Performance

Report

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| Name: | Anglican Care Storm Village |
| Commission ID: | 0230 |
| Address: | 109 Cowper Street, TAREE, New South Wales, 2430 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 14 November 2023 to 17 November 2023 |
| Performance report date: | 20 December 2023 |
| Service included in this assessment: | Provider: 3186 Anglican Care  Service: 246 Anglican Care Storm Village |

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 Anglican Care Storm Village (**the service**) has been prepared by G-M. Cain, 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 Assessment contact (performance assessment) – site 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 13 December 2023

# 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 | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* Requirement 3(3)(b) – The approved provider must demonstrate the high impact and high prevalence risks associated with the care of consumers are effectively identified and managed. This includes in relation to medication management, falls, and unplanned weight loss.
* Requirement 3(3)(g) – The approved provider must demonstrate the service has implemented practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. Consumer monitoring is effective in identifying and responding to potential infection. Standard and transmission based precautions to prevent and control infection are effectively implemented at the service.
* Requirement 7(3)(a) – The approved provider must demonstrate the workforce deployed enables the delivery and management of safe and quality care and services. This includes personal and clinical care, and leisure and lifestyle services. The service has effective processes in place to manage unfilled shifts without compromising quality consumer care and services.
* Requirement 7(3)(d) – The approved provider must demonstrate staff are trained, recruited, and supported to deliver the outcomes required by the Quality Standards. Effective orientation and induction is undertaken for new staff. Regular and as required training is undertaken by staff, and evaluation of the effectiveness of the training is considered.
* Requirement 7(3)(e) – The approved provider must demonstrate a system to ensure the regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Information including incidents and feedback is used to inform staff performance reviews.
* Requirement 8(3)(c) – The approved provider must demonstrate the organisation wide governance systems implemented at the service are effective. This includes in relation to information management, continuous improvement, workforce governance, and regulatory compliance. Gaps in the implementation and delivery of these governance systems are identified and action is taken to rectify these gaps.
* Requirement 8(3)(d) – The approved provider must demonstrate risk management systems are consistently effective in identifying and managing high impact or high prevalence risks associated with the care of consumers, and managing and preventing incidents, including the use of an incident management system. Incidents reportable under the serious incident response scheme are identified and responded to appropriately. Effective monitoring and oversight of the risks at the service, with information provided to the organisation to ensure well-informed decisions.
* Requirement 8(3)(e) – The approved provider must demonstrate the clinical governance framework implemented at the service is effective in ensuring safe and quality clinical care to consumers. This includes minimising the use of restrictive practices, antimicrobial stewardship, and open disclosure. Effective monitoring and oversight of the clinical care delivery at the service, with information provided to the organisation to ensure well-informed decisions.

# 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 |

Findings

The performance report dated 06 March 2023 found the service non-compliant in Requirement 1(3)(a). Deficiencies related to consumers not being treated in a respectful and dignified manner. The Assessment Contact Report contained information that demonstrated overall consumers are treated with respect and dignity. Consumers and representatives spoke of staff being polite, treating consumers with respect, maintaining consumer dignity when providing care, and staff being gentle and polite. While some observations were made that showed practices which did not maintain consumer dignity and privacy, such as doors being left open during personal cares, overall observations showed staff interacting with consumers in a friendly and respectful manner. The Assessment Contact Report evidenced the service has taken action to improve its performance under this requirement, for example the service has recruited new staff and management and provided education and training for all staff around consumer identity, culture and diversity. Management performs a daily walk around and spot check of the service and its operations. Care documentation reflected individual consumers’ interests, needs and preferences, including consumer’s identity, people of importance, life story, their culture background. For the reasons detailed, it is my decision that Requirement 1(3)(a) is Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The performance report dated 06 March 2023 found the service non-compliant in the 5 Requirements under Standard 2. Deficiencies related to consumer assessment and care planning not consistently including assessment of risks to consumers, or identifying consumers’ needs, goals and preferences which had impacted on their health and well-being. Consumers and representatives spoke of not being involved in consumer’s assessment and planning or feeling informed of the outcomes of the assessment and planning process. Most consumers and representatives had not been offered a copy of their consumer’s care plan and care and services were not reviewed on a regular basis, when circumstances change, or when incidents impact on consumer’s needs and preferences.

