations, review of clinical data and incidents, peer review and feedback from consumers and representatives.
	+ Documentation demonstrated two consumers were administered time-sensitive medication consistently late. Of the two consumers, medication was administered more than 30 minutes late on 22 of 56 and 12 occasions over an eight and 14 day sampled period respectively.
	+ Care documentation for three consumers demonstrated ineffective management of skin integrity, including dressing regimes for pressure injuries not being adhered to and inconsistent application of wound documentation and charting.
	+ Management stated a competency assessment and training has not yet been provided to one staff who has had eight medication incidents in the five months.

The provider did not agree with the Assessment Team’s findings and maintains assessment, monitoring, review and appraisal processes are effective. While the provider’s response includes general information in relation to performance review and management processes, it did not address the Assessment Team’s assertion that incorrect staff practices had not been identified through monitoring processes.

The response explains that performance appraisals were conducted as a whole staff group in December 2020, therefore, annual appraisals were not overdue and were scheduled to commence in December 2021. The response details improvements implemented to address deficiencies identified by the Assessment Team, including conducting leadership and management training with managers and improving performance review processes.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate assessment, monitoring and review of the performance of the workforce is ineffective.

The provider’s assertion that annual performance appraisals were last conducted with all staff during December 2020 was somewhat supported by evidence presented by the Assessment Team. While the Assessment Team’s report did not include evidence that performance appraisals are conducted annually, it is reasonable to assume they are conducted on an annual basis in line with workplace and industry standards. Additionally, the Assessment Team’s report included statements from management that performance appraisals were up-to-date effective December 2020, not that they were all conducted during December 2020. In the absence of a performance appraisal schedule for 2020, I have placed weight on the provider’s claim that all staff performance appraisals were conducted during December 2020. This, therefore, demonstrates performance appraisals were not outstanding at the time of the Site Audit.

In relation to two consumers that are often administered time-sensitive medication, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, including Requirement (3)(a) in this Standard and Requirement (3)(b) in Standard 3 Personal care and clinical care.

In relation to the ineffective management of three consumers’ skin integrity, I find the core deficit relates to management of high impact or high prevalence risks and governance and have considered the evidence in my findings for Requirement (3)(b) in Standard 3 Personal care and clinical care and Requirement (3)(e) in Standard 8 Organisational governance.

While management reported one staff did not have a competency assessment or complete training following eight medication incidents, I have considered there is no evidence that corroborates this statement, including the nature of the incidents, when they occurred, impact to consumer, results of internal investigations, outcomes of informal discussions, whether a competency assessment was scheduled and any action considered.

I find that evidence presented does not indicate systemic failure in the monitoring of staff performance.

Based on the information summarised above, I find the service compliant with Requirement (3)(e) 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 of the five specific Requirements have been assessed as non-compliant.

The Assessment Team recommended the service does not meet Requirements (3)(d) and (3)(e) in Standard 8, as the service did not demonstrate:

* an effective risk management system relating to managing high impact or high prevalence risks; and
* an effective clinical governance framework relating to behaviour support plans, diabetes management and antimicrobial stewardship.

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

In relation to all other Requirements in this Standard, consumers consider the organisation is well run, with the governing body having a presence within the service and their community.

Documentation showed consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement via multiple channels.

Documentation showed the organisation’s governing body is accountable for and promotes a culture of safe, inclusive and quality care and services by analysing clinical incidents, hazards and feedback from consumers and representatives to evaluate effectiveness of care and services and identify opportunities for improvement.

Interviews with staff and documentation showed there are effective organisation wide governance systems in place to support information management, continuous improvement, workforce governance, financial governance and feedback and complaints.

Based on the above evidence, I find the service compliant with Requirements (3)(a), (3)(b) and (3)(c) in Standard 8 Organisational governance.

## 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) 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.*

### 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 Assessment Team was not satisfied risk management systems were effective in managing high impact or high prevalence risks associated with the care of consumers. While the Assessment Team found the organisation has some policies and procedures to guide staff practice in addressing risks, they were not consistently followed and monitoring systems were ineffective in identifying inconsistency in staff practice. The Assessment Team provided the following evidence relevant to my finding:

* Documentation demonstrated risk management systems and practices did not identify three consumers’ pressure injuries were not documented and measured in line with best practice guidelines.
* Time-sensitive medication for two consumers that was consistently administered late over a sampled period was not identified through monitoring processes, as the electronic system does not populate alerts for delayed medication.
* Training records show all staff have received SIRS training.
* Documentation shows reportable incidents have been recorded and reported within legislative timeframes and internal investigations were undertaken. Continuous improvement measures were implemented when identified.

