Performance

Report

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| Name of service: | Acacia Living Group Menora Gardens Aged Care Facility |
| Service address: | 51 Alexander Drive MENORA WA 6050 |
| Commission ID: | 7151 |
| Approved provider: | Acacia Living Group Limited |
| Activity type: | Site Audit |
| Activity date: | 15 May 2023 to 17 May 2023 |
| Performance report date: | 18 July 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Acacia Living Group Menora Gardens Aged Care Facility (**the service**) has been prepared by R, Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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 Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the 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; and
* the provider’s response to the Assessment Team’s report received 11 July 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

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

**Standard 1 Requirement (3)(a)**

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

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

* Ensure each consumer receives safe and effective personal and clinical care, specifically in relation to continence care.
* Ensure the high impact or high prevalence risks associated with care are effectively managed for each consumer.
* Ensure staff recognise and respond to changes in consumer condition and deterioration.
* Ensure staff adhere to and following infection control principles to ensure the minimisation of infection related risks.

**Standard 4 Requirements (3)(a), (3)(c) and (3)(f)**

* Ensure each consumer receives services and supports for daily living in line with their needs goals and preferences to promote independence and quality of life, optimising health and well-being.
* Ensure each consumer has services and supports for daily living that enables them to do the things of interest to them.
* Ensure where meals are provided, they are of suitable quality and quantity for consumers

**Standard 5 Requirements (3)(a) and (3)(b)**

* Ensure the environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction, and function.
* Ensure the environment is safe, clean and well maintained specifically in relation to the memory support unit.

**Standard 6 Requirements (3)(c) and (3)(d)**

* Ensure appropriate action is taken in relation to feedback and complaints and an open disclosure process is used in response when things go wrong.
* Ensure feedback and complaints are used to improve the quality of care and services.

**Standard 7 Requirements (3)(a), (3)(c), (3)(d) and (3)(e)**

* Ensure there are the right number and mix of members of the workforce to enable to the delivery of safe and quality care and services.
* Ensure the workforce is competent and have the knowledge and qualifications to perform their roles effectively, specifically in relation to managing clinical risks, including falls and deterioration, and understanding restrictive practices.
* Ensure the workforce is trained, equipped. and supported to deliver the outcomes required by these standards.
* Ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

**Standard 8 Requirements (3)(b), (3)(c), (3)(d) and (3)(e)**

* Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and is accountable for the delivery.
* Ensure the organisation has effective governance systems, specifically in relation to workforce governance and feedback and complaints.
* Ensure the organisation’s risk management systems and practices is effective. specifically in relation to the management of high impact or high prevalence risks associated with consumer care, supporting consumers to live their best life and an incident management system that prevent recurrence.
* Ensure the organisation’s clinical governance framework includes antimicrobial stewardship, minimising the use of restraint and open disclosure.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | 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. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | 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. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the six specific Requirements has been assessed as non-compliant. The Assessment Team recommended Requirement (3)(a) in Standard 1 Consumer dignity and choice not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied the service treated each consumer with dignity and respect, specifically in relation to personal care. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

* Consumers A and B, who reside in the memory support unit, were observed walking through communal areas of the service in soiled and urine-soaked clothing.
* Consumer A was noted to have a strong smell of urine surrounding them.
* A further three consumers, also residing in the memory support unit, were observed during meal service to be assisted by staff in a rushed and undignified manner, with large spoonful’s of food being served to them at one time without being afforded time to take a break between mouthfuls. Two of the three consumers were observed to be physically restrained by staff during meal assistance, having their arms held to prevent free movement and unable to participate in assisting themselves.
* The provider acknowledged the Assessment Team’s recommendation. The provider’s response included a plan for continuous improvement with actions that included, but was not limited to:
* Discussing expectations of the organisation with staff.
* Commencing daily rounding by senior management team.
* Undertaking a survey and collecting feedback about dignity and respect from consumers and representatives.

I acknowledge the provider’s response. However, I find each consumer was not treated with dignity and respect. For the five consumers observed, including Consumers A and B, staff did not maintain their dignity in relation to their personal hygiene nor did staff treat them in a respectful manner in relation to the provision of meal assistance.

I acknowledge the provider has submitted with their response a plan for continuous improvement with actions to remedy the deficits identified in this Requirement with a planned completion date of November 2023. I acknowledge the provider’s commitment to improving their performance, and I encourage the provider to continue with those actions. However, in coming to my decision, I have considered the planned actions will require time to achieve efficacy and improved outcomes for consumers.

For the reasons detailed above, I find requirement (3)(a) in Standard 1 Consumer dignity and choice non-compliant.

**In relation to Requirements (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f)**, consumers confirmed care and services are delivered in a way that is right for them and in a culturally safe manner, including where consumers have preferences for care delivered by gender specific staff or consumers with diverse cultural background are able to communicate with staff in their own language.

Consumers confirmed they are able to make choices and decisions about when and how their care and services are delivered and have choice over who consumers wish to be included on the decision-making process. Consumers were observed spending time with other consumers they had connections with and confirmed they are able to make decisions on maintaining those connections, including intimate relationships.

Documentation reflected where a consumer wishes to take risks to live their best life, they are done so with their safety as a priority, including discussion about risks and strategies to mitigate those risks. Consumers confirmed information is provided to them is current, accurate and communicated in a way that enables them to make decisions about the way care and services are delivered. Consumers were satisfied their personal information is kept confidential.

Staff could describe how they engage consumers in making choices about their care and services and how they support them to take risks they wish to take. Staff confirmed they assist consumers to understand information provided, and how they ensure consumers’ privacy is respected and personal information is kept confidential.

For the reasons detailed above, I find Requirements (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |
| Requirement 2(3)(b) | 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. | Compliant |
| Requirement 2(3)(c) | 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. | Compliant |
| Requirement 2(3)(d) | 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. | Compliant |
| Requirement 2(3)(e) | 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. | Compliant |

Findings

Consumers and representatives confirmed they are included in the development of consumers’ care and services and were confident consumers’ assessments and planning considered risks associated with their care. Consumers and representatives confirmed information about consumer care planning is current and in line with their needs, goals, and preferences and is documented and accessible for consumers.

Consumers and representatives were satisfied with how outcomes of assessments and care planning are communicated and in a way that consumers are able to understand and confirmed where changes or incidents occur consumer care documentation is updated in response.

Staff demonstrated understanding of the assessment and planning process and confirmed risks are considered when assessments are undertaken at the admission process or where changes and incidents occur. Staff were able to describe the care planning process and how consumers and consumer representatives are engaged to input into those processes.