*In relation to Requirement 2(3)(a)*

Consumers and representatives provided positive feedback about the consumer assessment and care planning process. A review of care and service documentation demonstrated consumer assessments, including consideration of risk; staff described how these are considered and informed consumer care planning. The Assessment Contact Report identified 2 name consumers who had been residing at the service for 3 to 4 weeks did not have an interim care plan completed at the time of the assessment contact. The approved provider’s response submission provided clarifying information, including evidence that whilst an interim care plan was not documented, some assessments had been completed for the named consumers at the time of the assessment contact. The response submission included a copy of the 2 consumers’ care and services plan which had now been completed and other relevant risk assessments. Whilst I acknowledge that the assessment and care planning process, including understanding individual consumers including risks may take time, I am concerned that 2 consumers at the service did not have care plans established to guide staff in care delivery. I acknowledge the immediate actions taken by the service and the evidence that the 2 named consumers now have a documented care and services plan, which includes consideration of risk/s to their health and or wellbeing. On balance of the evidence before me, I am satisfied that the service’s consumer assessment and care planning processes include the assessment of risk/s and implementation of strategies to minimise these for consumers. For the reasons detailed, it is my decision that Requirement 2(3)(a) is Compliant.

*In relation to Requirement 2(3)(b)*

Consumers and representatives provided positive feedback relating to consumers’ needs being adequately addressed and staff described the service’s assessment and care planning process. However, the Assessment Contact Report contained information that consumer assessment and care planning documentation did not consistently include information relating to needs, goals and preferences to guide care and services delivery. These included:

* Two named consumers who had been residing at the service for 3 to 4 weeks and did not have current care plan. One of the named consumers has a diagnosis of diabetes mellitus (Type 2) and had been identified by the service as subject to chemical restrictive practice. Care documentation did not evidence information to guide staff in the management of the consumer’s diabetes and the behaviours support plan did not include information relating to the restrictive practice.
* Behaviour support plans for:
  + One consumer identified by the service as subject to environmental did not include information relating to the restrictive practice.
  + One consumer who has been diagnosed as experiencing post-traumatic stress disorder did not include identified triggers, including loud noises.
* Consumers with current wounds and/or pressure injuries did not have care plans which included preventative strategies.
* Pain assessments for consumers experiencing acute and chronic pain were not consistently completed.

I have considered this information alongside the Approved Provider's response, which provided clarifying information that confirmed the completion of care plans for the 2 consumers new to the service by the end of November 2023. The response submission evidenced information which included the completion of assessments (from the time of admission) to inform care and service delivery for these 2 consumers. Relating to consumers identified by the service as subject to restrictive practices, the response submission including behaviour support plans which evidenced information relating to restrictive practices. The Approved Provider acknowledge that for 1 consumer, a restrictive practices comprehensive assessment had not been completed at the time of the assessment contact, however this is now complete.

For assessment and care planning related to wound management, pressure injuries and pain assessments, I have considered information contained in the Assessment Contact Report under other Requirements:

* Wound management – information contained under Requirement 3(3)(a) identified clinical documentation for consumers reflected when a wound is identified a wound assessment occurs and a wound chart is commenced. The Assessment Contact Report contained conflicting in relation to wound charting, identifying that monitoring of wounds to undertaken weekly by the clinical care coordinators; however, when wounds are reviewed by registered staff wound charting did not consistently evidence documented evaluation and preventative strategies. I have place weigh on evidence contained under Requirement 3(3)(a) which identified wound charts are reviewed regularly and consistently the care coordinators and include a full assessment and photograph of the wound taken which is evidenced documented in wound charting.
* Pressure injuries – information contained under Requirement 3(3)(a) identified care documentation for consumers reflected preventative measures were in place to ensure the minimisation of pressure areas or issues with skin integrity occurring such as the use of skin care plans and regular assessments.
* Pain assessments – information contained under Requirement 3(3)(a) identified pain assessments are completed and include non-pharmacological interventions prior to the administration of pain relief medication. While pain charting was not consistently completed, I am of the view that this does evidence consumer’s current needs, goals and preferences are not considered.

