Performance

Report

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| Name of service: | Aegis Parkview |
| Service address: | 6 Drummond Street REDCLIFFE WA 6104 |
| Commission ID: | 7307 |
| Approved provider: | Lakeside Hostel Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 20 June 2023 to 22 June 2023 |
| Performance report date: | 15 August 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 Aegis Parkview (**the service**) has been prepared by E. Blance, 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
* the provider’s response to the assessment team’s report received 19 July 2023
* the Performance report completed 19 December 2022, for the Assessment contact-site conducted 10 November 2022
* other information and intelligence held by the Commission in relation to the service.

**Assessment summary**

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| Standard 1 Consumer dignity and choice | 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 | **Compliant** |
| **Standard 5** Organisation’s service environment | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **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.

* The service is required to ensure informed consent for restrictive practices and environmental restraint is managed in line with legislative requirements.
* The service is required to ensure for consumers who consumers are able to freely move both indoors and outdoors of the service environment.
* The service is required to ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* The service is required to ensure restrictive practices are in line with legislative requirements.

**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. | 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**

I find this Standard Compliant.

Requirement 1(3)(a)

Most consumers confirmed they were always treated with dignity and respect. Staff demonstrated a knowledge and understanding of individual consumers and their backgrounds, the people important to them, their preferences, and choices. Staff were observed engaging with consumers in a respectful way. Care planning documents detailed consumers’ background stories, individual preferences and identified those people important to them. The service had current policies on respect and dignity, and culture and diversity. All staff complete mandatory training relating to dignity and respect.

Requirement 1(3)(b)

Consumers stated staff knew their background and what was important to them. Staff identified consumers from various cultural backgrounds and how this could influence their approach to care. Care planning documents evidenced consumers’ cultural backgrounds, interests, and preferences, and staff demonstrated awareness of how to access language information relevant to consumers from non-English speaking backgrounds. Staff were observed engaging with consumers in a culturally sensitive way.

Requirement 1(3)(c)

Consumers could exercise choice and make decisions about their care and services, and they were supported to maintain relationships that were important to them. Staff supported consumers to make decisions and maintain relationships, including intimate relationships. Care planning documents detailed how consumers wished their care to be delivered and who would be involved in their care.

Requirement 1(3)(d)

Consumers were supported by staff to take risks and to live their best life. Risk assessments were undertaken to identify the risks involved in various activities and how these assessments were used to assist consumers to make informed decisions. Policies guided staff in supporting consumers in choice and decision making and maintaining their independence.

Requirement 1(3)(e)

Most consumers and/or representatives confirmed they received current and timely information that enabled them to exercise choice, such as daily menu and weekly activity options. Consumers were invited to attend meetings and participate in food surveys, and a range of notices were on display within the service which included the weekly activity calendar, and advocacy and complaints information.

Requirement 1(3)(f)

Consumers expressed satisfaction their privacy was respected by staff and their information was kept confidential. Staff demonstrated how they maintained consumer privacy. The service had policies regarding privacy and the confidentiality of information. The service’s information management system was password protected. Staff were observed knocking on consumer doors prior to room entry and doors and curtains were closed to ensure privacy. Staff confirmed computers were be logged off before leaving and were password protected.

**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**

I find this Standard Compliant.

Requirement 2(3)(a)

The site audit report raised assessments including consideration of risks to the consumer’s health and well-being are not always completed for consumers who have pain, changed behaviours or are subject to restrictive practices including:

* For one named consumer who had been placed on a palliative care pathway, the site audit report identified the consumer’s pain management was not assessed and documentation was not consistently commenced and completed in line with policy. The provider has acknowledged a pain chart was not commenced in line with the policy and the service has implemented immediate targeted actions to support continuous improvement of the information raised in the site audit report. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + the consumer’s pain was considered as part of 3 assessments by an external palliative care service which documented the consumer was not experiencing pain at that time. Staff were frequently assessing the consumer’s experience of pain as evidenced within progress noting and administering pro ra nata (PRN) charted pain medication where required. Pain medication was being evaluated for its effectiveness as well as staff noting the comfort of the consumer in progress notes as evidenced within charting. The consumer was reviewed by the physiotherapist and the registered staff following a change to the consumer’s experience of pain, and staff have referred the consumer to the medical practitioner where required.
* For a second named consumer the site audit report identified the consumer was not assessed in relation to environmental restrictive practice, a risk assessment had not been completed in relation to their bed placed against the wall and an assessment had not been undertaken in relation to the consumer placing themselves on the floor. The service has implemented immediate and targeted actions to support continuous improvement of the information raised within the site audit report. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + the consumer does not reside in the secure area of the service. The consumer is assessed as not requiring environmental restrictive practice due to being unable to mobilise to the front door as documented within the behaviour support plan. The consumer’s bed has been placed against one wall as a falls prevention strategy. This information has been updated within the consumer’s risk care plan. I note the consumer’s mobility care plan included the consumer’s behaviour of placing themselves on the floor, the consumer’s behaviour support plan has now been updated by the service to also include this information including management strategies. The consumer has been assessed by the physiotherapist. The consumer was referred to external support services for the management of their behaviour (including placing themselves on the floor) to Dementia Services Australia and a mental health service in consideration of the risks to the consumer’s health and well-being. The report identifies the consumer reports a need to sit on the ground and it is unclear why this might be occurring, and that there has been no loss of consciousness, head strike or injuries as a result of this behaviour. The report identifies the consumer feels safe and the representative has noticed an improvement to the consumer’s wellbeing and a reduction in fatigue following review from the medical practitioner. Also noted is the consumer was reviewed again by mental health with a suggested neurological referral. The service has reviewed the consumer’s care documentation and advise the consumer has been reviewed in line with the falls management policy and strategies to manage the falls are documented in the care plan which include hip protectors, sensor alarms, bed against the wall and toileting scheduling. The behaviour support plan evidenced other strategies tailored for exhibited changed behaviours for the consumer, and the service have demonstrated monthly behaviour reviews which evaluate recommendations by external Dementia Services Australia. I note no impact to the consumer was identified by the Assessment Team.
* For a third named consumer the site audit report identified the consumer’s risk of wandering was not included within the risk care plan. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + the consumer’s care plan has been updated to reflect the consumer is at risk of wandering. I note no impact to the consumer was identified by the Assessment Team. I note the consumer is considered under environmental restrictive practice as they reside within the secure area of the service. I note the consumer has a behaviour support plan in place to guide staff practice for changed behaviours.
* For a fourth named consumer the site audit report identified the consumer did not have a risk assessment in place for one I have considered the approved provider’s response which challenged the information within the site audit report including:
  + the service does not consider one bedrail a restrictive practice. I note no impact to the consumer was identified by the Assessment Team.