Documentation for sampled consumers confirmed risks, including falls, skin integrity, pain, and behaviours and evidence of strategies to manage those risks included in consumer care planning. Consumer assessments and planning showed evidence of discussions with consumers and representatives about end of life and advanced health care needs and recorded the outcomes of those discussions. Documentation confirmed consumers’ assessment and planning is reviewed at regular intervals, and where changes in consumer condition or incidents occur strategies for care delivery and reviewed and new interventions documented where appropriate.

For the reasons detailed above, I find all Requirements in Standard 2 Ongoing assessment and planning with consumers, Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | 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. | Non-compliant |
| Requirement 3(3)(e) | 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. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as four of the seven specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(a), (3)(b), (3)(d) and (3)(g) not met.

**Requirement (3)(a)**

The Assessment Team was not satisfied each consumer received safe and effective personal care, specifically in relation to personal hygiene. The Assessment Team’s report provided the following information and evidence gathered through observations, documentation, and interviews relevant to my finding:

* Consumer A was observed sitting in a wet continence aid that had soaked through their clothing with an offensive odour in the area they were seated.
* Documentation confirmed Consumer A is not receiving personal care, specifically continence care in line with their required needs and progress notes through March 2023 and May 2023 note this is often due to a refusal by Consumer A to continence care.
* Consumer B and D’s representatives were not satisfied with the personal care delivered to the consumers confirming they often find both consumers in wet soiled clothing due to their continence care not being delivered.
* Two representatives confirmed they often find the lounge and other chairs in communal areas wet through with urine when they visit.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* A review of the cleaning schedule.
* Provision of equipment required to ensure furniture is cleaned in a timely manner.
* Collecting feedback from consumers and representatives on cleanliness of the service.

I acknowledge the provider’s response; however, I find that each consumer does not receive safe and effective personal care that is best practice or optimises their health and well-being. In coming to my finding, I have considered feedback from representatives that indicated they were not satisfied with the personal care, more specifically continence care that was delivered to Consumers A, B and D, along with observations provided in the Assessment Team’s report. For Consumer’s A, B and D, the observations of them being in soiled and soaked through clothing on multiple occasions which was confirmed by their representatives, demonstrates they are not delivered personal care in line with their needs or that their health and well-being in relation to continence care is safe or effective.

I have also considered evidence provided in other Requirements, including Standard 1 Requirement (3)(a) that shows Consumers A and B were not delivered personal hygiene in a dignified manner and were observed with urine soaked clothing and faecal stains on their clothes and Standard 7 Requirement (3)(a) where staff provided feedback indicating they did not have enough time to deliver effective personal care.

For the reasons detailed above, I find Requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied that high impact or high prevalence risks associated with consumer care, specifically in relation to the se of restraint, pain in relation to wound care and falls management. The Assessment Team’s report provided the following information and evidence gathered through interview and documentation relevant to my finding:

* Consumer’s B and D were observed by the Assessment Team being physically restrained by staff providing meal assistance. Staff were observed to hold their hand on Consumer B’s arm to prevent them from grabbing the clothing protector and moving it whilst providing meal assistance. Staff were also observed placing their arm over Consumer D’s left arm to prevent them from assisting themselves. Consumer D’s representative confirmed Consumer D is able to eat without assistance with close supervision and prompting.
* Management was informed but were unaware of this staff practice occurring.
* In relation to pain management, Consumer G has pain associated with a pressure injury and osteomyelitis. Consumer G stated they were not satisfied with how their pain is managed as they often wait up to an hour for staff to provide pain relief medication when they have advised they are experiencing pain. Consumer E has ongoing pain associated with peripheral vascular disease and arthritis and confirmed they are not asked about their pain prior to medication administration.
* In relation falls management, staff do not follow the service’s falls management processes and ensure falls risk strategies are reviewed and updated post fall or investigation undertaken to prevent further recurrence.
* Consumer B sustained five falls between October 2022 and March 2023 and their representative raised concerns about the number of falls Consumer B has had. Staff have not analysed the clinical data nor implemented new strategies to prevent further falls from occurring.
* Consumer F sustained two falls during May 2023 but did not have their falls risk reviewed or strategies updated post fall.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* Having a senior clinical team on site to review daily actions via the electronic management system.
* Implementation of daily clinical huddles.
* Introduction of the clinical manager and registered nurse clinical work plan to support role requirements, documentation, and expectations.
* Education on all high risk or high prevalence risks.
* Inclusion of high-risk high prevalence risks as an agenda on clinical meetings.

I acknowledge the provider’s response and actions to address the deficits. However, I find each consumer’s high impact or high prevalence risks associated with care have not been managed effectively, specifically in relation to use of restraint, pain and falls management. In coming to my finding, I have considered the observations made by the Assessment Team of care staff physically restraining Consumers B and D during meal assistance and the lack of awareness by registered staff and management that this practice was occurring. I have also considered for Consumer E, who was observed to show signs of pain, confirmed staff do not ask about pain prior to administration of pain relief and Consumer G, who has constant pain and confirmed they have extended wait times to get pain relief. Further to this, staff do not follow pain management policies and procedures and only monitor pain when as required pain relief is administered. I find that interviews with Consumers F and G, along with documentation confirms pain management for both consumers has not been effective.

In relation to falls for Consumer B, I have considered the evidence included in the Assessment Team’s report that shows staff do not follow the service’s own falls management processes and review falls risk post fall or evaluate the strategies in place for effectiveness and staff record the same information on the incident form. I have also considered that Consumer B’s representative is concerned about the number of falls the consumer has had. In relation to Consumer F who had two falls on the same day during May 2023, staff did not review the falls strategies to prevent further recurrence. I find the service has not effectively managed Consumer B or G’s falls.

For the reasons details above, I find Requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)**

The Assessment Team was not satisfied deterioration or change in a consumer’s condition is recognised or responded to in a timely manner for three consumers (Consumers C, E and F). The Assessment Team’s report provided the following information and evidence gathered through interviews, observations and documentation relevant to my finding:

In relation to Consumer C

* Consumer C, who resides in the memory support unit, was observed on day one of the Site Audit to be unwell and with a cough. On day two, Consumer C appeared to have declined in condition and was observed to be choking or aspirating whilst being assisted with their lunch meal.
* Staff were observed attempting to force feed Consumer C who was observed to be attempting to push the staff’s hands away from putting food into their mouth.
* Consumer C was heard gurgling and choking throughout the meal assistance and staff advised they were escalating the incident to a registered staff member.
* A registered staff member did not attend to Consumer C for 15 minutes at which point Consumer C had passed away.