From the evidence before me, I am satisfied that the service ensures consumer assessment and care planning processes includes the consumer’s current needs, goals and preferences. For the reasons detailed, it is my decision that Requirement 2(3)(b) is Compliant.

*In relation to Requirement 2(3)(c)*

Consumers and representatives spoke of being involved in discussions about consumer care and services. Care documentation evidenced that consumers, representatives, and other providers were involved in ongoing assessment, planning and review of consumers' care and services, including case conferences and referrals to other health professionals. For the reasons detailed, it is my decision that Requirement 2(3)(c) is Compliant.

*In relation to Requirement 2(3)(d)*

Consumers and representatives spoke of being informed of the outcomes of assessment and planning and confirmed being offered and provided a copy of the consumers’ care plan. Staff said, and documentation confirmed that the outcomes of assessment and planning were communicated with consumers, representatives, and others through the electronic care management system and consumers are offered a copy of their care plan as case conferences. Whilst the Assessment Contact Report contained information in relation to 2 named consumers who were new to the service not having current care plans, I have considered this under my decision for Requirement 2(3)(a). The Assessment Contact Report evidenced the service has taken action to improve its performance under this requirement, for example the service has developed a case conference and care plan schedule. For the reasons detailed, it is my decision that Requirement 2(3)(d) is Compliant.

*In relation to Requirement 2(3)(e)*

Consumers and representatives spoke of being contacted when changes occurred in the consumers’ care plans, and registered staff said they are allocated consumer care plans to review each month. A review of care and service documentation confirmed consumers’ care plans are reviewed when circumstances change or incidents impact on the needs, goals and preferences of consumers. However, the Assessment Contact Report contained information that:

* A review of the service’s care plan schedule identified 17 consumers’ care plans were due for review in October 2023, however dates on the schedule were not consistently completed to evidence when this were finalised, including behaviour support plans.
* For 2 consumers new to the service interim care plans were not in place. I have considered this under my decision for Requirement 2(3)(a).
* Behaviour support plans were not consistently reviewed and updated to include information about restrictive practices.
* Consent forms for restrictive practices were not reviewed in accordance with the organisation’s timeframe or the responsibilities under the Quality of Care principles 2014, and consent forms were not consistently completed including signatures of medical officer.

I have come to a different decision following the submission of a response by the approved provider. I have decided that Requirement 2(3)(e) is Compliant. This was based on a lack of consumer feedback regarding care and services not being reviewed, lack of evidence that consumers’ care and services are not regularly being reviewed and evidence of impact on consumers’ care. I have placed weight on information in the response submission which evidenced the completion of assessments (from the time of admission) to inform care and service delivery for the 2 consumers new to the service. For the 17 consumers care plans due for review, the response submission included a copy of the ‘care plan review tracker’ which evidenced the completion of required care plan reviews. In addition, the approved provider has subsequently reviewed the care plan review schedule and changed to a different format for ease of use for staff and to allow for improved monitoring and compliance. Relating to consumers identified by the service as subject to restrictive practices, the response submission stated that all required psychotropic medication consents are up to date and reviewed yearly in line with the organisation’s policy, I have considered information provided in the Assessment Contact Report and response submission under Requirement 3(3)(a), which included evidence that the service has completed a review of all restrictive practices and of the service’s psychotropic register.

# 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not Compliant |

Findings

The performance report dated 06 March 2023 found the service non-compliant in the 7 Requirements under Standard 3. Deficiencies related to:

* Clinical care delivery and identified impacts on consumer’s health and well-being, including the management of high impact and high prevalence risks, restrictive practices, maintenance of skin integrity, unplanned weight loss, pain, medications and falls.
* Restrictive practice management regarding chemical and environmental restrictive practice was not demonstrated to be best practice and tailored to consumer needs to optimise well-being. Legislative requirements relating to the regular review, informed consent and content of behaviour support plans when restrictive practices are implemented have not been followed.
* The service did not demonstrate the needs, goals and preferences of consumers nearing the end of their life were always recognised and addressed in a timely manner, and that their comfort and dignity maximised.
* Deterioration in consumer condition was not always recognised and responded to in a timely manner which had a negative impact on consumers.
* Consumer condition, needs and preferences were not well communicated within the organisation and with others where responsibility is shared, including information regarding medications, wounds, current injuries, and overall care needs. Dissatisfaction was expressed by consumers and representatives regarding communication within the service.
* The service did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services where required, including regarding weight loss, wounds and behaviour support.
* Consumers and representatives raised concerns regarding infection control practices at the service, particularly regarding personal protective equipment use and management of urinary tract infections. These deficiencies were confirmed on review of documentation and observations.

