Performance

Report

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| Name of service: | Alwyndor Aged Care |
| Service address: | 52 Dunrobin Road HOVE SA 5048 |
| Commission ID: | 6931 |
| Approved provider: | City of Holdfast Bay |
| Activity type: | Site Audit |
| Activity date: | 14 March 2023 to 16 March 2023 |
| Performance report date: | 28 April 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 Alwyndor Aged Care (**the service**) has been prepared by K Richards 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 consumers, representatives, staff, management, and others.
* the provider’s response to the Assessment Team’s report received 13 April 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-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 | **Compliant** |
| **Standard 6** Feedback and complaints | **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.

* **Standard 2 Requirement (3)(a):** The provider should ensure assessments and planning include consideration of risks to the consumer’s health and well-being, and are undertaken in a timely manner to inform the delivery of safe and effective care and services. Where chemical restraint is prescribed, behaviour support plans are to be developed in line with legislative requirements to include all behaviours, triggers, and non-pharmacological strategies.
* **Standard 2 Requirement (3)(e):** The provider should ensure care and services are reviewed for effectiveness and when incidents or changes of circumstances impact on the needs, goals, or preferences of consumers. Reviews should consider efficacy of current management and development of new personalised strategies.
* **Standard 3 Requirement (3)(a):** The provider should ensure consumers receive personal and/or clinical care tailored to their needs to optimise health and well-being in line with best practice guidelines. The provider is to ensure staff provide care in line with directives and personalised care plans, with documentation undertaken in line with policies and procedures that are reflective of best practice guidelines.
* **Standard 3, Requirement (3)(b):** The provider should ensure high impact or high prevalence risks associated with the care of each consumer are monitored for effective management. Ensure risks and management strategies should be captured in care planning to inform staff and monitored for effectiveness. Identification of incidents through reporting should be used to identify emerging risks to consumers for monitoring and management.
* **Standard 8, Requirement (3)(d):** The provider should ensure incidents are captured in line with the service’s policies and procedures to inform an effective risk management system to identify trend and drive improvements in care and services. Where audits expose areas of risk to consumers through identifying deficiencies, the provider should schedule improvement actions and monitor for effectiveness.

# 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

Consumers and representatives said consumers are treated with dignity and respect and provided examples of how staff do this, such demonstrating patience and spending time getting to know consumers. Staff demonstrated awareness of consumer preferences and where they could find additional information, and were observed treating consumers with kindness, dignity, and respect. Care planning documentation demonstrated consumers’ culture and identity is captured within their care plans.

Comprehensive information about a consumer’s personal history is obtained through assessment processes and incorporated into care planning. Staff confirmed they receive cultural awareness training and could describe how they communicate with consumers who have English as a second language.

Consumers said they are empowered to make decisions about their care and how and when services are delivered, and felt their choices were respected. Consumers indicated they enjoyed the social relationships they have developed at the service and were encouraged to maintain these connections. Care planning captured consumer preferences, including who they wished to be involved in their care.

Consumers said they are supported to life their best life, even when risk is involved, and these risks are discussed with them. Staff could describe mitigating strategies used in response to risks consumers wished to take, with information captured in risk assessments in line with policies and procedures.

Consumers and representatives confirmed information is communicated through emails, messages, and verbally, enabling them to make choices. Activity calendars were observed throughout the service and consumers stated staff verbally communicate these choices to them. Resident/Relative meetings are also used to communicate information to consumers. Visual cues are used to communicate with consumers who do not speak English.

Consumers and representatives were confident consumers’ privacy was respected. Staff were observed knocking on doors prior to entry, and securing doors and using signage when personal care was being undertaken. Personal information was observed to be stored in the electronic care system which requires password access.

For the reasons outlined above I find all Requirements 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. | Non-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. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as two of the five specific Requirements have been assessed as Non-compliant. The Assessment Team recommend Requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(a)**

The Assessment Team found assessment and planning did not provide sufficient information to guide staff in the delivery of safe and effective care in relation to restrictive practices and behaviour management, and wounds had not been effectively assessed and staged. The Assessment Team provided the following evidence relevant to my finding:

* Consumer A did not have a behaviour support plan in line with the *Quality of Care Principles 2014* or assessments and behaviour charting identifying triggers, or alternate strategies to apply prior to the use of chemical restraint.
  + Consumer A does not have a diagnosis of dementia, however, has psychotropic medication prescribed with indications for use including agitation and sundowning and this information is captured in the restraint assessment. When the medication was administered it was during the night to aid sleep or in response to anxiety.
  + Non-pharmacological strategies documented in the restraint assessment and trialled prior to the administration of the psychotropic medication were generic in nature.
  + Staff gave different information on when behaviour charting should be undertaken for new consumers, and not all staff were familiar with behaviour support plans.
* Consumer B’s behaviour support plan did not identify their dislike for an aspect of personal care. Strategies for management of Consumer B’s personal hygiene needs and preferences were not in line with feedback from the representative and not consistently being followed in terms of number or gender of staff providing assistance. Strategies in the behaviour support plan were generic, triggers had not been captured and behaviour charting did not capture behaviours of aggression towards staff.
* Pressure injuries had not been effectively assessed and staged. Wound assessments did not always distinguish between pressure injuries and incontinence associated dermatitis (IAD). Whilst the service reported a total of 19 pressure injuries, five wounds were documented as possible IAD. Three of the five wounds documented as IAD also had classification as stage 2 pressure injury. Management plans were not individualised to each wound.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, providing the following supporting evidence by way of explanation, and progress notes, assessments, and charting for consumers relevant to my finding:

* Consumer A was admitted on respite for comfort care, did not have a diagnosis of dementia, and the medication was prescribed as a sedative to reduce restlessness and agitated behaviours in line with end of life care management.
  + Indications for administration were not the responsibility of the service but the Medical officer, however, all staff were aware it was for management of agitation and restlessness to reduce risk of harm.
  + Consumer A’s agitation and restlessness caused them to be unable to sleep, which is why the medication was administered.
  + Behaviour charting is not undertaken on admission as consumers take time to settle into the facility, and charting would not give an accurate result, however, behaviour charting was undertaken following the consumer becoming permanent in February 2023, and a behaviour support plan with specific strategies and interventions completed.
  + Not all staff may recognise the term behaviour support plan, and in recognition of this, the care plan wording has been changed to match legislated terminology to guide staff. The provider refutes the Assessment Team’s report in relation to comments from management on ensuring all consumers have a behaviour support plan undertaken within the first week.
* Consumer B’s representative said the consumer lacked insight into the need for hygiene, rather than a dislike, and the care plan was informed by this.
  + The implemented strategies for showering the consumer were subsequently established for staff safety, as the consumer has displayed inappropriate behaviours, rather than in relation to consumer preference.
  + The consumer has subsequently been reviewed by the Medical officer and Dementia Support Australia with recommendations incorporated into the behaviour support plan.
  + An investigation was undertaken into the Assessment Team’s comments of the consumer being attended by only one carer during the Site Audit, and confirmed a second staff member was in attendance to provide assistance.
* The provider refuted comments in the Assessment Team’s report attributed to management, saying wounds were being misclassified and there was an identified need for further education. Instead, management agreed ongoing education could improve consistency in wound documentation and continuous improvement was being undertaken to determine whether IAD may be contributing to development of pressure injuries, and how this could be better identified.
  + Further information on wound management has been provided in response to the consumer’s wound care and considered in other Requirements, however, there are no comments or further evidence in relation to differentiating between IAD and pressure injuries.

I acknowledge the provider’s response. I do not find the evidence before me demonstrates deficiencies in assessment and planning of wound care, and have considered the deficiencies in wound management in Requirement (3)(a) of Standard 3 Personal care and clinical care. I note the provider’s response identifies actions to be taken to improve wound care and would encourage the provider to actively pursue continuous improvement in the assessment and classification of wounds, including differentiating between IAD and pressure injuries for appropriate management strategies.

However, I find the service did not demonstrate assessment and planning included consideration of risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services in relation to management of changed behaviours.

Consumer A had been prescribed a psychotropic medication two days after admission following agitation and multiple falls. In coming to my finding, I have placed weight on the service obtaining consent for the use of chemical restraint, documentation within the behaviour support plan identifying the medication as a restrictive practice, and indication for administration, including for ‘sundowning’, a term used to describe behavioural disturbances at a particular time of day. Whilst the *Quality of Care Principles 2014* does identify medication prescribed for end of life care for the recipient is not chemical restraint, the service identifies the consumer was receiving comfort care, which is not the same as end of life care. Documentation within the provider’s response includes evidence of some deterioration in health prior to the Site Audit, however, also includes reference to improved health and well-being in reviews after the Site Audit. I consider there to be sufficient information demonstrating the medication was prescribed and administered as a restrictive practice.

I have considered the provider’s position to not to undertake behaviour charting and development of a behaviour support plan as part of the initial care planning for respite care, considering it may not be reasonable nor provide accurate assessment. However, assessment and planning should identify and consider risks for each consumer to inform staff of strategies, and where chemical restraint is prescribed, legislation requires the provider to ensure a behaviour support plan is included in the care and services plan. Whilst I accept the provider’s comments in relation to behaviours settling as the consumer becomes more familiar with the environment, I do not consider this removes the need to assess the risk and develop initial strategies in the interim, especially when the consumer is being administered a psychotropic medication in response to behaviours.