In relation to Consumer E

* Consumer E stated they were vomiting the day prior to the Site Audit visit and advised they told staff and that they also told staff they felt weak.
* Staff did not escalate or document Consumer E’s change in condition or record they had been vomiting.

In relation to Consumer F

* Consumer F sustained two unwitnessed falls on 9 May 2023 which was later identified as a possible stroke contributing to the falls.
* Consumer F’s representative confirmed they spoke to them on the evening post the falls and noted Consumer F’s speech was slurred and observed a facial droop the following day when they visited the service.
* Neurological observations recorded post falls did not include slurred speech or facial drooping and staff recording the observations two days post fall did not document the right-side weakness and Consumer F being unable to hold a spoon themselves.
* On 10 May 2023, a review by physiotherapist recommended a hoist transfer post falls due to right side weakness.
* Clinical staff and medical officer reviews did not identify need for hospital transfer until 11 May 2023, two days post falls when a second medical officer reviewed Consumer F and they were transferred to hospital
* Consumer F’s representative raised concerns they did not feel Consumer F’s deterioration in condition was recognised and felt there was a delay in transferring Consumer F to hospital

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* Delivering clinical deterioration training to all staff.
* Implementation of daily clinical huddles.
* I acknowledge the provider’s response; however, I find that for Consumers C, F and E, their change in condition and deterioration was not recognised or responded to in a timely manner. In coming to my finding, I have considered the evidence for all three consumers, including for Consumer C there were signs of deterioration the day prior to and day of their passing, including a cough that became moist with gurgling sounds and their attempt at pushing food away from a staff member who appeared to be force feeding them. Consumer F was observed choking and gurgling and whilst a care staff member escalated to a registered staff member, there was no urgency in their response to the incident.
* In relation to Consumers E and F, I have considered feedback provided by Consumer E about their vomiting and feeling unwell and for Consumer F following two falls on the same day, their representatives advising they observed slurring of speech in the hours following, facial drooping the next morning and right side weakness two days later identified by the physiotherapist; none of which was recorded in progress notes, incident documentation or on neurological observations for either consumer. I find for both Consumers E and F, staff did not recognise their signs of deterioration or change in condition in a timely manner when they both displayed signs of changes.

For the reasons detailed above, I find Requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(g)**

* The Assessment Team were not satisfied the service’s infection control processes and practices were effective in preventing or controlling infection. The Assessment Team’s report provided the following information and evidence gathered through interviews and observation relevant to my finding.
* Feedback from representatives included chairs in the communal areas of the memory support unit are often soiled from consumers with incontinence.
* Consumer H was observed in the memory support unit on day one of the Site Audit picking up used tissues from another consumer and picking up a piece of cake. Consumer H tested positive for COVID via a rapid antigen test (RAT) on Day three of the Site Audit visit.
* Staff did not undertake additional cleaning when consumers were being tested for signs and symptoms of COVID in the memory support unit.
* Staff were observed not adhering to appropriate infection control practices or wearing personal protective equipment (PPE) when consumers were identified with signs and symptoms and being tested for COVID in the memory support unit.
* The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:
* A review of infection control processes at the service.
* A review and update of the Outbreak Management Plan.
* Undertaking an environmental audit.
* Review and update of the service’s cleaning schedule.
* Infection control practices training for staff to be delivered.

I acknowledge the provider’s response. However, I find staff did not demonstrate appropriate infection control practices to minimise the transmission of infections to other consumers. In coming to my finding, I have considered the observations that were made throughout the Site Audit visit, including discarded used tissues being picked up by a consumer who later tested positive for COVID, staff being observed to not have PPE on, high touch point cleaning not being undertaken in the memory support unit where consumers showed signs and symptoms of COVID were moving freely and not isolating from other consumers, and the feedback from representatives which included chairs in the communal areas are often spoiled from consumers with incontinence. I have also considered evidence in other Requirements to support my finding, including Standard 1 Requirement (3)(a) and Standard 3 Requirement (3)(a) in relation to consumers being observed sitting in soiled continence aids, being soaked through with wet clothing from urine and faecal stains on their clothing, and evidence in Standard 5 Requirement (3)(b) that confirms staff are unable to compete their cleaning schedule and furniture was observed to be soiled and wet from incontinent episodes.

For the reasons detailed above, I find Requirement (3)(g) in Standard 3 Personal care and clinical care non-compliant.

* **For Requirements (3)(a), (3)(b), (3)(d), and (3)(g),** I acknowledge the provider has included actions planned to address the identified deficiencies and improve their performance in these Requirements. However, these planned actions have outcome dates set for the end of July 2023, August 2023 and September 2023 and will require time to be fully embedded to enable efficacy and improve the personal and clinical care outcomes for consumers.
* **In relation to Requirements (3)(c), (3)(e) and (3)(f),** consumers and representatives confirmed staff knew consumers and the care they required, and they receive referrals to other providers of care appropriately and in a timely manner. Staff were able to describe the processes for referring consumers to other providers of care and demonstrated knowledge of consumers and their personal and clinical care needs. Documentation confirmed consumers’ information is communicated appropriately and referrals to other health professionals are actioned in a timely manner. Staff described the ways in which they care for consumers nearing the end of life ensuring their dignity and comfort is maximised.
* For the reasons details above, I find Requirements (3)(c), (3)(e) and (3)(f) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | 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. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | 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. | Non-compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as three of the seven specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(a), (3)(c) and (3)(f) in Standard 4 Services and supports for daily living not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumers received services for daily living in line with their needs, goals and preferences that optimised their independence and promoted a quality of life. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

* Multiple consumers, including Consumers A, B and D, were observed in the memory support unit seated in lounge areas with little or no resources for lifestyle, no engagement and little to no staff interaction across each day of the Site Audit visit.
* Consumer B’s representative raised concerns about the lack of engagement Consumer B received in relation to daily living supports and their independence is not optimised.
* The service environment in the memory support unit specifically communal areas was observed to be barren, uninviting, and not promoting well-being or quality of life.
* Care planning documentation for Consumers A, B and D included their preferences for daily living services, however, activity charts, progress notes, feedback from representatives and observations showed supports to deliver services in line with these needs was not demonstrated.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* The implementation of a Care Champion model of care with key indicators of extra staff on the floor to embed the action plan for lifestyle services.
* A review of consumer social and leisure profiles.