The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement including clinical discussion at meetings, adjustment to admission processes and education provided to staff. I am satisfied these deficiencies have had no impact to consumers. Information about the consumers’ were known to be recorded within other care plan information. Policies and procedures guide staff practice. The site audit report identifies that consumers and representatives provided positive feedback about the delivery of care and services, and staff could describe the care planning process. I am satisfied the service has demonstrated assessment and care planning including the consideration of risks, informs the delivery of care and services and it is my decision Requirement 2(3)(a) is Compliant.

Requirement 2(3)(b)

The site audit report raised documentation reviewed was observed to be generic and for some consumers their current needs were not assessed and documented including:

* For one named consumer the site audit report raised the lifestyle plan was not clearly documented. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + Evidence the consumer’s condition has deteriorated and the consumer was placed on a palliative end of life pathway. It is noted in the review from the external palliative care team the consumer is fatiguing and to preserve energy for meaningful activities.
  + The lifestyle plan for the consumer was reviewed and updated in March 2023. Information is tailored to the interest and capacity of the consumer. It is noted within the consumer’s care plan they prefer not to engage in group activities and enjoy spending leisure time on their own doing other things of interest. It is noted the consumer participated in two group activities on 1 and 2 June 2023 prior to commencing on a palliative care pathway on 7 June and received hand massages in the weeks following.
  + I note no impact to the consumer was identified by the Assessment Team
* For a second named consumer the site audit report raised strategies to manage changed behaviour of the consumer to place themselves on the floor was not documented in the behaviour support plan. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer’s behaviour support plan is updated to include this information.
  + The consumer’s mobility plan documented this changed behaviour at the time of the site audit.
  + I note no impact to the consumer was identified by the Assessment Team
  + Refer to Requirement 2(3)(a) for information more broadly.
* For a third named consumer the site audit report raised strategies to manage some changed behaviours were minimally documented within the consumer’s behaviour support plan. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer was referred to Dementia Services Australia prior to the site audit and their behaviour support plan was later updated to reflect changed behaviours. The report does not contain information related to impact to other consumers.
  + The consumer was subject to environmental restrictive practice and this information has been added to the behaviour support plan
  + The approved provider’s response includes information which demonstrates consumer’s behaviours are reviewed monthly.
  + I note no impact to the consumer or other consumer’s was identified by the Assessment Team.
* In relation to advance care planning and end of life planning, both the site audit report and the approved provider’s response, is silent in relation to a potential 42 of 78 consumers’ advance care planning documentation being incomplete. I must consider that this is undertaken where the consumer wishes and that this is reviewed annually as per the service’s policy.

The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement including clinical discussion at meetings, adjustment to admission processes and education provided to staff. I am satisfied these deficiencies have had no impact to consumers. Information about the consumers’ were known to be recorded within other care plan information. Policies and procedures guide staff practice. The site audit report identified processes are in place to ensure assessment and planning addresses consumers’ individual preferences or current needs. Consumers and representatives are satisfied with assessment and planning. I am satisfied the service has demonstrated assessment and care planning identifies and addresses consumer’s needs including advance care planning and end of life planning and it is my decision Requirement 2(3)(b) is Compliant.

Requirement 2(3)(c)

The site audit report raised that feedback from one representative and review of documentation showed involvement of the consumer or their representative or other providers of care has not always occurred:

* For one unnamed consumer, the representative raised the medical practitioner had commenced a medication prior to informing the consumer’s representative. No further corroborating information was brought forward by the Assessment Team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The approved provider was unable to provide further details.
* For one named consumer, a palliative end of life pathway was commenced by the service after the consumer was identified as deteriorating and required pain management. The site audit report raised the pathway was commenced without documented consultation from a medical practitioner. No further corroborating information was brought forward by the Assessment Team. The site audit report documents under Requirement 3(3)(c) the organisation has systems in place for palliative care and end-of-life care which have been implemented at the service. Care and services documentation for consumers who were receiving or had received end of life care showed appropriate care was provided, their comfort was maximised, and their dignity was preserved. Representatives provided positive feedback and staff knowledge around end-of-life care was sound. I note no impact to the consumer was identified by the Assessment Team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + A palliative end of life care pathway was commenced by the service after care conferences were held with the family, the consumer was reviewed by allied health services and a medical practitioner in relation to the consumer’s deteriorating condition. Under Requirement 3(3)(d) The provider has acknowledged a progress note in relation to a conversation with the medical practitioner was not documented, and the service has implemented immediate targeted actions to support continuous improvement of the information raised in the site audit report including performance management, however I am also of the view that the consumer was monitored for deterioration, was seen by a medical practitioner who conducted a review of essential oral medication and prescribed subcutaneous palliative medications (PRN morphine), two days prior to staff commencing palliative end of life pathway, and that family were present at the time of initiating a palliative end of life pathway and aware of the consumer’s condition
* For a second named consumer, environmental restraint was in place without consent. I note no impact to the consumer was identified by the Assessment Team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer does not reside in the secure area of the service, the consumer is unable to mobilise to exit the service and is not considered as subject to environmental restrictive practice.

The site audit report identifies the service has processes in place to ensure assessment and planning is based on an ongoing partnership with consumers, the people they wished to be involved in their care and other organisations and providers of care. Most consumers and representatives confirmed they had been involved in their care planning and their needs were being met. The approved provider’s response included that care plans are fully reviewed at least annually. I am satisfied consumers, representatives and others are involved in assessment and planning and it is my decision Requirement 2(3)(c) is Compliant.

Requirement 2(3)(d)

The site audit report raised the service did not demonstrate 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, including:

* Three named consumer’s representative had not been offered a copy/or could not recall receiving a copy of the consumer’s care plan. Two of 3 representatives provided positive feedback to the Assessment Team about the care the consumer receives. No impact to the consumers was identified by the Assessment Team. Staff confirmed to the Assessment Team a copy of the care plan is not routinely provided following a case conference. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + Evidence of recent case conferencing has occurred with the named consumer’s representatives and the representative were satisfied that outcomes of assessment and planning are effectively communicated.
  + The organisation’s policy includes that access to care and clinical documentation for the consumer is provided.
  + Evidence that care conference procedure’s include that access to care and clinical documentation for the consumer is provided in the care conference as a means of information transparency.