I accept the explanations in relation to differences for Consumer B relating to communication about them lacking insight into the need for hygiene instead of disliking, and the provider has identified responsive behaviours to care delivery in the behaviour support plan. The provider’s explanation of the guidance for female staff members, where possible, due to inappropriate sexual behaviours for the safety of staff is reasonable, however, I note these behaviours are not identified on the behaviour support plan dated 7 March 2023 submitted as part of the provider’s response, highlighting deficiencies within the assessment and planning documentation.

For the reasons outlined above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers Non-compliant.

**Requirement (3)(e)**

The Assessment Team found care and services were not reviewed regularly for effectiveness following incidents. Consumers experiencing frequent falls did not have review of strategies for effectiveness, and sampled care plans did not capture consumer needs and preferences for pressure relieving strategies or incorporate wishes from the representative about comfort. The Assessment Team provided the following evidence relevant to my finding:

* Consumer A had multiple falls in a short period, and although risk assessments were updated, management strategies were generic and remained unchanged after each fall.
* Consumer C’s care plan was updated following identification of wounds, but did not identify all wounds, and strategies for pressure area care to prevent progression.
* Consumer D’s care plan includes comments from the family requesting minimal intervention and movement, however, this was not captured in the skin assessment care plan requiring repositioning every two hours.
* Consumer E’s care plan had not been updated accurately following a fall.
* Consumer F did not have updated falls strategies reviewed for effectiveness or updated, falls prevention strategies for night-time continence care was only in the continence assessment, and staff were unaware of it being an intervention to prevent falls.
  + Lifestyle assessments for Consumer F did not consider the negative impact on participating in activities due to reduced mobility following a significant injury sustained in a fall.

The provider’s response includes supporting evidence by way of explanation, and progress notes, assessments, and charting for consumers providing the following evidence relevant to my finding:

* Consumer A’s strategies are considered to be effective in minimising injury, which is the current goal. Consumer A’s falls are not falls from standing positions, but from rolling out of bed as part of confusion and restlessness relating to disease deterioration, and there are no further interventions to assist.
  + The falls risk assessment information provides personalised interventions, however, the strategies within the care plan are best practice for injury prevention, which will remain generic.
  + A falls analysis conducted for Consumer A did not identify any trends for time of day, and the frequency of falls have reduced after February 2023, demonstrating effective management.
* The provider acknowledges areas for improvement in documentation relating to Consumer C’s wound, however, as Consumer C is mobile, they do not require regular repositioning.
  + Assessments had been undertaken for Consumer C’s need for pressure relieving devices, however, the recommended management options were not accepted by the consumer.
* The provider’s response did not address Consumer D in relation to this Requirement.
* All possible measures have been taken to reduce Consumer F’s ongoing falls and risk of injury.
  + The falls risk assessment identifies falls at night could be due to a need for the toilet, however, this was added into the continence care plan rather than falls, as staff would refer to this first for toileting needs.
  + The consumer has had a reduction in falls and rolling out of bed, so interventions must be effective.
  + The consumer’s interest and participation in activities had reduced following the injury due to pain and mobility issues, however, as these are now resolving, lifestyle staff are working with the consumer to identify and include them in activities of interest.
* The provider states the Assessment Team have misread the date on the most recent fall experienced by Consumer E and provided supporting documentation. I accept the provider’s information and have not considered Consumer E within my finding.

In coming to my finding, I have placed weight on the evidence presented relating to Consumers A and F, and find they did not have review of care and services to meet needs and preferences following falls. I do not agree with the provider’s assertion that best practice care can result in generic management strategies, as this contradicts the premiss of person centred care. Documentation for Consumer A includes Allied health reviews following falls, identifying individual triggers for falls due to underlying medical issues, however, these have not been incorporated into management strategies. The provider’s response does not recognise the difference between prevention of fall and prevention of injury, which has influenced the review of strategies for effectiveness. Whilst the provider notes both consumers have had reduction in falls, there is also evidence of improved health for Consumer A.

The provider has included a copy of Consumer F’s continence plan demonstrating it includes scheduled toileting times. However, I do not have any evidence to demonstrate staff awareness of the importance of this as being a planned action to prevent night-time falls.