I acknowledge the provider’s response and actions developed to address the deficiencies identified in this requirement. However, in relation to Consumers A, B and D, I have considered observations documented in the Assessment Team’s report that indicated for all three consumers and multiple others the lack of engagement, meaningful resources or staffing did not demonstrate the services and supports for daily living meet the needs, goals, and preferences for those consumers to support and promote well-being, a quality of life and optimise independence was effective. I have also considered for other consumers, the service was not able to demonstrate it provides safe and effective services and supports for daily living enabling quality of life or optimising their well-being and independence.

For the reasons detailed above, I find for Requirement (3)(a) in Standard 4 Services and supports for daily living non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied each consumer is supported to participate within the internal and external community or do the things of interest to them, specifically those residing in the memory support unit. The Assessment Team’s report provided the following information and evidence gathered through interviews, observation, and documentation relevant to my finding:

* Nine representatives raised concerns about the lack of engagement in lifestyle activities for their consumers residing in the memory support unit. Two of the nine representatives have raised concerns with management, however, indicated it has not improved as a result. Over half of the representatives indicated they wanted their consumers to be assisted to utilise the service’s expansive garden area to join with the service’s community for fresh air, enjoyment, and sensory stimulation, however, three representatives expressed dissatisfaction their consumers are only taken to this area when staff take them.
* Multiple consumers, including Consumers A, B and D were observed throughout the Site Audit visit to be sitting in chairs without any engagement for extended periods of time, were not engaged in any meaningful activities nor had any staff interaction.
* Consumer D’s representative confirmed Consumer D is always unengaged and indicated they would like Consumer D to be assisted with walks, however, stated Consumer D is only walked when they attend the service to assist. The physiotherapist confirmed therapy staff can only assist with walks if Consumer D is seated in the reclining chair in their room, however, as most days care staff have already transferred Consumer D to the communal lounge area they are not assisted with walks in the outside garden.
* Consumer D’s lifestyle participation documentation confirmed they do not receive regular walks or one-to-one therapeutic massage or is engaged in any activities of interest as per their needs, goals and preferences recorded in their care plan.
* Two staff allocated to the memory support until confirmed they do not have time to assist engage consumers in group or individual activities.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* A review of all consumers’ social and leisure profiles.
* A review of the lifestyle activity calendar for the memory support unit.

I acknowledge the provider’s response; however, I find that each consumer is not supported to do the things of interest to them or participate in the service community. For multiple consumers residing within the memory support unit, including Consumers A, B and D, observations made by the Assessment Team on multiple occasions throughout the Site Audit visit showed the service did not demonstrate they are supported to do things of interest and there is little to no engagement in the activity or individual lifestyle program. I have also considered feedback from at least nine representatives indicating dissatisfaction with lack of engagement with the lifestyle program for their consumers who reside in the memory support unit.

For the reasons detailed above, I find Requirement (3)(c) in Standard 4 Services and supports for daily living non-compliant.

**Requirement (3)(f)**

The Assessment Team were not satisfied meals were provided in a dignified manner to consumers and the dining experience was not positive. The Assessment Team’s report included the following information relevant to my finding:

* Observations of meal services on multiple occasions throughout the Site Audit visit showed for consumers residing in the memory support unit they were rushed, meal assistance where required was not dignified and there was not enough room for each consumer to have their meals in the dining room if they chose to.
* Tablecloths and placemats on tables in the memory support unit were observed to be dirty with leftover food from the previous meal service stained on them.
* Consumers B and C were observed to be physically restrained by staff during meal assistance to prevent them from using their hands and interrupting the staff member assisting both consumers with their meals.
* Meals for Consumers B and C were observed to be left out of the hot box and found to be lower temperature with staff not rechecking the temperature to ensure it was of optimal quality.
* Food for one consumer, who stays in their room for meals, was observed to be placed out of reach of the consumer and they were unable to have their meal.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included the following actions to address the deficits identified:

* A review of the dining experience included the set up and protected time.
* Delivering toolbox training to staff around Dining Room standard.
* Investigate the options of having two sittings for meal service.

I acknowledge to provider’s response; however, I find that meals are not of quality and the dining experience for consumers residing in the memory support wing is not positive or enjoyable. For Consumers B and C, I have considered while they may have food that is of suitable quality the act of physically restraining both consumers to limit their interaction with their own meal assistance does not provide a safe or quality dining experience. I have also considered that where meals are provided in the memory support unit only a reduced number of consumers are able to sit in the dining area and enjoy their meals.

For the reasons detailed above, I find Requirement (3)(f) in Standard 4 Services and supports for daily living non-compliant

**In relation to Requirements (3)(a), (3)(c) and (3)(f),** I acknowledge the provider has included actions planned to address the identified deficiencies and improve their performance in these Requirements. While the planned actions have an outcome date set for 9 September 2023, I find that these actions will require time to be fully embedded to improve consumer outcomes.

**In relation to Requirements (3)(b), (3)(d), (3)(e) and (3)(g),** consumers described how they are supported by staff with their emotional, spiritual, and psychological needs, including through individual sessions, volunteers visiting, and church services delivered. Consumers confirmed equipment is provided to them when they need it to maintain their independence, including mobility and engage in the lifestyle program and were satisfied it was right for them.

Staff confirmed information about consumers’ condition and lifestyle supports required is communicated with them to enable them to deliver the right care to consumers. Documentation confirmed referrals to other providers of care, including volunteers is done in a timely manner when requested or required.

For the reasons detailed above, I find Requirements (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 4 Services and supports for daily living compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Non-compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Non-compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the three specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(a) and (3)(b), in Standard 5 Organisation’s service environment not met.

**Requirement (3)(a)**

While consumer’s residing in the main non-secure area of the service felt they were safe living at the service and satisfied the service environment was welcoming and easy to navigate, the Assessment Team were not satisfied consumers residing in the memory support secure unit had a service environment that was welcoming, easy to understand or optimised each consumer’s sense of belonging. The Assessment Team’s report included the following information and evidence gathered through observations and interviews relevant to my finding.

* One representative was not satisfied the service environment was welcoming and felt the corridors and dining areas lacked furnishings and brightness and did not promote a positive dining experience.
* Five representatives were not satisfied their consumer’s independence was supported by the service environment as they were not supported by staff to access garden areas.
* Observations of the service environment in the memory support unit showed each of the lounge and dining areas were cold in temperature with little furnishings, dimly lit and did not promote a welcoming environment.
* The dining area was not large enough to host consumers comfortably and consumers were observed to be cramped and seated very close when having their meals. Some consumers were observed to have tables placed in front of where they were seated in the lounge area to have lunch as they were unable to be accommodated in the dining area due to the lack of space.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included action to address the deficits identified, including undertaking an environmental audit of the service.