*In relation to Requirement 3(3)(a)*

The Assessment Contact Report contained information that consumers care documentation relating to personal care was maintained, including care preferences and staff demonstrated understanding of individual consumers personal care preferences such as shower times and preferred clothing.

However, the Assessment Contact Report contained information of deficiencies relating to consumer clinical care, specifically in care documentation of wounds, pain, restrictive practices, psychotropic medication, changed behaviours and urinary catheter management as follows:

* Skin integrity and wound management: Two named consumers with skin changes (bruising and pustules) were evidenced as not having completed wound charting or prevention strategies, however, in relation to the 2 consumers, there is lack of evidence that this has impacted on their clinical care. In consideration of information in the response submission, I am satisfied that wound charts are reviewed regularly and consistently by care coordinators (weekly) include a full assessment and photograph of the wound taken which is evidenced documented in wound charting. In relation to skin integrity, care documentation for consumers reflected preventative measures were in place to ensure the minimisation of pressure areas or issues with skin integrity occurring such as the use of skin care plans and regular assessments. Staff confirmed pressure area care is provided to consumers every 2 to 4 hours or as required.
* Pain management. The Assessment Contact Report identified pain assessments are completed and include non-pharmacological interventions prior to the administration of pain relief medication. However, pain charting was not consistently completed, included general comments about pain experienced, and for one consumer who recently experienced a fractured hip pain charting was ceased and evaluation of pain did not align with the administration of pain relief medication. The response submission provided clarifying information and evidence, including that for the named consumer that pain charting is continuing, and that the service utilises a standardised assessment tool for the assessment of consumers’ pain. Consumers and representatives confirmed that staff had explained the risks and benefits of pain medications in use and said staff assist consumers with pain management.
* Restrictive Practices. The Assessment Contact Report contained information that care documentation was not consistently completed including:
* Behaviour support plans were not consistently reviewed and updated to include information about restrictive practices.
* Consent forms for restrictive practices were not reviewed in accordance with the organisation’s timeframe or the responsibilities under the Quality of Care principles 2014, and consent forms were not consistently completed including signatures of medical officer.
* For 1 consumer prescribed psychotropic medication, a supporting diagnosis was not evidenced.
* The service’s psychotropic register did not include antiemetic medication.
* Observations of 2 doors at the main entrance were locked from the inside.

The response submission stated that all required psychotropic medication consents are up to date and reviewed yearly in line with the organisation’s policy, and that the service has completed a review of all restrictive practices and of the service’s psychotropic register. Evidence of the review of psychotropic medication was also supported by an example of the cessation of prescribed psychotropic medication for one consumer. In relation to antiemetic medication, the response submission and it is my view that antiemetic medication is not classified as a psychotropic medication. Regardless, there was a lack of evidence that antiemetic medication has been prescribed for a consumer for the primary purpose of influencing behaviour. In relation to the locked doors at the main entrance, the response submission and it is my view that consumers were not environmentally restrained by the security of the front door to the service. The approved provider submitted information to support consumers were able to exit the service through the main door which opens automatically from both sides, giving consumer's free access (in and out). The second door (parallel door to the back side of reception) opens automatically from the outside in and requires anyone exiting to press a green button to open the door.

* Management of changed behaviours. The Assessment Contact Report contained information that care documentation for consumers who have changed behaviours is inconsistent, episodes of changed behaviours are not consistently documented including implemented strategies to support consumers. Observations showed two consumers, one presenting with agitation and a second calling out for staff, however staff were observed to not respond to these requests advising it was normal behaviour for the consumer. The response submission acknowledged this feedback, and evidenced actions taken in response including staff training in behaviour support and assessment and charting documentation. The training plan provided as part of the response submission identified date of completion 31 March 2024. I will consider this information under my decision for Requirement 3(3)(b).
* Catheter management. Overall, care documentation showed the appropriate management of consumers with catheters. However, for one consumer, care documentation did not contain guidance for staff on the management of the urinary catheter and the catheter had not been changed in 10 weeks. The response submission provided clarifying information, including that due to concerns in relation to the safe changing of the catheter at the service, the consumer had been reviewed by the medical officer and referred to a urology specialist. The response submission evidenced that while the catheter had not been changed, the service had managed risk/s associated with urinary catheters including monitoring fluid intake and management of the urinary drainage bag.