I have also considered the changes to Consumer F’s ability to participate in activities, and whilst the care plan reviewed 2 March 2023 identifies changes to mobility following injury, it did not demonstrate consideration of activities of interest following changes in health. Evidence within the Assessment Team’s report recognises the consumer was participating in regular activities prior to the injury, with a significant reduction to six activities over a 10 week span afterwards. The care plan submitted by the provider includes preferred activities, but does not identify how activities, such as exercise activities and Men’s shed may need to be adapted due to reduced mobility. Whilst I accept the need for time to adjust to pain and changed mobility and adapt needs for the consumer, the provider’s response shows discussions are just beginning, despite pain evaluation in February 2023 indicating no signs of pain on management regime. I do not find this demonstrates care and services were reviewed in response to changes to the consumer’s needs and preferences.

Consumer C did not have needs and preferences captured in care planning to reduce or heal their wounds, and prescribed pressure relieving equipment used was not identified, although some staff were aware. Requests from Consumer D’s family for conservative management were not incorporated into needs, goals, and preferences resulting in contradicting management strategies.

For the reasons outlined above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers Non-compliant.

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

Consumers and representatives said they have been provided the opportunity to discuss consumers’ current care needs, goals and preferences, including advance care planning and end of life care. Staff described what is important to consumers in terms of how their care is delivered. Assessments, including, but not limited to, pain, diabetes, communication and specialised nursing needs contained individualised preferences and goals of care. Audits are undertaken to identify consumers without advance care directives, copies are uploaded to the care management system and a copy printed and stored in the nurses’ station for ease of access.

Consumers and representatives said they are satisfied with the quality of care and services consumers receive, and that assessments and planning are based on partnership with them and include others they choose to involve in their care. Clinical staff could explain the referral process to Allied health, dementia specialists and Medical officers and care planning documentation included input from these providers of care.

Most consumers and representatives reported outcomes of care planning are communicated to them. Clinical staff explained the process of accessing care plan documents on the electronic care system and said they communicate outcomes of assessments to consumers by talking to them and allowing time for them to ask questions. Care planning information is available on the electronic care management system with both summary and extended care plan options reflecting consumer needs.

For the reasons outlined above I find Requirements (3)(b), (3)(c), and (3)(d) 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. | 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

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant. The Assessment Team recommend Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care are not met.

**Requirement (3)(a)**

The Assessment Team found the service was unable to demonstrate each consumer gets safe and effective personal and/or clinical care that is best practice, tailored to their needs and optimises health and well-being in relation to skin and wound care, and use of restrictive practices. The Assessment Team provided the following evidence relevant to my finding:

* Consumer A did not have a diagnosis of dementia, however, had consent and authorisation for use of chemical restraint. Behaviour charting had not been undertaken, a behaviour support plan had not been created to guide staff, and strategies for behaviour management were generic.
* Consumer B has a behaviour support plan, however, strategies were generic and not personalised.
  + Despite an increase in incidents linked to Consumer B’s behaviours, behaviour charting had not been undertaken, behaviours were not reviewed in line with processes, and did not include triggers or effective management strategies.
* Consumer D had a pressure injury that was not effectively managed or monitored in relation to measurements, classification and staging, and photographs of the wound.
  + A wound audit was undertaken in August 2022 identifying deficiencies in relation to regular review of wounds, accuracy of measurements, consistency of photographs, and accuracy of wound assessments, however, this has not led to changes in clinical practice.
  + Most clinical staff said they had not received training about wound management, although some were familiar with wound classification and best practice wound photography requirements.

The Assessment Team provided evidence in relation to wound assessment and management to Consumer C under Requirement (3)(b) of this Standard, finding the wounds had not been identified in a timely manner or monitored in line with the service’s policy. I find the evidence relates to inconsistencies in documentation and have included this within this Requirement.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, providing the following supporting evidence by way of explanation, and progress notes, assessments, and charting for consumers relevant to my finding:

* As reflected in Requirement (3)(a) of Standard 2 Ongoing assessment and planning with consumers, Consumer A does not have dementia but was for comfort care, and no further investigations would be undertaken and a diagnosis would not be made.
  + Behaviour charting was undertaken when Consumer A became a permanent admission, and an extended care plan was developed with a behaviour support plan.
  + To reflect the service did not minimise the use of restraint for Consumer A is not accurate, as the confusion and restlessness is a symptom of deterioration and end of life status.
  + Intervention strategies have been successful as the need for the psychotropic medication has decreased, reflecting minimisation of the use of restraint.
* One of Consumer C’s wounds was not able to be identified by staff, as it was discovered when the Podiatrist removed an overlying growth. Consumer C is not always cooperative with care, which combined with multiple skin folds makes it difficult to detect skin changes early.
  + In relation to the other wound, it is acknowledged photographs were not of high standard and whilst a disposable ruler is always used to capture measurements, it is not always visible in photographs. There are plans for further education for staff on wound measurement, documentation, and photographs.
  + The service has developed a wound management procedure to guide staff on requirements for wound documentation, and this is waiting ratification at the Clinical Governance Meeting.
* Consumer D’s wound developed during a hospital admission, and a complaint has subsequently been lodged with the hospital over the quality of care.
  + The provider acknowledges the ongoing wound documentation was not satisfactory, and measurements not always accurately completed, however, do not accept this had any negative impact on progression of healing.
  + A Wound specialist was consulted after the wound was identified, and a review by the specialist after the Site Audit identifies improvement. The provider stated due to the severity of the injury there was little possibility of the wound healing, and the specialist had documented ‘likely client deterioration given overall condition’ but did not explain why the wound specialist did not review for nearly five months.
  + Actions were added to the plan for continuous improvement following the wound audit, including discussing issues at staff meetings, emailing nursing staff, and undertaking a further audit in February 2023. The second audit showed ongoing documentation issues, with mandatory training scheduled for staff in late April 2023 and early May 2023 in response, and plans to develop a monitoring system.

The provider did not offer any further evidence for Consumer B in their response.

Whilst I do not consider the use of chemical restraint without a supporting behaviour support plan for staff guidance demonstrates principles of best practice and tailored consumer care, I acknowledge the provider’s actions to improve the consumer’s physical and emotional well-being and minimise the use of the psychotropic medication. I have considered the issues relating to Consumer A within Requirement (3)(a) of Standard 2 Ongoing assessment and planning with consumers, as care planning documentation for management of behaviours and administration of psychotropic medication was not sufficient to guide staff.

I find the evidence for Consumer B aligns with the intent of Requirement (3)(b) of Standard 3 Personal care and clinical care, and Requirement (3)(a) of Standard 2 Ongoing assessment and planning with consumers, and have considered the evidence further in these Requirements.

With relation to Consumer D, I find the service did not demonstrate provision of safe and effective personal and/or clinical care that is best practice, tailored to consumer needs, and optimising health and well-being. I accept the provider’s explanation of formation of the wound in hospital, and actions to refer to a Wound specialist once the wound had been assessed. I note the provider’s acknowledgement of deficiencies within wound documentation, however, deficiencies had been identified in internal audits in August 2022 and February 2023 without effective change. Clinical staff reported they did not receive training, and not all could describe wound care assessment and management in line with best practice guidelines. The wound was promptly assessed by a Wound specialist, however, whilst I accept healing of the wound would be slow, I do not believe it best practice to wait nearly five months for a follow up review.

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

**Requirement (3)(b)**

The Assessment Team found the service was unable to demonstrate management of high impact or high prevalence risks in relation to falls management, restrictive practices, and pressure injuries. The Assessment Team provided the following evidence relevant to my finding:

* Consumer F had multiple incidents of falls with injuries, however, did not have an effective falls prevention strategy, and when observed, the consumer did not have appropriate footwear, could not reach their call bell or mobility aid, and crash mats were not positioned in line with care plan directives when sitting out of bed, demonstrating strategies were not being implemented. Care staff were unaware the scheduled night-time toileting was implemented as a falls prevention strategy. The consumer had 11 falls in the three months prior to the Site Audit, including one requiring transfer to hospital for management of pain and injury.
* Consumers C and D did not have effective skin and wound care, with deficiencies in wound charting and an absence of monitoring to ensure effective skin and wound care.
  + Consumer C’s wounds were not identified in early stages, and despite showing signs of deterioration, the service has not referred them to a Wound specialist.
  + The service’s policy does not provide guidance for measuring of wounds.
* Consumers B and G display challenging behaviours with incidents of aggression towards others, however, these are not being reported as incidents and behaviour charting is not being undertaken to capture triggers and show effective strategies.

The provider’s response indicates they do not agree with the Assessment Team’s recommendation, providing the following supporting evidence by way of explanation, and progress notes, assessments, and charting relevant to my finding:

* The provider refutes that identification of Consumer C’s wounds was not timely. One wound was evidently only following removal of a growth. The second wound was not identified before the skin broke as the consumer has multiple skin folds and can be uncooperative with staff attempting to provide assistance.
* The provider states they believe all possible measures to reduce falls and risk of injury for Consumer F have been taken. A copy of the Falls Prevention Review of Interventions for Consumer F dated 17 February 2023 shows risk factors, strategies, history of falls in past three months, including eight falls, previous strategies, and relevant documentation. This information was used to identify and implement some new strategies, which were included in the care plan. Strategies have been evaluated as effective as there were no falls or rolls out of bed in March 2023, and only one in April 2023.
* Consumer G’s behaviours are an exacerbation of previously known behaviours, were triggered by a planned reduction in psychotropic medication, and as they are not new the existing behaviour support plan remains appropriate. Behaviour charting was commenced the week after the Site Audit, following directives of the Medical officer to monitor effectiveness of the changes.
* The provider acknowledges there was some misunderstanding by staff on when incident forms should be completed in response to consumer behaviours, and corrective action has been taken.