I acknowledge the provider’s response. However, I find the service environment was not welcoming or easy to navigate for consumers and the lack of furnishings and brightness did

not demonstrate the service environment gave consumers a sense of belonging. I have considered that observations and feedback in relation to the main non-secure service environment included satisfaction from consumers and observed to be easy to navigate, however, for each consumer residing in the memory support unit the service environment did not provide a service environment that optimised their sense of belonging, including not being able to comfortably sit in a dining area for meal service or independently navigate garden areas.

For the reasons detailed above, I find Requirement (3)(a) in Standard 5 Organisation’s service environment non-compliant.

**Requirement (3)(b)**

While the service environment in the main non-secure area of the home was observed to be clean, safe, and well maintained, the Assessment Team were not satisfied the service environment for consumers residing in the memory support secure unit was safe, well-maintained, and comfortable. The Assessment Team’s report included the following information and evidence gathered through observations and interviews relevant to my finding:

* Two representatives were not satisfied with the cleanliness of the service environment with one of the two representatives describing they observe some consumers in the memory support unit wandering with soiled continence aids and urine and faecal stained clothing. The second representative described how they need to check chairs in the communal area for wetness before they sit down, and they have observed consumers walking with wet pants and the unit has an unpleasant smell.
* Hospitality staff confirmed they are unable to complete scheduled cleaning in the time allocated to do so.
* Chairs in consumers’ rooms, including those used for mobility and armchairs in communal lounge and chairs in dining areas were observed to be soiled, marked and unclean.
* The Assessment Team noted a musty offensive faecal odour smell for the duration of the Site Audit visit in the memory support unit.

The provider acknowledged the Assessment Team’s recommendations. The provider’s response included action to address the deficits identified, including but not limited to:

* Undertaking an environmental audit of the service.
* Delivering toolbox training on hospitality standards.
* Engaging with a specific Dementia specialist to review the environment.

I acknowledge the provider’s response. I have considered for consumers residing in the main non secure areas of the service the service environment is safe and clean; however, I find for each consumer residing in the memory support secure unit the service environment was not clean, safe, well maintained, or comfortable. In coming to my finding, I have also considered evidence included in Standard 6 Requirement (3)(d) that shows the service received formal feedback from a representative that highlighted the issues identified in the Assessment Team’s report in relation to the lack of cleanliness in the memory support unit.

For the reasons detailed above, I find Requirement (3)(b) in Standard 5 Organisation’s service environment non-compliant.

**In relation to Requirements (3)(a) and (3)(b),** I acknowledge the provider has summitted a plan for continuous improvement with actions to address the identified deficits in the Assessment Team’s report. However, I consider time will be required to establish efficacy and improvements in the service environment with the planned actions related to these requirements, specifically for consumers residing in the memory support unit.

**In relation to Requirement (3)(c),** consumers and representatives were satisfied with the maintenance and cleanliness of the service’s equipment and confirmed they were suitable to use and if they identify an issue requiring fixing this is done so in a timely manner. Staff demonstrated understanding of the service’s maintenance process and described how they report any issues requiring fixing. Maintenance records showed routine and preventative maintenance is undertaken where required by internal staff and external contractors.

For the reasons details above, I find Requirement (3)(c) in Standard 5 Organisation’s service environment compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the four specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met.

**Requirements (3)(c) and (3)(d)**

Consumers and representatives were not satisfied appropriate action was taken in response to feedback or complaints and the service did not demonstrate it uses an open disclosure process when incidents occur, or that feedback and complaints improved the quality of care and services. The Assessment Team’s includes the following information and evidence gathered from interviews and documentation relevant to my finding:

* Consumer C’s representative advised they made a complaint to the service about an injury caused by incorrect wound care delivered to Consumer C. While this was followed up, with the service passing this to the registered nurse to action, there was no evidence this had been appropriately addressed, what the outcome was or if open disclosure had been used.
* One representative confirmed they were not notified by the service when their consumer sustained a fall and was transferred to hospital in March 2023. While management responded to the complaint stating they would investigate, there was no documented outcome or evaluation of the representative’s satisfaction with action.
* A complaints register is maintained; however, it does not record any outcomes of complaints made.
* Two complaints made by representatives during February 2-23 about the cleanliness of one consumer’s bathroom, including faecal matter observed in their bathroom vanity and on tissues in the bin not removed was not responded to for one month When management responded, the actions taken did not resolve all elements of the complaint. For the other consumer, the complaint included concerns about lack of staffing, décor of the service and drinks not being replenished. While management responded in a timely manner to this complaint, the representative advised some issues from the initial complaint remain unresolved.

The plan for continuous improvement showed improvement actions were added during the Site Audit visit.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:

* Delivery feedback management training.
* Undertaking a review of all feedback received over three months prior to the Site Audit visit to ensure actions have been taken and open disclosure process used.
* Review of feedback and complaints provided over the previous six months to identify areas of improvement.

I acknowledge the provider’s response, however, find that the service has not taken appropriate action in response to complaints made by consumers and representatives. In relation to complaints raised by consumer representatives about the cleanliness of the service environment, specifically in the memory support unit where their consumers reside, I have considered the evidence included in Standard 1 Requirement (3)(a) and Standard 5 Requirements (3)(a) and (3)(b) that demonstrate complaints about cleanliness of the service environment have been made for some time without resolution or improvement resulting in consumers being treated in an undignified or disrespectful manner, and communal and private areas being malodourous, urine soaked communal chairs and faecal matter on bathrooms and other furnishings.

In relation to Consumer C, I have also considered that while management responded to the complaint made by Consumer C’s representative, this was passed to another member of staff to action and there were no recorded outcomes documented and no way of identifying the actions taken and if they improved outcomes of care for Consumer C.

In relation to open disclosure, I have considered that while information in Standard 8 Requirement (3)(e) indicates open disclosure is used for one consumer, they were not afforded open disclosure when their consumer sustained a fall, and they were also not informed of them being transferred to hospital.

For the reasons detailed above, I find Requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints non-compliant.

**In relation to Requirements (3)(c) and (3)(d),** I acknowledge the provider has included actions planned to address the identified deficiencies and improve their performance in these Requirements. While the planned actions have an outcome date of 31 July 2023, I find that these actions will require time to be fully embedded. In coming to my finding, I have also considered information in Standard 8 Requirement (3)(c) that shows systemic deficiencies in the overall governance of feedback and complaints.