The provider did not agree with the aspects of the Assessment Team’s findings that relate to Requirement (3)(b) in Standard 3 Personal care and clinical care. The provider’s response does not address the deficiencies identified in relation to the organisation’s risk monitoring processes.

The provider’s response includes a copy of the service’s Continuous improvement plan to demonstrate action has either been taken or included in the plan to address deficiencies identified, including but not limited to, conducting spot checks of medication administration timing, providing staff education and training, and observing staff practice.

I acknowledge the provider’s response and associated documentation provided.

In coming to my finding, I have considered that information and evidence in the Assessment Team’s report and provider’s response does not demonstrate risk management systems and practices are ineffective.

In have considered that while monitoring processes did not identify incorrect staff practice in relation to documenting and measuring three consumers’ pressure injuries, I find the core deficiency relates to the organisation’s clinical governance framework. I have considered the evidence in my findings for Requirement (3)(e) in this Standard.

In relation to the incidents of delayed medication administration, I find that evidence presented by the Assessment Team indicates areas for improvement to ensure all aspects of medication incidents are monitored and reviewed, and the organisation’s Continuous improvement plan suggests this may have already occurred. However, it is not proportionate to suggest the organisation’s incident management system is ineffective based solely on the deficiency identified. I have considered that non-medication related incidents sampled by the Assessment Team were appropriately recorded, reported and responded to in line with legislative requirements.

Based on the information summarised above, I find the service compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### 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 was satisfied the service demonstrated an effective clinical governance framework in relation to open disclosure and minimising the use of restraint. However, the Assessment Team found the organisation’s clinical governance framework in relation to implementation of behaviour support plans, diabetic management and antimicrobial stewardship was not effective. The Assessment Team provided the following evidence relevant to my finding:

Behaviour support plans

* The organisation’s restrictive practices policy requires all interventions to be documented in a behaviour support plan, including actions taken before the use of the restrictive practice and strategies used to prevent the need for the restrictive practice.
* Documentation showed the organisation’s governance processes were not effective in ensuring the abovementioned policy had been implemented. For example:
	+ Of the one, eight and 33 consumers subject to environmental, mechanical and chemical restraint respectively, only three had behaviour support plans in place at the time of the Site Audit.
	+ Of the three behaviour support plans implemented, monitoring details of the restrictive practice were not documented in line with regulatory obligations under the *Quality of Care Principles*.
	+ In the absence of a behaviour support plan, there was no alternate document(s) that contained information as required under the *Quality of Care Principles*. For two of three sampled consumers without behaviour support plans, the use of restraint, including duration, frequency and monitoring requirements was not documented.
* Management reported they were liaising with a nursing consultant to establish whether the service is compliant with their regulatory obligations.

Diabetes management

* The organisation does not have a policy or procedure to guide staff practice in relation to diabetes management.
* Documentation demonstrates for one consumer, BGLs out of range were reported to the medical officer on only one of four occasions and for two consumers, diabetic management plans contained insufficient information to guide staff practice in relation to the frequency of BGL monitoring, actions to take when BGLs are outside of range and general diabetic management.

Antimicrobial stewardship

* The organisation has an antimicrobial stewardship policy that outlines actions to optimise the treatment of infection while reducing adverse events associated with antibiotic use, however, monitoring processes did not identify prolonged antibiotic usage and risk of increasing resistance to microbials. For example:
	+ Monitoring processes did not identify one consumer who received three courses of antibiotics in relation to a recurrent infection. Documentation showed the organisation’s procedure was not followed, as behavioural charting prior was not undertaken to identify whether the consumer was symptomatic.
	+ While current infections are reported to the Board, the reports did not include the consumer’s name, the duration of their infection, whether antibiotics have been administered and how many courses of antibiotics have been prescribed to treat the infection.