The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement including reminding staff about access to information and the provision of consumer’s care plans and to offer opportunities to consumer’s and representatives to view and access consumer’s care plan at reviews, conferences and other times such as hospital admission or incident. I am satisfied these deficiencies have had no impact to consumers. I am satisfied that as evidenced within other Standards a care and services plan is readily available to the consumer as they are a live document accessible anytime through the electronic care management system and the organisation’s policies support that information about consumer’s is accessible. I also note the representatives for the named consumer’s had participated in care conferences and were satisfied with the delivery of care and services and information shared by the staff at the service. I am satisfied the service has demonstrated 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 it is my decision Requirement 2(3)(d) is Compliant.

Requirement 2(3)(e)

The site audit report raised the service did not demonstrate care and services are reviewed regularly when circumstances change or when incidents impact on the needs, goals or preferences for the consumer including:

* One named consumer’s lifestyle documentation was not updated to reflect their participation levels following commencement of a palliative care pathway when their health deteriorated. I note no impact to the consumer was identified by the Assessment Team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer’s lifestyle documentation was reviewed and updated in March 2023. Information is tailored to the interest and capacity of the consumer. It is noted in the review from the external palliative care team the consumer is fatiguing and to preserve energy for meaningful activities. It is noted within the consumer’s care plan they prefer not to engage in group activities and enjoy spending leisure time on their own doing other things of interest. It is noted the consumer participated in two group activities on 1 and 2 June 2023 prior to commencing on a palliative care pathway on 7 June and received hand massages in the weeks following.
* For a second named consumer, a mobility and transfers care plan had not been reviewed and updated following a number of falls (where the consumer places themselves on the floor). I note no impact to the consumer was identified by the Assessment Team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer’s mobility care plan included the consumer’s behaviour of placing themselves on the floor (which is considered a ‘fall’ at the service), the consumer’s behaviour support plan has now been updated by the service to reflect this information including management strategies
  + the consumer has been assessed by the physiotherapist
  + the consumer has been assessed as requiring referral, and has been referred, to external support services for the management of their behaviour including to Dementia Services Australia and a mental health service in consideration of the risks to the consumer’s health and well-being
  + the service has reviewed the consumer’s care documentation and advise the consumer has been reviewed as per the falls management policy
  + strategies to manage the impact of falls documented in the care plan include hip protectors, sensor alarms, bed against the wall and toileting scheduling.
  + the behaviour support plan included other strategies tailored for exhibited changed behaviours for the consumer
* A care plan review report showed 10 consumers have care plans which have not been reviewed in a one year period. I note no impact to these consumers was identified by the Assessment Team. The site audit report did not contain further information. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + All care plans are reviewed at least annually as per organisational policy and/or where there are changes identified.
* An advance care directive report showed 20 consumers with incomplete advance care directives. I note no impact to these consumers was identified by the Assessment Team. The site audit report did not contain further information. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + the service has reviewed the care plan schedule to include an advance care directive review. I must consider that this is undertaken where the consumer wishes and that this is reviewed annually as per the service’s policy. I note that for other consumers where recent deterioration has been identified the service have initiated advance care planning conversation with the consumer and representative.
* Several consumer’s did not have a life history completed in their lifestyle care documentation. I note no impact to the consumer was identified by the Assessment Team. The site audit report did not contain further information.
  + While the life history was identified as incomplete within the lifestyle documentation, I have considered that there has been no impact to consumer’s which is supported by the feedback from consumers and representatives within Standard 4 regarding services and supports for daily living.

The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. I am satisfied the service has demonstrated care and services are reviewed regularly and when circumstances change and it is my decision Requirement 2(3)(e) is 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. | 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. | 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. | Compliant |

**Findings**

I find this Standard Non-compliant.

Requirement 3(3)(a)

Skin integrity:

The site audit report raised that wounds were not consistently reviewed, photographed and measured including:

* For one named consumer a Stage I pressure injury was not photographed with a measurement device, the wound was not reviewed regularly and the wound site is incorrectly documented. The site audit report does not contain information in relation to the wound care regime for this wound. The site audit report discusses a second wound as not having a wound chart in place however no further information is provided by the assessment team. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The Stage I pressure injury site of the wound was located in the same general area as documented and the chart has now been closed.
  + A wound chart was not required for a second mentioned wound. Documents reviewed evidenced the consumer was referred to the medical practitioner upon discovery of change to consumer’s physical health. The medical practitioner referred the consumer for a medical procedure in March 2023 (3 months prior to the site audit), however there is no evidence to support that this procedure occurred or that a wound occurred for a wound chart to be in place. The service provided evidence of regular daily skin care reviews to support that no wound was identified by the service and a wound chart was not required. No impact has been identified for the consumer.
* For a second named consumer the site audit report identified the consumer had 5 active wounds. The site audit report does not contain information in relation to the required wound care regime for these wounds, however documents that the wounds have been inconsistently measured and photographed. The site audit report does not contain information about the impact to the consumer in relation to the inconsistency of taking measurements and photographs. The site audit reports that for an unstageable pressure injury the wound was not reviewed daily with the last documented review being 5 days prior to the site audit. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer’s unstageable pressure injury is now closed on the service’s pressure injury wound tracker and there are no other pressure injuries noted for this consumer.
  + The consumer’s representative reported they were recently involved a case conference with the service and advised the Assessment Team that the service are managing the wounds “very well” and the Assessment Team observed the consumer had clean dressings.
  + The approved providers response did not include a response directly in relation to some of the information raised within the site audit report, however, refers back to the organisation’s policy for wound management which requires a photograph to be taken on initial identification, and at least monthly thereafter or as otherwise required.

The service is currently managing 5 wounds which have been reviewed by the Clinical manager. The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. Evidence of education was included within the approved provider’s response. I am satisfied wound management is effective.

Pain management:

The site audit report raised that pain assessments were not being undertaken by the service in line with the organisation’s policy including;

* One named consumer commenced a palliative end of life pathway on 7 June 2023. A pain chart (separate to the pathway charting) documented pain relief provided to the consumer on the 7 June 2023. Progress notes identified the consumer received further pain management as per their medication chart between 17 and 21 June 2023 however there were no pain evaluations completed. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + While the pain chart was not completed specifically within the end of life pathway pain charting area of the electronic care management system, pain management was documented within the care plan.
  + The consumer’s pain was considered as part of 3 assessments by an external palliative care service which documented the consumer was not experiencing pain at that time.
  + Staff were assessing and evaluating the consumer’s experience of pain in frequent progress noting and administering pro ra nata (PRN) charted pain medication where required. Pain medication was being evaluated for its effectiveness as well as staff noting the comfort of the consumer in progress notes.
  + The consumer was reviewed by the physiotherapist and the registered staff following a change to the consumer’s experience of pain, and staff have referred the consumer to the medical practitioner where required.