This Requirement requires that each consumer gets safe and effective personal care and/or clinical care that is best practice tailored to their needs and optimises their health and well-being. Following a review of the information contained in the Assessment Contact Report alongside the Approved provider's response, I have decided that Requirement 3(3)(a) is Compliant. Whilst the approved provider has acknowledged improvements in relation to the management of changed behaviours, I will consider this under my decision for Requirement 3(3)(b).

*In relation to Requirement 3(3)(b)*

The Assessment Contact report found the service had failed to effectively identify and/or manage consumer risks in relation to medication management. In addition, I have considered the management of consumers with changed behaviours under Requirement 3(3)(b) as a high impact and high prevalence risk.

*Medication management*

A review of service and organisational documentation, and consumer care documentation identified deficiencies including practices to ensure the safe administration of medications such as supervision of consumers when administering medication with one consumer reporting swallowing their rings instead of medication; medication stock being readily available; medication incidents not consistently reported (including when consumers had not been administered medication due to supply issues); sometime delays in prescribed medications being loaded to the electronic medication system; and interim medication chart for one consumer not including month or year for the prescribed medications. Observations showed open medication bottles which did not record the date of opening, and one consumer advised they had been hiding medications due to concerns regarding possible side effects of the medication.

I have considered this information alongside the Approved Provider's response, which acknowledged the deficiencies in relation to the delays in prescribed medications being loaded to the electronic medication system, interim medication chart for one consumer not including month or year and observations of open medication bottles. The response submission evidenced immediate and planned actions in response to the deficiencies identified, including medication management and documentation training for all staff, and missed medication follow up for team leaders with date of completion identified as 31 March 2024; and the implementation of medication audits (of pharmacy supplied medications) to ensure correct supply of medication and timely follow up on any issues to ensure medications are readily available for consumer when prescribed. The submission response included clarifying information relating to the first named consumer who advised they had been hiding medications and a second named consumer who reported swallowing their rings and evidenced the service had implemented immediate actions including for example, the completion of a dignity of risk assessment for the second named consumer who due to cognitive impairment lacks insight to their actions.

In coming to my decision for this requirement, I acknowledge the improvements made by the service in this Requirement in relation to falls management, diabetes management and management of consumers at risk of choking as evidenced in the Assessment Contact report. I acknowledge the immediate and planned actions taken by the service in response to the deficiencies identified in medication management and behaviour management. This requirement requires the effective management of high-impact or high-prevalence risks associated with the care of each consumer, the service has not demonstrated effective management of medication and consumers with changes behaviours. Therefore, it is my decision that Requirement 3(3)(b) is Non-compliant.

*In relation to Requirement 3(3)(c)*

Care documentation showed that consumers nearing end-of-life had their dignity preserved and care provided in accordance with their needs and preferences. Representatives for consumers who had recently passed away at the service provided positive feedback, and staff described how they support and care for consumers at end of life. It is my decision, Requirement 3(3)(c) is Compliant.

*In relation to Requirement 3(3)(d)*

The Assessment Contact Report evidenced the service has taken action to improve its performance under this requirement, for example, a nurse practitioner commenced at the service (one day a week for 3 months), the implementation of tools to support staff in recognising changes in consumers health and/or wellbeing, and observations showed staff regularly monitoring and reviewing consumers and utilising evidence-based practice tools. However, representative feedback for one named consumer advised of delays in the treatment for a urinary tract infection and being upset the consumer experienced pain during this time. The Assessment Contact Report also contained information that improvement actions in response to deficiencies identified at the Site Audit in January 2023 had not been actioned. I have come to a different decision following the submission of a response by the approved provider. I have decided that Requirement 3(3)(d) is Compliant. The Approved Provider's response evidenced the service had recognised and responded to changes in the first named consumers condition with clinical observations recorded at the time and across the following 2 days and included notification to the medical officer. While I acknowledge they was a delay in the pathology testing of the specimen, the service did evidence ongoing monitoring of the consumer’s condition including administration of pain management medication. In relation to improvement actions not being actioned, the response submission evidence the completion of these including development of relevant procedures and identified in the service’s plan for continuous improvement. For the reasons detailed, it is my decision Requirement 3(3)(d) is Compliant.