**In relation to Requirements (3)(a) and (3)(b),** consumers and representatives confirmed they are encouraged to provide feedback and complaints in various ways, including to staff, in writing and via the resident relative meetings. Consumers confirmed they are aware of advocacy services and how to access those services if they needed to. Staff demonstrated knowledge of the feedback system and described how they respond to complaints when consumers make those.

For the reasons detailed above, I find Requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as four of the five specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources not met.

**Requirement (3)(a)**

Consumers and representatives, specifically in the memory support unit, were not satisfied the service had enough staff to deliver care in a way that met consumers’ needs, goals, and preferences. The Assessment Team’s report provided the following information and evidence gathered through interview, documentation, and observations relevant to my finding:

* While some consumers were happy with staffing levels, five representatives were not satisfied with staffing levels.
* Consumers A and B‘s representatives raised concerns the lack of staffing contributed to the delivery of poor personal care, specifically personal hygiene. For Consumer A, their representative confirmed they are not aided with the bathroom due to not enough staff resulting in them finding Consumer A soiled when they visit them. Consumer B’s representative confirmed they regularly visit the service to assist with personal care as staff are often not available to assist them in a timely manner.
* Consumer D’s representative confirmed they often find Consumer D’s clothing is wet through when they visit and there are not enough staff to provide Consumer D with engagement in meaningful activities and they are transferred from their room to a chair in the lounge area most days.
* One representative felt the lack of staffing contributed to their consumer’s falls and the consumer recently broke their hip from a fall whilst walking unassisted and unsupervised.
* One consumer, who resides in the non-secure area of the service, described how they often have to wait up to an hour to get their pain medication when they are experiencing severe pain.
* Staff confirmed they often work short staffed and are unable to provide care to consumers in a way they need. In one area of the memory support unit, staff described working short staffed up to three times per week.
* Staff allocation documentation confirmed between 1:00pm and 3:00pm each day all five wings in the memory support unit have one care staff only per 10 to 11 consumers. There is one float care staff allocated in that time, however, staff advised they don’t come when called as they are too busy elsewhere.
* The Assessment Team observed on multiple occasions consumers in the memory support unit sitting in soiled clothing and left unsupervised without staff interaction for long periods of time in a communal lounge area with nothing meaningful or of interest to do.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:

* Implementing a care champion model of care across the service.
* Rostering extra staff.

I acknowledge the provider’s response; however, I find the service does not have the right number or mix of staff to deliver safe and quality care to consumers. In coming to my finding, I have considered the feedback provided by representatives for Consumers A, B and D around the impact the lack of staffing in the memory support unit has had on the delivery of personal care, resulting in poor personal hygiene care for each of those and other consumers. I have also considered the observations made by the Assessment Team throughout the Site Audit of consumers walking with soiled and soaked through clothing, no interactions with staff or engagement in meaningful activities of interest.

For the reasons detailed above, I find Requirement (3)(a) in Standard 7 Human resources non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the workforce and members of the workforce, including clinical and care staff were competent and had the right skills and knowledge to effectively perform their roles, specifically in relation to the use of physical and chemical restraint, management of falls and recognising and responding to signs of deterioration in consumers. The Assessment Team’s report provided the following information and evidence gathers through interviews, documentation, and observations relevant to my finding.

* Care staff did not understand they were using physical restraint when delivering meal assistance to Consumers B and D and holding down either their hand or arm to prevent them from using or assisting themselves.
* Clinical staff did not follow the service’s policies and procedures for post fall management and for four consumers their risk of falls was not reviewed nor was the strategies in place to manage and prevent those for effectiveness considered.
* Care and clinical staff did not recognise signs of deterioration for two consumers in a timely manner. For Consumer C, staff did not respond to signs of deterioration, including coughing, choking, and gurgling and continued to assist Consumer C with their meal. For Consumer F staff did not respond to signs of deterioration in Consumer F’s condition when they experienced two falls on the same day, speech slurring, facial drooping and noted to have right side weakness and there was a delay in transferring Consumer F to hospital for further review.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:

* A review of mandatory training modules.
* Implementation of post education surveys.

I acknowledge the provider’s response; however, I find the workforce and members of the workforce are not competent or have the qualifications and knowledge to effectively perform their roles. In coming to my finding, I have considered the evidence provided in relation to Consumers B and D around the use of physical restraint and that the care staff providing meal assistance to both consumers did not identify their actions were applying a physical restraint to Consumers B and D. I acknowledge the information in the Assessment Team’s report, however, I find that this evidence is more aligned with another Requirement within this Standard and have considered it under Requirement (3)(d).

I have also considered for two consumers (C and F), care and clinical staff did not recognise the signs of deterioration or change in condition or respond to those in a timely manner. For Consumers C and F, I have considered the evidence in the Assessment Team’s report and evidence included in Requirement (3)(d) of Standard 3 that shows there were signs of change in condition and decline in health. Consumer C was recorded as having a cough that became a moist cough on day one and the following day two of the Site Audit it was observed to get worse to a moist cough with gurgling sounds heard whilst care staff were attempting to feed Consumer C. Whilst care staff did alert clinical staff they did not recognise the decline in condition or respond to the gurgling of Consumer C and continued to attempt to feed them. For Consumer F, staff did not recognise the signs of deterioration when the consumer had two falls on the same day, slurred speech, facial drooping and still did not respond when a physiotherapist noted right side weakness and unable to use cutlery.

For the reasons detailed above, I find Requirement (3)(c) in Standard 7 Human resources non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied the workforce was trained, equipped, and supported to deliver the outcomes required by the Standards. The Assessment Team provided the following information and evidence gathered through observations and documentation relevant to my finding:

* Staff did not have the training or knowledge to identify their actions with Consumers B and D whilst assisting them with their meals, including holding their arms or hands to prevent them disrupting the meal assistance, was a physical restraint.
* Training records indicated staff have not attended training in relation to restrictive practices.
* Two registered staff did not recognise signs of deterioration for Consumer F which included two falls on the same day, facial drooping and slurred speech and escalate in a timely manner.
* Training record indicated staff have not attended education in relation to identifying deterioration.
* Staff did not recognise that Consumer E’s episodes of vomiting as a sign of change in health condition and monitor them further.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:

* A recruitment and retention plan and a full roster review is in place for the service.
* Implementation of a care champion model of care.
* Implementation of live team huddles focusing on clinical risk.