The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement including providing a memorandum to staff and initiation of palliative care training for staff. I am satisfied these deficiencies have had no impact to consumers. I am satisfied pain management is effective.

Restrictive Practices:

The site audit report raised management of restrictive practice management was ineffective including:

* A discrepancy of numbers of consumers identified as subject to restrictive practice across the service’s monitoring registers. No impact was identified by the Assessment Team to consumers. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + Review of the approved provider’s response demonstrates the psychotropic register reflects that 8 consumers are receiving a chemical restrictive practice as assessed by the service.
* A lack of understanding of restrictive practice by the service where consumers who are receiving a psychotropic medication for a diagnosed condition have been identified on the psychotropic register as subject to restrictive practice. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + Review of the approved provider’s response demonstrates the restrictive practices register identifies 8 consumers are receiving a chemical restraint, 2 consumers have a mechanical restraint and 46 consumers are subject to environmental restraint. Both registers have been reviewed to ensure accuracy and some consumers’ psychotropic medications have been ceased following review which is in line with minimising the use of restraint, Requirement 8(3)(e). No impact was identified by the service to the consumer in the discrepancy of information between both registers.
* Two consumers identified on the psychotropic register are identified as subject to chemical restrictive practice, however no consent form was observed. No impact was identified by the assessment team to these consumers I have considered the approved provider’s response which challenged the information within the site audit report including:
  + Informed consent forms for 2 consumers identified as subject to restrictive practices was provided. Some details of the informed consent form are incomplete.
  + Informed consent was obtained by a registered nurse. It is not known if the registered nurse is also an endorsed nurse practitioner as required by legislation to obtain informed consent. Specifics discussed with the consumer’s representative to obtain informed consent was not evidenced within the approved providers response, however I do not believe this has impacted the consumers’ care.
  + The psychotropic register indicates that chemical restraint for the same 2 consumers, have been ‘requested/preference’ for use by the consumer’s representatives. The restrictive practices register in itself does not contain sufficient information that demonstrates the restrictive practice is being assessed ‘as required’, by a medical practitioner and/or approved health practitioner in line with legislative requirements.
* For one named consumer who receives a psychotropic medication identified in the site audit report, the service identify this as a chemical restraint as the medication is not indicated for the consumer’s diagnosis. The site audit report identifies the service obtained informed consent from the consumer’s representative.
* The entry doors to the service were observed as locked and consumers required staff assistance to enter and exit the service with no available swipe cards or access codes provided. The service’s restrictive practices register identified 30 consumers subject to environmental restraint, however the service advised at the time of the site audit, not all consumer’s had informed consent for the use of the restrictive practice. The service had identified this within the continuous improvement plan however had not actioned this by the due date and the action was still outstanding. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The service identified 32 consumers as subject to environmental restraint outside of the memory support unit. The approved provider has acknowledged there had been a delay in obtaining informed consents from consumers and their representatives with only 2 consents not obtained at the time of the site audit, however, now asserts that all assessments, and informed consents have been obtained as evidenced within the restrictive practice register. I note the restraint register in itself does not sufficiently demonstrate environmental restraint has been applied in line with legislative requirements.
* One named consumer subject to mechanical restraint is not identified on the restrictive practice register. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The consumer previously used a mechanical restraint however was reassessed by the occupational therapist as requiring different equipment, which is not considered a mechanical restraint, and therefore not listed on the restrictive practices register. The approved provider advised an expired informed consent form (for previous mechanical restraint) remained within the informed consent folder at the time of the site audit. The expired consent form has now been removed from the folder. While the approved provider did not provide documentation to support this change in equipment, no impact was identified for this consumer. Review of the restrictive practices register does not identify the consumer as subject to mechanical restraint, however I note the mitigating risk log identifies on 5 April 2023 that a lap belt is used when the consumer is transferred to a chair and the consumer’s representative said the consumers has been at the service for 2 months and they had signed a consent form for a lap belt.
* Consumers were observed waiting for assistance to enter and exit the service, no codes were observed near the door and the site audit report identifies management confirmed the doors to the service are locked and consumers are not provided a swipe card or code to move freely in and out of the service. I have considered the approved provider’s response which challenged the information within the site audit report including:
  + The doors to the service are locked to manage COVID-19 screening of visitors and acknowledges that for a time the front administration staff were unavailable to assist persons entering and exiting the service. I am of the view while the staffing for the administration area for the service has been actioned, the approved provider’s response does not contain information on how the service supports consumers who are not at risk of leaving the service (26 consumers are not recorded on the environmental restrictive practices register) to do so freely, in the absence of a code at the door, a swipe card, or some other mechanism to exit and enter the service without requiring staff to activate the locked doors. Evidence within the approved provider’s response included a restrictive practice admissions letter in relation to perimeter restraint. The letter states, “for those who can exit safely, a number of staff will be happy to assist”, confirming consumers are unable to freely exit without the assistance from staff. The letter also confirms consumers, “know who I need to speak with to discuss concerns relating to my freedom to exit the facility when I wish to”, supporting that consumers are unable to freely exit the service without the assistance of staff. The approved provider’s response challenges information in Requirement 5(3)(b) that a named consumer requires permission to exit the service. The named consumer is not listed on the service’s restrictive practices register as subject to environmental restrictive practice, yet the consumer requires a staff member to activate the locked doors to be able to leave the service and the mitigation strategies listed for the consumer includes instructions that specifically state the consumer “will request staff to go out” and they are to be “monitored prior to allowing” the consumer to go out.

In relation to skin integrity, while an absence of best practice measures including the use of a measuring device, and photographing the wound was identified as inconsistent, The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. Policies and procedures guide staff practice.

In relation to pain management the approved provider’s response has acknowledged an end of life pain chart was not commenced in line with the policy and the service has implemented immediate targeted actions to support continuous improvement of the information raised in the site audit report including providing a memorandum to staff and initiation of palliative care training for staff. I am satisfied pain management and monitoring for this consumer was documented within the care plan and effectively managed.