Information and evidence presented by the Assessment Team under Requirement (3)(d) in this Standard and Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care indicates the organisation does not have adequate policies and procedures to guide staff in documenting and measuring wounds. Additionally, the organisation’s clinical governance framework did not recognise ineffective management of three consumers’ pressure injuries. For example:

* Documentation showed changes in skin integrity were not always identified in a timely manner and specialist input was not sought in relation to an ongoing wound.
* Dressing regimes were not consistently followed and specialist recommendations were not fully implemented.
* Despite staff attending to one consumer’s foot every two to three days, two further pressure injuries developed on the same foot.
* One consumer did not have a wound management plan in line with the organisation’s policy and another consumer did not have a wound management plan until their wounds had developed to stage two.
* Wounds were not documented and measured in line with best practice guidelines.
* The organisation’s policies in relation to pressure injuries and wounds states that a wound management plan is to be implemented and the medical officer notified. While the policies and procedures detail the skin assessment process, they do not include guidance in relation to wound management and documentation.
* Management reported 24 hour progress note reviews, clinical audits and monthly clinical indicator reports are used to monitor wounds and pressure injuries. Deficiencies found by the Assessment Team were not identified in any of these monitoring processes.
* Despite having at least three consumers with pressure injuries, the clinical statistics report identified only one consumer with a pressure injury. Deficiencies in relation to wound documentation were not highlighted in the report.

The provider did not agree with the Assessment Team’s findings and maintains at the time of the Site Audit, all consumers had a suitable assessment that had been carried out regarding behaviours, known triggers and causes, and alternative strategies. The provider’s response includes copies of sampled consumers’ risk assessments in place at the time of the Site Audit.

The response also states that the Assessment Team’s findings have been considered and the organisation’s wound policies and procedures have been updated to include information in relation to documentation and measurement of wounds.

The response includes a copy of the service’s Continuous improvement plan, which addresses some deficiencies identified by the Assessment Team, including but not limited to, conducting spot check audits, updating policies and procedures, providing staff education and conducting additional monitoring processes.

I acknowledge the provider’s response and the associated documentation provided. However, based on the Assessment Team’s report and provider’s response, I find at the time of the Site Audit, the organisation’s clinical governance framework was not effective in ensuring behaviour support plans were implemented and identifying recurring antibiotic use, incorrect staff practice and ineffective management of wounds.

In coming to my finding, I have considered the organisation’s clinical governance framework was not effective in ensuring all consumers subject to restraint had behaviour support plans as required under the *Quality of Care Principles*. At the time of the Site Audit, substitute documents for consumers without a behaviour support plan did not include information to guide staff practice in relation to the use of restraint, including the duration, frequency and monitoring requirements. In relation to the behaviour support plans that were in place, monitoring details of the use of restraint was not documented. Evidence included in the provider’s response supports the Assessment Team’s assertion that the organisation’s regulatory obligations under the *Quality of Care Principles* had not been met.

In relation to diabetic management, I have considered that at the time of the Site Audit, policies and procedures did not guide staff practice in relation to diabetes management. Evidence demonstrates staff did not always report BGLs outside the reportable range to a medical officer as required, and diabetic management plans lacked information to guide staff in monitoring risks to consumers’ health and providing clinical care tailored to their needs.

I have considered that processes to monitor antibiotic usage were ineffective, as they did not identify extended periods of antibiotic use and staff practice that was not in line with the organisation’s procedure. While I acknowledge infections are reviewed by the Board, infection reports did not contain sufficient information to highlight recurrent antibiotic use.

In relation to pressure injuries, I have considered that at the time of the Site Audit, the organisation’s policies and procedures did not guide staff in documenting and measuring wounds. As staff were not regularly measuring, staging and documenting wounds, they could not be effectively monitored to ensure they were healing. I have also considered that monitoring processes did not identify staff were not regularly measuring and documenting wounds and clinical reports submitted to the Board did not include all active wounds.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 8 Organisational 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 2 Requirements (3)(a), (3)(b) and (3)(e)**

* Ensure staff have the skills and knowledge to initiate assessments and develop and/or update care plans, including in relation to changes in consumers’ health and well-being.
* Ensure consumer care plans are updated in response to consumers’ changing condition and clinical incidents.
* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(b), (3)(d) and (3)(g)**

* Ensure staff have the skills and knowledge to:
	+ Provide appropriate care relating to pressure injury management and medication administration.
	+ Recognise changes to consumers’ health and well-being, including clinical deterioration and acute conditions, take appropriate action, implement management strategies and initiate referrals in a timely manner to medical officers and relevant specialists.
	+ Ensure care plans are accurate and reflective of each consumer’s current care and service needs.
	+ Identify changes to consumers’ personal and clinical care needs and implement appropriate monitoring processes.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wound management, medication management, minimising the risk of infection and antimicrobial stewardship 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, wound management, medication management, minimising the risk of infection and antimicrobial stewardship.

**Standard 7 Requirement (3)(a)**

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.

**Standard 8 Requirement (3)(e)**

* Review the organisation’s clinical governance framework in relation to non-compliance identified in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care.