I accept the provider’s explanation about the timeframe of identification of wounds, and have considered the deficiencies in wound care documentation under Requirement (3)(a) of this Standard.

In relation to Consumer F’s falls, the provider did not respond to documented observations within the Assessment Team’s report around falls prevention strategies not being used. Whilst I accept the service identified Consumer F’s risks relating to falls, with evidence of monitoring of effectiveness of strategies, I find the service did not demonstrate the risks were managed in line with the consumer’s care and services plan. Not all staff were aware of the link between scheduled toileting times and reducing falls, and the consumer was observed in a chair without all documented strategies being implemented.

The provider acknowledges improvements for identifying and reporting incidents and accordingly I find the service did not identify risks for consumers relating to increased frequency of challenging behaviours. While I note the provider has acted in response to the information raised in the Assessment Team’s report, I was not provided sufficient evidence in the provider’s response to satisfy me that the service has addressed all of the deficiencies identified during the Site Audit.

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

**Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g)**

Consumers and representatives confirmed staff had spoken to them about advance care planning and end of life. Care and clinical staff could relay what was important when delivering end of life care. Care files included details of end of life preferences and choices during end of life care, and sampled files for late consumers demonstrated actions to maximise comfort and preserve dignity.

Consumers and representatives said they are satisfied with the delivery of care, including the recognition of deterioration or changes in the consumer's condition. Staff described escalation pathways and provided examples of when deterioration or change in a consumer's condition was recognised and responded to. A review of care planning documents, progress notes, and charting demonstrated identification and actions taken in response to deterioration in a consumers health capacity and function.

Consumers and representatives were satisfied with the delivery of care, including the communication of consumers’ conditions. Staff described how changes in consumers’ care and services are communicated through daily handovers, meetings, care plan alerts, and emails. Consumer documentation identified adequate and accurate information to support safe and effective sharing of consumers’ care.

Most consumers and representatives said they are satisfied with the referral processes, although not all representatives were happy with telehealth processes used by some providers. Clinical staff describe the process for referring consumers to health professionals and Allied health services. Consumers’ care planning documentation included input from other services, such as Medical officers, Allied health professionals, and external specialist providers.

Overall, consumers and representatives said they were satisfied with the service’s management of COVID-19 precautions and infection control practices. Staff reported an increase in education and training related to infection control measures pertaining to COVID-19 precautions, including use of personal protective equipment and outbreak management processes. Care and registered staff interviewed demonstrated an understanding of how to minimise the need for antibiotics and ensure they are used appropriately. The service has a nominated Infection prevention and control (IPC) lead, and guidance material available for staff includes policies and an infection control flowchart on testing and antibiotic use.

For the reasons outlined above I find Requirements (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) 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. | 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

Consumer and representatives were satisfied with services and said supports are in place to meet consumers’ needs, goals, and preferences for daily living. Staff were aware of consumers’ needs and preferences, and care planning identified consumers’ choices, preferences, and wishes in relation to lifestyle and well-being activities.

Consumers and representatives said they felt comfortable speaking with staff if consumers needed increased emotional support. Services and supports to promote emotional, spiritual, and psychological well-being include church services, pastoral visits, and one-on-one visits from lifestyle staff. Consumers isolating in their rooms are prioritised for one-on-one visits.

Consumers said they felt supported to participate in activities within the service and in the community. Lifestyle staff gave examples of planned activities for consumers with limited mobility and sensory needs. Care planning documentation identified people important to consumers, their individual interests and hobbies, and level of assistance required to participate in planned activities.

Consumers confirmed staff generally understand their needs. Staff confirmed the ways in which changing needs are communicated, including through emails and verbal handovers, and how this influences their daily tasks. Dietary information, including meal choice and dietary preference, is recorded on the meal choices list for kitchen staff.

Staff described involvement of other providers and individuals to support consumers’ care and needs, including coordinating activities and visits to the service with external organisations. The service works with several organisations to coordinate volunteers for consumers with specific needs.

Whilst many consumers were happy with the food and options provided, some raised concern about the temperature and quality of meals, although it was acknowledged there had been recent improvements. The service implemented a dining program in January 2023, with lifestyle staff dining with consumers during the week, which the service considers to be successful in improving the dining experience with food survey satisfaction rating increased from 65% to 90%. Regular food safety checks are undertaken and the kitchen was clean and well-maintained.