In relation to restrictive practices, the approved provider’s response acknowledges some deficits in relation to documentation for restrictive practice of which the approved provider has advised the service has reviewed and completed. I note the following in relation to evidence provided within the response:

* For one named consumer, the approved provider advised the consumer previously used a mechanical restraint however was reassessed by the occupational therapist as requiring different equipment, which is not considered a mechanical restraint, and therefore not listed on the restrictive practices register. I note the mitigating risk log identifies on 5 April 2023 that a lap belt is used when the consumer is transferred to a chair. It is not known if this is the same lap belt which is currently not considered a restrictive practice or the previous lap belt. I note the consumer’s decision maker recalls providing consent for a mechanical restraint at a point in time.
  + However, while the approved provider’s response did not include information to support this change in equipment, no impact was identified for this consumer.
* Details of the informed consent forms are incomplete.
* Informed consent for chemical restraint was obtained by a registered nurse. It is not known if the registered nurse is an endorsed nurse practitioner as required by legislation to obtain informed consent.
* Details about what was discussed with the decision maker when obtaining informed consent is not evidenced within the approved providers response nor on the informed consent form to demonstrate informed consent was obtained.
* The psychotropic register indicates that chemical restraint for the same consumers, have been ‘requested/preference’ for use by the consumer’s representatives. The restrictive practices register in itself does not contain sufficient information that demonstrates the restrictive practice was assessed ‘as required’, by a medical practitioner and/or approved health practitioner in line with legislative requirements for those same consumers.
  + I am not satisfied the service has demonstrated that informed consent has been obtained in line with legislative requirements.
* Consumers who are not at risk of leaving the service, in the absence of a code at the door, a swipe card, or some other mechanism to exit and enter the service, are required to have staff activate the locked doors so they may leave the service.
* A consumer is not listed on the service’s restrictive practices register as subject to environmental restrictive practice, yet requires a staff member to activate the locked doors, and must gain consent from staff to leave.
* A restrictive practice admissions letter in relation to perimeter restraint confirms consumers who are not at risk of leaving the service require the assistance of staff to exit the service.
  + I am not satisfied consumers are supported to move freely in and out of the service and that environmental restrictive practices are managed in line with legislative requirements.

It is my decision Requirement 3(3)(a) is Non-compliant.

Requirement 3(3)(b)

The site audit report identifies documentation reviewed by the Assessment Team identified high impact high prevalence risks were not managed appropriately and monitoring was inadequate including for falls management, behaviour support, medication management and restrictive practices.

The approved providers response included information that I have previously considered under Requirement 2(3)(a), Requirement 2(3)(b) and Requirement 3(3)(a). No impact has been identified for these consumers. I am satisfied policies and procedures guide staff practice in relation to risk and that consumers are supported in the management of identified risks. I am satisfied with the information included within the approved provider’s response in relation to improved handover documentation and that the service has an electronic care management system which documents risks associated with the care needs of consumers. The approved provider’s response confirms risks for consumers are reviewed at least annually in line with their policy or where when circumstances change or when incidents impact on the needs, goals or preferences of the consumer and the site audit report identifies the service were aware of and could identify the high impact high prevalence for consumers. The approved provider’s response under Requirement 3(3)(d) also includes that regular multi-disciplinary team meetings monitor clinical risks within the service and that these will be increased to weekly meetings. I am satisfied with the information provided within the approved provider’s response in relation to cytotoxic medications; refer to Requirement 3(3)(g). Most consumers and representatives provided positive feedback about their care and services and staff demonstrated knowledge about the management of the identified high risk high prevalent risks within the service and for individual consumers. The service has implemented immediate and targeted actions to support continuous improvement of the information raised within the site audit report and education will be provided at next nursing meeting in relation to information within the site audit report and it is my decision Requirement 3(3)(b) is Compliant.

Requirement 3(3)(c)

The organisation has systems in place for palliative care and end-of-life care which have been implemented at the service. Care and services documentation for consumers who were receiving or had received end of life care showed appropriate care was provided, their comfort was maximised, and their dignity was preserved. Representatives provided positive feedback and staff knowledge around end-of-life care was sound and it is my decision Requirement 3(3)(c) is Compliant.

Requirement 3(3)(d)

The site audit report identified deterioration or change of consumers’ mental health, cognitive or physical function, capacity or condition was not identified and responded to in a timely manner including:

* + For one named consumer, documentation did not demonstrate deterioration of the consumer’s condition and escalation to a medical practitioner prior to commencing an end of life pathway.
  + For a second named consumer, a representative said the service had not identified a change to the consumer’s physical condition and that a wound chart was not in place.
  + For a third named consumer, documentation did not demonstrate investigation into the behaviour of the consumer placing themselves on the floor.

The approved providers response included information that I have previously considered under Requirement 2(3)(a), Requirement 2(3)(b), Requirement 2(3)(c) and Requirement 3(3)(a). The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. Policies and procedures guide staff practice, and as demonstrated under Requirement 3(3)(f) where deterioration is recognised, consumers are referred in a timely manner and it is my decision Requirement 3(3)(d) is Compliant.

Requirement 3(3)(e)

The site audit report identified communication of information about consumers is ineffective including:

* + For one named consumer, the representative expressed a communication barrier with some staff.
  + For a second named consumer, strategies to manage changed behaviour was not documented within the behaviour support plan.
  + Handover sheets observed to have minimal information and individual copies of the handover were not available for agency staff.
  + Documentation did not support that a medical practitioner had been consulted prior to a palliative end of life pathway being initiated.
  + Documenting of case conferencing was inconsistent across recording mechanisms.

The approved providers response included information that I have previously considered under Requirement 2(3)(a), Requirement 2(3)(b), Requirement 2(3)(c), Requirement 2(3)(d), Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(c) and Requirement 3(3)(d). In addition, the approved provider’s response includes that information is shared within multi-disciplinary clinical team meetings, staff meetings, handover processes, electronic messaging, daily huddles and the service’s electronic care management system. The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. The approved provider’s response evidenced information is shared and that policies and procedures guide staff practice. I am satisfied information about consumer’s condition, needs and preferences is documented and communicated within the organisation and with others and it is my decision Requirement 3(3)(e) is Compliant.

Requirement 3(3)(f)

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services is being undertaken. A review of care and services documentation showed appropriate referrals to relevant health professionals were undertaken in a timely manner. Consumers and representatives provided positive feedback regarding access to health professionals. Staff were able to describe the processes for referring consumers to other health professionals and it is my decision Requirement 3(3)(f) is Compliant.