I acknowledge the provider’s response; however, I find the actions of staff in relation to Consumers B, C, D and F can be directly attributable to inadequate training and education. In coming to my finding, I have considered that members of the workforce have not received training in the areas where deficits were identified, including restrictive practices, and recognising deterioration in consumers. I have considered information provided in other Requirements (3)(d) in Standard 3 that shows for Consumer F there were multiple signs of change in condition and deterioration, including slurred speech and facial drooping that was not identified as requiring escalation by clinical staff and while registered staff should operate within a scope of practice that includes recognising and responding to in a timely manner changes in consumer condition, the lack of regular training in deterioration has a direct impact on this. I have also considered information provided in Standard 3 Requirement (3)(b) and Standard 8 Requirement (3)(e) that shows care staff did not understand or recognise their actions with Consumers B and D during meal assistance was a form of physical restraint. I find that the lack of training and education in restrictive practices has directly contributed to this practice occurring and encourage the provider to continue to educate staff around these areas.

For the reasons detailed above, I find Requirement (3)(d) in Standard 7 Human resources non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied each member of the workforce was monitored or had their performance regular assessed or reviewed. The Assessment Team’s report provided the following information and evidence gathered through documentation, observations, and interviews relevant to my finding:

* Representatives for consumers residing in the memory support unit reported dissatisfaction with the care and services staff provided.
* In relation to Consumer C, care staff actions were not monitored when they continued to provide meal assistance to Consumer C when they were choking and gesturing for staff to stop.
* Management stated they were not aware this practice was occurring and would follow this up.
* Staff are not consistently completing incident forms in line with their own processes and did not identify a pressure injury for Consumer D.
* Several consumers residing in the memory support unit were not having personal care delivered in a timely or effective manner by staff and many were observed with soiled continence aids or wet through clothing.
* Documentation showed more than 75% of staff are overdue for a performance appraisal, with some up to 10 years overdue.
* Four care staff and two clinical staff could not recall discussing their performance with their manager or being asked about their learning needs.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:

* A review of staff performance appraisal schedule.
* Completing overdue and outstanding appraisals.

I acknowledge the provider’s response; however, I find that the service does not undertake regular assessment, monitoring or review of each member of the workforce’s performance which has contributed to the poor delivery of personal and clinical care, specifically in relation to consumers residing in the memory support unit as outlined in Standard 1 Requirement (3)(a) and Standard 3 Requirements (3)(a), (3)(b) and (3)(d). In coming to my finding, I have considered that staff have not had adequate training in restrictive practices and as a result care staff did not identify they were applying a physical restraint to Consumers B and D during meal assistance. Further to this, I have considered that management were not aware of staff practice of physical restraint during meal assistance for Consumers B and D demonstrates the monitoring of staff practice was not occurring. I have also considered that staff have not had regular training in recognising deterioration and for Consumers C and D this may have contributed to the delay in escalating changes in condition.

For the reasons detailed above, I find Requirement (3)(e) in Standard 7 Human resources non-compliant.

**In relation to Requirements (3)(a), (3)(c), (3)(d) and (3)(e),** I acknowledge the provider has included actions planned to address the identified deficiencies and improve their performance in these Requirements. While the planned actions have an outcome date of end of September 2023 and end of October 2023, I find that these actions will require time to be fully embedded. In coming to my decision, I have also considered information in Standard 8 Requirement (3)(c) that shows systemic deficiencies in the overall governance of the workforce.

**In relation to Requirement (3)(b),** consumers and representatives confirmed staff treated consumers in a kind and caring manner. Observations in the non-secure area of the service showed staff interacting with consumers in a respectful and caring manner.

Accordingly, I find Requirement (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Non-compliant |
| Requirement 8(3)(c) | 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. | Non-compliant |
| Requirement 8(3)(d) | 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. | Non-compliant |
| Requirement 8(3)(e) | 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. | Non-compliant |

Findings

The Quality Standard is assessed as non-compliant as four of the five specific Requirements have been assessed as non-compliant. The Assessment Team recommended Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied the organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The Assessment Team’s report provided the following information and evidence relevant to my finding:

* While the service provides monthly reports to the Board, including reports that showed issues requiring attention, management was unable to advise how the Board is supporting the service to address their deficits identified.
* Consumer representatives indicated they do not feel confident the service is run well or support consumers’ health, safety, and well-being.
* The governing body has identified the memory support unit needs a refurbishment to improve the service environment, however, they have other deficits, including staffing levels leading to poor delivery of care and services.
* Not all complaints data is being recorded, as such the Board is not aware of the level of dissatisfaction and are unable to respond to those complaints about care and service.
* While the governing Board have identified some risks in relation to incident management, staffing, consumer care plan reviews overdue and staff mandatory training being overdue, they were unbale to describe how they put quality, safety, and cultural goals into action.
* The provider acknowledged the Assessment Team’s recommendation. The provider’s response included actions to address the deficits identified, including but not limited to:
* Implementing an internal timeline for improvement at the service.
* Having twice weekly meetings with the organisation’s quality compliance manager to monitor progress.

I acknowledge the provider’s response and actions in place to address the deficits identified. However, I find the provider did not demonstrate the organisation’s governing body, the Board, promoted a culture of safe, inclusive and quality care services and were not accountable for the delivery of these. In coming to my finding, I have considered the feedback provided by consumers’ representatives of not being confident the service is run well with the consumer’s health, well-being and safety in mind and that the Board does not have access to up-to-date complaints information as they are not recorded accurately by the service and as such is not accountable for the delivery of safe and quality care and services. I have also considered deficits identified in other areas, including Requirements (3)(a), (3)(b), (3(d) and (3)(e) in Standard 3, Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 4, and Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 7, and while the Board has identified some deficits in relation to those identified in the Assessment Team’s report they have not identified all issues, specifically those identified with staff practice and competency, personal and clinical ongoing in the memory support unit.

For the reasons detailed above, I find Requirement (3)(b) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the service demonstrated effective organisational wide governance, specifically in relation to workforce governance and feedback and complaints. The Assessment Team’s report included the following information and evidence relevant to my finding:

* Consumers representatives indicated there are not enough staff, specifically in the memory support unit and provided examples of where they have to deliver care because there are not enough staff.
* Staff confirmed they cannot assist consumers with care delivery as there is only one float staff member to assist with 52 consumers.
* Staff could not demonstrate understanding of restrictive practices or show they recognise and respond to deterioration appropriately.
* Staff performance appraisals are overdue for almost three quarters of the service’s workforce with timeframes out to almost 10 years without a performance appraisal.