Consumers said they felt safe using their equipment and staff assisted them in organising maintenance for items that are personally owned. Lifestyle staff said they can access additional equipment from management, and had reporting processes for equipment needing repair or replacement. Equipment was observed to be clean and well-maintained.

For the reasons outlined above I find all Requirements 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. | 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. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers and representatives stated consumers felt safe in the service and it is a home-like environment. Signage assists consumers and visitors to navigate through the service, and there are various communal areas for consumers to engage with others, including a café. Consumer rooms were observed to be personalised.

Consumers confirmed they have access to the outdoor gardens and were observed to be moving freely throughout the service, including both indoor and outdoor areas. The environment was well-maintained and clean, with staff observed cleaning communal areas several times during the day. The service was responsive in arranging maintenance action for identified hazards, and had an up-to-date fire evacuation plan and equipment.

Lounge areas and outdoor furniture settings appeared suitably furnished, well maintained, and equipment was clean and safe, with adequate storage. The service has an online system to monitor preventative and reactive maintenance activities. Staff were aware of mechanisms to report hazards and said issues are attended promptly.

For the reasons outlined above I find all Requirements 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives said they were aware of mechanisms to provide feedback and felt management listened when they raised concerns. Staff demonstrated awareness with the complaints handling process, and described methods to support consumers providing feedback or make complaints. Feedback and complaints captured through various mechanisms were recorded in the feedback log.

Consumers and representatives said they are aware of external agencies who could assist them in raising concerns, and representatives said they can also directly advocate for consumers with communication barriers. Information on complaints pathways and language and advocacy services were displayed on noticeboards and explained within the admission pack. Advocacy groups are invited to attend the service each year to meet with consumers and representatives.

Most consumers and representatives said complaints were actioned promptly and managed to satisfaction, with offer of an apology. Staff were familiar with the concept of open disclosure, describing the importance of transparency and providing an apology when things go wrong. Documentation, including feedback logs, showed how open disclosure was applied when incidents occurred or complaints made, including description of actions undertaken in response.

Consumers and representatives could identify changes made in response to feedback and said improvements to care and services in response to feedback are communicated directly by staff and/or discussed during consumer meetings and care plan conferences. Management provided examples of improvements made as a direct result of feedback and/or complaints about food, with comprehensive actions undertaken, including formation of food focus groups and monitoring improvements through food surveys and feedback forms. The organisation has processes in place to ensure all feedback is captured, monitored, analysed, trended and reviewed for areas of continuous improvement with improvements logged on their plan for continuous improvement (PCI).

For the reasons outlined above I find all Requirements 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. | 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

Consumers and representatives were satisfied with staffing skills and numbers, and said consumers did not need to wait long when assistance was required. Staff reported there are sufficient numbers of staff rostered to ensure consumer care was undertaken in a timely manner, with minimal shifts left unfilled. Management stated rosters are regularly reviewed to ensure consumer care needs are met, with monitoring through feedback, clinical indicators, and call bell data.

Consumers and representatives interviewed said staff are kind and caring and treat consumers with respect. Staff demonstrated familiarity of consumer needs, preferences and cultural requirements in line with care planning. Processes and systems are in place to monitor consumer satisfaction with staff interactions, such as feedback forms, surveys, and consumer meetings. The feedback log showed consumer satisfaction/compliments with staff interactions and care.

Overall, consumers and representatives said care and clinical staff are competent in their roles and understand the care needs of consumers. Staff confirmed they are supported by management and have the tools and training to undertake their duties confidently, although some staff said they had not received recent training on wound management. Staff competency is monitored through internal audits and competency assessments, however, deficiencies in wound care had been identified in internal audits in August 2022 and February 2023 without effective change, as identified in Requirement (3)(a) of Standard 3 Personal care and clinical care.

Consumers and representatives were generally satisfied with the skills and knowledge of staff and have confidence in them to deliver care and services. Staff said they are provided training opportunities, are supported in their role, and seek can guidance from the clinical team or management for further guidance when required. The service has an orientation process to ensure the workforce is competent and to maintain a required standard of knowledge during their employment through training opportunities. Documentation showed the service reviews its training regime to meet the needs of consumers.

Staff stated they participate in reviews where they can discuss their performance and identify areas for further training or support. Management said they monitor staff performance through complaint data, auditing processes, including daily progress note review, and observation of practices. Management described the performance management framework to address concerns relating to staff practice. An audit schedule is in place to monitor staff performance with audits being conducted in line with audit schedule to ensure staff practices and performance is monitored.