Requirement 3(3)(g)

The site audit report details numerous deficiencies identified by the Assessment Team in relation to the service’s infection control practices and antimicrobial stewardship practices. The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. Infection control policies and procedures guide staff practice. An infection prevention and control lead is available to support staff and guide infection control best practice. There is PPE available for staff use including gloves and sanitisers. There are no consumers at the service receiving cytotoxic medications which require specialist PPE and disposal. Equipment including spill kits are available for staff to manage infection control hazards. The service has access to infection control management resources. The service has an outbreak management plan which is reviewed by an external agency for effectiveness, and an antimicrobial stewardship guidance to guide staff practice in promotion of appropriate antibiotic prescribing and use. Review of infections include antimicrobial use and inform organisational processes and clinical practices. I am satisfied the approved provider’s response has comprehensively addressed the information within the site audit report, supporting evidence demonstrates the service has effective minimisation of infection related risks and it is my decision Requirement 3(3)(g) is 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. | 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. | 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. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

I find this Standard Compliant.

Requirement 4(3)(a)

Consumers expressed satisfaction with the services and supports for daily living and provided examples of how they are supported to engage in activities of interest to them. Staff demonstrated knowledge of individual consumers’ needs and preferred activities. Care planning documentation captured information to guide staff practice regarding services and support required by consumers and their activities of choice. The activity program is developed based on consumer preferences. Management advised new staff to have recently been engaged to replace vacant positions and lifestyle staff are now available to support consumers 7 days a week.

Requirement 4(3)(b)

Consumers described the services and supports available to them which help promote their emotional, spiritual, and psychological well-being. Consumers provided examples such as receiving individual worship support, attending church services, and access to one-on-one visits from volunteers and staff. Staff described ways they support individual consumers. Care planning documentation includes information about the emotional, spiritual, and psychological needs of consumers to guide staff practice.

Requirement 4(3)(c)

Consumers said they are encouraged to participate in activities within and outside the service that interest them, and to maintain social and personal relationships. Staff demonstrated knowledge of consumers’ interests and relationships important to them; this aligned with information under care planning documentation. The lifestyle schedule provides varied activities including but not limited to regular bus trips, musical entertainment, volunteer visits, pet therapy and celebration of international theme days.

Requirement 4(3)(d)

The service has processes and systems in place for recording and communicating information regarding each consumer’s condition, needs, and preferences within the organisation and with others when required. Staff described how they keep up to date on the changing condition and needs of consumers related to services and supports of daily living such as through handover meetings, reading care plans and progress notes, and speaking directly to consumers and other staff.

Requirement 4(3)(e)

The service demonstrated timely and appropriate referrals in relation to services and supports for daily living. Care planning documentation reflected the service collaborates with external providers to support the diverse needs of consumers.

Requirement 4(3)(f)

Most consumers and representatives commented that meals are of an acceptable quality and quantity, and consumers have access to alternative meal options. Staff advised meals are cooked fresh daily on site, the menu is designed in consultation with a dietician, and described the provision of texture-modified meals and how they receive information on changes to consumers’ dietary needs and preferences. The organisation is currently engaged in an excellence in dining program to enhance the consumer dining experience.

Requirement 4(3)(g)

The site audit report brought forward information identifying several deficiencies. Some consumer lifting equipment had not been regularly serviced. Feedback was received from one representative regarding their mother’s wheelchair not being regularly serviced or cleaned. Nil improvement actions were evidenced in response to internal audits identifying lack of preventative maintenance. I have considered the approved provider’s response which challenged the information within the site audit report including:

* Equipment servicing records demonstrating consumer lifting equipment is subject to a regular external maintenance schedule.
* In response to feedback from one consumer’s representative, progress note entries identifying occupational therapist review, wheelchair repair and air cushion inflation occurring in response to past requests, and lodgement of a current maintenance request for wheelchair repair. New processes have been implemented to ensure weekly air cushion pressure checks and regular wheelchair cleaning.
* Documentation evidencing actions taken by the service in response to identifying lack of preventative maintenance, including performance management and support for the maintenance officer, and processes to ensure ongoing completion of the preventative maintenance schedule.

I am satisfied the service has appropriately responded to identified issues and submitted satisfactory evidence to demonstrate cleanliness and maintenance of furniture and equipment and it is my decision Requirement 4(3)(g) is 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. | 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**

I find this Standard Non-compliant.

Requirement 5(3)(a)

The service had a welcoming environment and consumers, visitors and staff were observed interacting with each other in common areas; providing consumers with a sense of belonging and independence. Positive feedback was provided by consumers in relation to their living environment. Corridors were wide and generally unobstructed. Quiet lounge areas were used by consumers. Consumers rooms were noted to be personalised with memorabilia and personal effects and it is my decision Requirement 5(3)(a) is Compliant.

Requirement 5(3)(b)

While consumer expressed satisfaction with the service environment, consumers were not able to move freely to indoor and outdoor areas.

Internal courtyards were accessible for consumers when the weather was suitable. This information was challenged by the Approved provider in its response, stating the only times these areas may become inaccessible are during extreme inclement weather, such as storms when staff will assist and monitor consumer risk.

The external door to the service was locked, requiring staff to provide access for anyone entering or leaving the service. Management provided feedback this was due to staff shortages and a recent COVID19 outbreak. Representatives provided feedback relating to lengthy delays in entering or leaving the service, consumers were observed waiting for assistance from staff to open the door and access codes or swipe cards were not available for consumers. The Approved provider in its response has clarified the Facility manager was alerted 12 June 2023 to concerns of considerable time taken for visitors to enter or exit the service, and a miscommunication had occurred relating to weekend administration hours, and the weekend Administration assistant was reinstated. Further human resource processes were undertaken when it was evident the Administration assistant was frequently absent from the administration area. While I agree this process may hasten the time taken to enter or leave the service, it does not address that for consumers not at risk to leave the service, do not have access codes or swipe cards to leave the service freely and require staff to activate the locked doors to move outdoors.