The provider acknowledged the Assessment Team’s recommendations and proved the following actions to address the deficits identified in the Assessment Team’s report:

* A full review of the staffing levels across the service to be undertaken.
* Education to be provided in areas, including but not limited to, persona centred care, continence management, restrictive practices, and clinical deterioration.

I acknowledge the provider’s response and the actions identified to address the identified deficits. However, I find the organisation’s governance systems have systemic failures in relation to workforce governance and the feedback and complaints mechanism. In coming to my finding, I have considered the evidence within this Requirement that shows the service’s workforce governance did not identify the deficits in staffing levels, competency and training and that the systemic failure in monitoring of staff performance both on the floor when delivering care to consumers and through the process of undertaking performance appraisals which has resulted in poor care delivered to consumers, specifically in the memory support unit. I have also considered that the service’s own governance processes did not identify complaints were not being accurately and appropriately recorded and escalated. A governance system is in place to identify deficits and issues in systems and processes to improve care and services in the areas in which they are identified, and I find for workforce, feedback and complaints the provider did not demonstrate they had effective governance systems in place. In coming to this finding, I have also considered information and evidence provided in other Requirements, including Standard 6 Requirement (3)(c) which shows complaints are not consistently being recorded or actions in a timely manner, and Standard 7 Requirements 3)(c), (3)(d) and (3)(e) which shows staff do not competently perform their roles, have not received training in the areas deficits have been identified (restrictive practices and clinical deterioration) and have not been effectively monitored for their performance. I have also considered the evidence in Standard 3 Requirements (3)(a), (3)(b) and (3)(d) that describes the deficits in personal and clinical care, including continence care, applying restrictive practices, and not recognising clinical deterioration.

For the reasons detailed above, I find Requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated they have an effective risk management system in place to ensure the safety of consumers, specifically in relation to high impact or high prevalence risks to consumer care and managing and preventing incidents. The Assessment Team’s report provided the following information and evidence relevant to my finding:

* The service collects and analyses clinical data, including incident that occur, however, it does not review consumers’ strategies to manage risks, such as falls for effectiveness or discuss during clinical meetings to prevent further recurrence. For Consumer B who experienced multiple falls, this information was not discussed during clinical meetings to develop new strategies to ensure Consumer B’s falls risk is managed effectively.
* Consumer C’s risk of choking was not identified or managed when they were observed to be choking and gurgling during meal assistance.
* Incidents are not always recorded in the service’s incident management system.
* The service had not monitored medication incidents for March 2023 and April 2023.
* The service did not consider reporting whether incidents are required via the Serous Incident Response Scheme (Serious Incident Response Scheme) within specific timeframes, and for Consumer C who passed away at the service during meal assistance on day two of the Site Audit visit the service was not considering this to be an unexpected death and as such not reporting via SIRS within 24 hours as required.
* For Consumers B and D, the service had not considered the use of restrictive practices as an incident requiring reporting under SIRS.

The provider acknowledges the Assessment Team’s recommendations. The provider’s response included actions to address the deficits identified which included:

* Reviewing all incidents to ensure appropriate escalation, reporting and follow up has occurred.

I acknowledge the provider’s response, including the actions they will implement to improve performance. However, I find the risk management system is not effective in managing high impact or high prevalence risks associated with consumer care, the incident management system is not effective in managing incidents and preventing recurrence and the service is not reviewing incidents to consider whether they are required to be reported under SIRS. In coming to my finding, I have considered that for consumers with high impact or high prevalence risks, including Consumer B with falls, the service is not using the information from incidents to review strategies through their own risk management committees to understand their effectiveness and if further strategies are required to prevent recurrence. I have considered that while the service’s incident management system captures incidents, they are not consistently reviewing those to consider the reporting requirements and for Consumer C who passed away at the service a choking episode, management had not considered if this should have been reported as an unexpected death and as such within 24 hours of occurring. I have also considered information provided in other areas of the Assessment Team’s report, including Standard 3 Requirement (3)(b) that shows clinical risks to consumer care, including Consumer B’s falls are not always reviewed or investigated to identify if strategies are effective or need updating.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied the service had an effective clinical governance framework, in relation to antimicrobial stewardship, and minimising the use of restraint, specifically for physical and chemical restraint. The Assessment Team’s report provided the following information and evidence relevant to my finding:

* The service doesn’t ensure staff are following antimicrobial stewardship policy and processes.
* The service records seven of 141 consumers are under a chemical restraint, however, the psychotropic register documents consumers (including Consumer A) are being administered psychotropic medication to manage behaviours.
* Behaviour support plans for consumers receiving psychotropic medications for behaviour management, including Consumer A, do not record the medications as a behaviour management strategy.
* Behaviour charting is in place, however, effectiveness of medications to manage behaviours is not recorded.
* Informed consent could not be shown for consumers receiving medication for behaviour management that were not considered chemical restraint due to having a diagnosis of behaviour and psychological symptoms of dementia.
* Staff were observed using physical restraint with Consumers B and D during meal service and this was not identified.

The provider acknowledged the recommendations of the Assessment Team. The provider’s response includes the following actions to address the deficits identified:

* A review of the service’s infection prevention and control processes to ensure they align with organisational processes.
* Regular review of the service’s plan for continuous improvement to ensure identification of issues, process, and mitigation of risk.

I acknowledge the provider’s response and commitment to improvement actions to address the deficits. However, I find the organisation’s clinical governance framework is not effective in relation to minimising the use of restraint and antimicrobial stewardship. In coming to my finding, I have considered information for antimicrobial stewardship, including in Requirement (3)(g) of Standard 3 that shows staff are not following the service’s own infection control processes and the governance system with oversight of this has not identified this occurring. I have also considered that the use of physical restraint and medications to alter consumers’ behaviours have not been considered as a form of restraint and as the clinical governance framework has not identified this, consumers have been inappropriately subject to restraint as identified in Requirement (3)(b) in Standard 3. Furthermore, the service has not followed the use of restraint as per legislative requirements.

For the reasons details above, I find Requirement (3)(e) in Standard 8 Organisational governance non-compliant.

**In relation to Requirements (3)(b), (3)(c), (3)(d) and (3)(e)** I acknowledge the provider has included actions planned to address the identified deficiencies and improve their performance in these Requirements. While the planned actions have an outcome date of end of September 2023 and end of November 2023, I find these actions will require time to be fully embedded.

**In relation to Requirement (3)(a),** consumers and representatives confirmed they are included in the development and evaluation of care and services through various platforms, including regular resident and relative meetings.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)