For the reasons outlined above I find all Requirements 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. | 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. | 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. | Compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant. The Assessment Team recommend Requirement (3)(d) in Standard 8 Organisational governance not met.

**Requirement (3)(d)**

The Assessment Team found the service was unable to demonstrate use of effective risk management systems and practices, as not all incidents of aggressive behaviour were being recorded within the incident management system. The Assessment Team provided the following evidence relevant to my finding:

* Incident reports were not consistently being completed for two sampled consumers following acts of aggression towards staff or other consumers.
* Staff were aware of reporting processes, but said repetitive or known behaviours did not need to be reported.
* Monitoring processes, including review of daily progress notes and review of incident data were not effective. As incidents were not being recorded in the incident management system, governance systems are not effective to manage, monitor, analyse, and prevent incidents.
* Audits for wound management and challenging behaviours showed some deficiencies were identified through this process, however, appropriate monitoring and action to address these deficiencies did not occur.
* Clinical governance and Clinical nurse/Enrolled nurse meeting minutes viewed discuss audit findings and trends associated with incident data but do not discuss or review current risks, strategies, interventions, and effectiveness of those interventions for consumers relating to falls.

The provider refutes the assertion that risks, strategies, and interventions for consumers are not discussed in clinical meetings, providing evidence of discussion of Consumer F as a case study and impetus for further education for staff. The Falls Prevention Review of Intervention assessment was introduced to identify any further interventions to incorporate into care plans. Where the tool has been used to analyse a consumer’s falls, evaluation showed a reduction in number and frequency. I accept the provider’s evidence of identification of consumer risks and oversight and monitoring of falls, and have considered the deficiencies relate to care planning, as identified in my findings within Standard 2.

The provider acknowledges not all incidents or challenging behaviours are recorded in the incident management system, and staff have been notified of the correct process with ongoing discussion scheduled for Clinical nurse/Enrolled nurse meetings in April and May 2023. Ongoing continuous improvement activities have been created to improve wound management and documentation following the poor audit results.

Incident data should be used to identify trends, drive continuous improvement to improve the quality of the care and services, and prevent similar incidents from occurring. I consider the deficiencies in identifying and reporting behavioural incidents do not demonstrate the service has an effective oversight through current risk management system and practices.

The service has an audit schedule to identify deficiencies and current or emerging high impact or high prevalence risks associated with the care of consumers. However, wound audit results found irregularities in assessment, measurements, quality of photographs, and use of timely referrals in August 2022 without quality improvements by the next audit undertaken in February 2023, impacting on consumer care as identified in Requirement (3)(a) of Standard 3 Personal care and clinical care.

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

**Requirements (3)(a), (3)(b), (3)(c), and (3)(e)**

Consumers described being involved in the development and delivery of care and services and have opportunities to suggest improvements through feedback forums and consumer meetings. Management said feedback and surveys are used to identify areas for improvement. The organisation’s strategic plan describes the Board, executive and management team’s commitment to creating an environment where consumers are actively supported to partner in care.

The organisation has an overarching code of conduct and values statement, with up-to-date policies and procedures in place which describe responsibilities, accountabilities and service expectations to promote quality, safe and inclusive care and services. There are a range of reporting mechanisms to ensure the Board and sub-committees are aware and accountable for the delivery of care and services, and most consumers and representatives felt the service was well run by management.

Consumers and representatives confirmed they are encouraged to participate in continuous improvement initiatives through feedback, surveys and meetings. The service has effective organisation wide governance systems, demonstrated through financial planning process and delegation systems, continuous improvement planning, and workforce planning processes to ensure staff are selected, trained and supported to meet the organisation’s values and job specifications of each role. The organisation has memberships with peak bodies to monitor changes to aged care law to ensure regulatory obligations are met. Feedback and complaints are managed at a site level and reported at relevant leadership and Board meetings and are monitored by the clinical governance and quality and risk management committees.

Clinical governance arrangements effectively guide and support the workforce to guide safe, quality clinical care. The framework includes the management of antimicrobial stewardship, minimising the use of restraint and open disclosure policies, procedures to guide staff practice. The use of restrictive practices is monitored, with informed consent sought and behaviour support plans completed, where it has been identified there is a restrictive practice in place. However, assessment and planning for consumers did not always provide sufficient information to guide staff to identify use of chemical restraint or ensure it is used as a last resort, as considered within Standards 2 and 3. The service has systems for preventing, managing and controlling infections and antimicrobial resistance, which is monitored and reported through clinical indicator data and internal audits.

For the reasons outlined above I find Requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 8 Organisational governance Compliant.

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