One consumer has been granted permission to leave the service unaccompanied following a request to leave. The Approved provider has challenged the information the consumer needs permission to leave the service, stating the named consumer is only required to inform staff of their plans to leave the facility, as per the Mitigating risk form completed by the consumer and their family. The named consumer is not listed on the service’s restrictive practices register as subject to environmental restrictive practice, yet the consumer requires a staff member to activate the locked doors to be able to leave the service and the mitigation strategies listed for the consumer includes instructions that specifically state the consumer “will request staff to go out” and they are to be “monitored prior to allowing” the consumer to go out. The Approved provider stated the named consumers speaks to the administration staff of their plan to leave, would like the door opened and provide the time the consumer plans for their return to the service. This information is then given to the Registered nurse. It is my opinion by requiring staff to open the door, that is still a form of permission, and the consumer is not able to move freely both indoors and outdoors at their own undertaking. The issue regarding environmental restraint has been considered further in Requirement 3(3)(a).

I am of the view consumers were not free to move outdoors without intervention by staff at the service, and it is my decision Requirement 5(3)(b) is Non-compliant.

Requirement 5(3)(c)

The site audit report records information the internal preventative maintenance schedule lacked detail for effective monitoring and review and gaps were identified by management in effective maintenance being provided. The Approved provider has refuted this information stating the preventative maintenance schedule are to be completed once the maintenance task has been completed. Anomalies were identified by the service for April and May 2023, which prompted discussion regarding staff performance and a performance management plan was implemented. The preventative maintenance schedule submitted by the Approved provider for June 2023, evidence actions from management have been effective in rectifying issues with the completion of preventative maintenance.

I am unable to establish any risks for consumers due to deficits in the preventative maintenance schedule, and positive feedback was provided by consumers relating to furniture, fittings, and equipment and it is my decision Requirement 5(3)(c) is 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

**Findings**

I find this Standard Non-compliant.

Requirement 6(3)(a)

Most consumers/representatives were generally aware of complaints processes and understood how to provide feedback and make complaints. However, some were not familiar with external complaints mechanisms and some representatives said the consumer was reluctant to make a complaint. Information about complaints and feedback processes, advocacy services and seniors’ rights groups was available in English and other languages and included information from the Aged Care Quality and Safety Commission. Information was also provided in the consumer information packs and via three monthly newsletters. It is my decision Requirement 6(3)(a) is Compliant.

Consumers were able to provide feedback via the suggestion box or at consumer meetings. The meeting agenda included consumer and representative feedback and an update on any improvements arising from previous feedback that had been received; meeting minutes demonstrated consumers used these forums to provide feedback.

Requirement 6(3)(b)

Consumers were aware they had access to advocacy services; several consumers reported that while they were aware they could access an advocacy service they had not had a reason to do so. Most consumers said they were happy for their representatives to advocate for them and to raise issues on their behalf. It is my decision Requirement 6(3)(b) is Compliant.

Requirement 6(3)(c)

Consumers/representatives provided mixed feedback about actions taken in response to complaints. Some were satisfied their complaints had been addressed and resolved and others felt their complaints had not been satisfactorily addressed. The site audit report stated the service could not consistently demonstrate appropriate action was taken in response to complaints or that an open disclosure process was applied.

The approved provider challenged the findings and its response to the Assessment Team’s report included evidence demonstrating that overall complaints had been responded to in a timely manner, that consumers/representatives were engaged in complaint resolution processes and that an apology was provided. The response included comment forms, communications with representatives, case conferences, maintenance logs and monitoring records, electronic alerts, staff toolbox sessions, daily ‘Huddle’ records demonstrating that staff education including in relation to areas of practice raised in complaints had occurred, emails from allied health professionals, and other related material. I accept that some complainants remained dissatisfied with the complaints process and have considered this under Requirement 6(3)(d); I also acknowledge that others were satisfied with the way their feedback was addressed. Overall, I am persuaded that complaints have been responded to promptly, that consumers and representatives have been involved in discussions about their concerns and that there is evidence that open disclosure has been applied. It is my decision Requirement 6(3)(c) is Compliant.

Requirement 6(3)(d)

The site audit report states that feedback and complaints were logged across two systems and that this was not effective in supporting the service to identify trends and patterns. The complaints register was incomplete with regard to details of investigations, actions taken and outcomes achieved. Feedback systems at the service such as the incident register, staff and resident meeting minutes and audits did not consistently feed into the complaints register and inform the continuous improvement plan. I note too that the Assessment Team’s report included mixed feedback from consumers/representatives about complaints processes.

The approved provider in its response has acknowledged there is room for improvement in the way feedback and complaints information is captured and used to inform continuous improvement processes. The plan for continuous improvement has been revised and included an action for management staff to log all complaints and feedback electronically and to use this information to identify trends and inform reporting.

The approved provider does not accept however that this deficiency has impacted the ability of the service to identify trends, take action and improve the quality of care and services. The response included limited evidence to support the approved provider’s position.

I am satisfied that feedback and complaints were not consistently being reviewed and used to improve the quality of care and services. Systems to capture complaints data were ineffective and inconsistently completed and this has been accepted by the approved provider. Additionally, the response failed to include information demonstrating how feedback and complaints are used more broadly to continually improve performance and the quality of care and service delivery. It is my decision Requirement 6(3)(d) is Non-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. | 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

I find this Standard Compliant.

Requirement 7(3)(a)

The site audit report raised the service does not have sufficient staff to ensure the delivery and management of safe and quality care and services.

I acknowledge the site audit report includes feedback from consumers and their representatives in relation to staff being rushed and experiences of delays for cares or services, however the site audit report has limited information which corroborates and details the impacts that were experienced by those consumers.

The site audit report asserts that staff shortages have impacted consumer’s care and services as evidenced within Standards 2 and 3, however I am of the view that while some deficits were identified within those Standards, they did not impact consumers, the delivery of care and services nor did staff feedback across those Standards infer that staff were unable to deliver care and services. Staff did report normal handover processes occur between shifts.

The service demonstrated the workforce is planned, including that where unplanned leave is experienced, the service have strategies in place to reduce impact to the experience of consumers. Strategies include the use of agency staff and a casual workforce to use in the event of unplanned leave. Existing shifts are adjusted and staff in senior roles assist with ensuring staffing are available. The service had recently undertaken significant change in staffing and a successful recruitment has resulted in 3 new staff.

I have considered the approved provider’s response which challenged information within the site audit report. The provider has acknowledged some deficiencies identified within the site audit report and implemented immediate targeted actions to support continuous improvement. I am satisfied these deficiencies have had no impact to consumers. I am satisfied the approved provider’s response has comprehensively addressed the information within the site audit report, supporting evidence demonstrates the workforce is planned to enable and the mix enables the delivery of safe and effective care and services. It is my decision Requirement 7(3)(a) is Compliant.

Requirement 7(3)(b)

Consumers and representatives reported most staff are kind, caring and respectful of consumers. The service monitors consumer feedback about the way care is delivered. The Assessment Team observed staff assisting consumers in a kind and respectful manner during the Site Audit

Requirement 7(3)(c)

The site audit report raised several pieces of information within this Requirement related to orientation and training which I have considered under Requirement 7(3)(d). The service has systems in place to identify that staff have the qualifications for their roles and provide staff with information to perform their roles. Onboarding procedures includes a review of prospective staff police checks, visa qualifications, registrations, references, fitness for work and vaccination status. Duty lists and position descriptions are provided to guide staff practice. There is no consumer voice expressing dissatisfaction with the knowledge and competency of staff. The deficits raised in the site audit report under Requirement 7(3)(c) did not relate to deficits identified under other Standards and contained limited information in relation to impact to consumers in relation to the delivery of care and services. I have considered the approved provider’s response which challenged the information in the site audit report under Requirement 7(3)(d). I am satisfied the service has demonstrated the workforce is competent and have the knowledge to effectively perform their roles. It is my decision Requirement 7(3)(c) is Compliant.

Requirement 7(3)(d)

The site audit report raised that training for staff is overdue and feedback about training of staff was provided by some consumer’s representatives. The site audit report contains limited information to support the information raised. I have considered the approved provider’s response which challenged information raised under Requirement 7(3)(c) and Requirement 7(3)(d). The approved provider has acknowledged that some training is overdue at the service and that the service had already identified the deficiency and was working towards rectification prior to the site audit as evidenced with the response. The approved provider has detailed the cause being due to changes in the way training was delivered over the past 3 years in relation to COVID-19 and that since training has now been centralised all new staff are completing training within required time frames. The service’s continuous improvement plan supports that the service are working towards currency of training for staff. I am satisfied training is occurring including mandatory training, competencies and toolbox training and acknowledge some staff are outstanding, however the service are managing this. I am satisfied the approved provider’s response has comprehensively addressed the information within the site audit report, supporting evidence demonstrates the workforce is recruited and trained to deliver the outcomes of these Standards. It is my decision Requirement 7(3)(d) is Compliant.

Requirement 7(3)(e)

The service has a system to regularly assess, monitor and review the performance of each member of the workforce. Appraisals include a staff self-check and interview with their line manager monthly and an annual appraisal. The service has a system to ensure staff who require performance management undertake a formal process depending on their performance. There is no consumer voice expressing dissatisfaction with the monitoring and performance of staff.

**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. | 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. | 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. | Compliant |

**Findings**

I find this Standard Non-compliant.

Requirement 8(3)(a)

The site audit report raised the organisation is unable to demonstrate that it actively engages and supports consumers in the development, delivery and evaluation of care and services. I have considered the approved provider’s response which challenges the information in the site audit report. The approved provider has provided a comprehensive response including evidence which supports that the organisation actively engages and supports consumers. I have considered information including feedback from consumers and representatives across the Standards, particularly in Standard 1 and 6 which demonstrate consumers are supported to express choice and independence in decision making and to provide feedback to the service through various avenues including consumer meetings. I am satisfied governance frameworks are in place to support this Requirement. It is my decision Requirement 8(3)(a) is Compliant.

Requirement 8(3)(b)

The site audit report raised the organisation’s governing body is not provided sufficient information to be accountable for the delivery of care and services. The site audit reports a leadership team is responsible for promoting and the delivery of a culture of safe, inclusive and quality care and services. The organisation is guided by a Strategic Plan. Regular Quality and Clinical meetings inform the leadership team about the risks within the service. The service undertakes audits to monitor compliance with the Standards. The site audit report demonstrates the organisation ensures consumers are respected, care and services are culturally safe and supported to exercise choice and independence. I have considered the approved provider’s response which challenges information within the site audit report including:

* The organisation has policies and procedures in place that support and promote a culture of safe and inclusive care which have been evidenced within the response.
* The organisation is working towards meeting future legislative changes in relation to organisational governance. I acknowledge the organisation’s policy was not reflective of practice, however I do not consider this has impacted the care to consumers. In response the approved provider has revised existing management structure policy to better reflect the organisation.
* The organisation has introduced a resident voice committee and the organisation is working towards future legislative requirements.
* Evidence of audits undertaken at the service to ensure compliance with these Standards.

The approved provider has provided a comprehensive response including evidence which supports that the organisation promotes and encourages the delivery of a culture of safe, inclusive and quality care and services. I am satisfied Requirement 8(3)(b) is Compliant.

Requirement 8(3)(c)

The site audit report raised the organisation’s information management system is ineffective. There was no consumer impact identified by the Assessment Team. I have reviewed the approved provider’s response and I am of the view the organisation has robust electronic systems in place to support information management and the policies and procedures guide staff practice. The site audit report raised the organisation’s continuous improvement is ineffective and the organisations system to collect and review the feedback of consumers has not been effectively integrated into the quality continuous improvement system. I have considered the information under Requirement 6(3)(d) in my decision. The governance body has authority delegation in place at each management level. Financial reports inform governance. The approved provider’s response included comprehensive information to demonstrated financial governance within the organisation. The site audit report raised deficits related to workforce governance and refers to Standard 7. I have considered the information under Standard 7 in my decision. The organisation has systems for receiving information about regulatory obligations which are monitored and communicated within the organisation, however I am of the view the organisation’s system for identifying and managing restrictive practices is ineffective to ensure regulatory compliance. While the organisation has policies and procedures in place to support feedback and complaints management, feedback and complaints were not consistently being reviewed and used to improve the quality of care and services. Systems to capture complaints data were ineffective and inconsistently completed and this has been accepted by the approved provider. Refer to Requirement 6(3)(d) for information more broadly. It is my decision Requirement 8(3)(c)(v) and (vi) is Non-Compliant in relation to regulatory compliance and feedback and complaints.

Requirement 8(3)(d)

The site audit report raised deficits related to the organisation’s incident management system. There is limited information within the site audit report to support the deficits raised. I have considered information under other Standards in coming to a view, as well as the approved provider’s response which challenges the information in the site audit report. It is my decision Requirement 8(3)(d) is Compliant.

Requirement 8(3)(e)

The site audit report raised deficits related to the organisation’s clinical governance framework. I have considered information under other Standards, as well as the approved provider’s response which challenges the information in the site audit report. It is my decision Requirement 8(3)(e) is Compliant.

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)