*In relation to Requirement 3(3)(e)*

Overall, consumer and representative provided positive feedback regarding the communication of consumer information. However, the Assessment Contact Report contained information that shift handover processes did not include handover of all consumers, only by exemption. Observations showed staff communicating incorrect information in relation to one named consumer and care staff were not observed to be using the service’s handover documentation, rather taken notes in books. Some examples brought forward in the Assessment Contact Report were not relevant to the requirement, for example, management of a consumer’s indwelling urinary catheter and deficiencies in pain and wound charting, and restrictive practices. I have considered these under Requirement 3(3)(a). I have come to a different decision following the submission of a response by the approved provider who provided clarification in relation to the handover of incorrect information (some but not all) for one named consumer, from the evidence before me, I am of the view this has not impacted the consumers care and services and I am satisfied the service took immediate action at the time of the Assessment Contact. I have decided that Requirement 3(3)(e) is Compliant. This was based on overall positive consumer and representative feedback regarding information communication, and lack of evidence that handover by exemption has resulted in impact to consumers’ care and services. In addition, I am of the view staff not utilising the service’s handover sheet does not demonstrate ineffective communication of information.

*In relation to Requirement 3(3)(f)*

Consumers and representatives spoke positively of the collaboration with allied health professionals. Staff described the referral process, and care documentation confirmed the referral to and input of others in consumers' care and services. It is my decision, Requirement 3(3)(f) is Compliant.

*In relation to Requirement 3(3)(g)*

Most consumers and representatives provided positive feedback in relation to infection control at the service. While one representative expressed concern about the delay in identifying a urinary tract infection for their consumer, I have considered this under Requirement 3(3)(d). However, the Assessment Contact Report contained information of deficiencies relating to monitoring of infections including reporting of clinical indicators, appropriate antibiotic prescribing, lack of contemporaneous policies and procedures to guide staff, and the service not having an appointed Infection Prevention and Control Lead. Observations showed staff not consistently wearing personal protective equipment correctly, and clinical and general waste not always stored appropriately. The response submission acknowledges these deficiencies and evidenced actions taken in response including an environmental review to ensure the appropriate management and storage of waste, policies are currently under review and will include reference to antimicrobial stewardship, and the enrolment of 2 registered nurse form the service to the Infection Prevention and Control Lead course. The service’s training plan, included in the response submission identified antimicrobial stewardship training to all staff with a completion date of 29 March 2024. I acknowledge the immediate and plan actions by the service in response to these deficiencies, however, it is my decision that Requirement 3(3)(g) is Non-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)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The performance report dated 06 March 2023 found the service non-compliant in Requirements 4(3)(a); 4(3)(b); 4(3)(c); 4(3)(d) and 4(3)(f). Deficiencies related to consumers not receiving safe and effective services and supports for daily living to meet their needs and optimise their overall health and well-being, including their emotional, spiritual and psychological well-being. Consumers were not engaged in activities in the service of interest to them; and consumers did not feel supported to participate in the community outside the service environment, or that their personal relationships are supported. The service did not have systems to ensure that information on the consumer’s condition, needs and preferences regarding daily living was communicated effectively and staff were not always familiar with consumer’s needs and preferences for daily living. Meals were not of a suitable quality, variety and quantity, consumers were not always provided with meals that meet their dietary requirements.

*In relation to Requirement 4(3)(a)*

Consumers spoke of feeling supporting in maintaining and optimising their independence, health, wellbeing, and quality of life including feedback that there have been improvements at the service. The Assessment Contact Report evidenced the service has taken action to improve its performance under this requirement, for example the introduction of a men’s group, review and updating of consumers’ care and services plans to reflect consumers preference for daily living, and the recruitment of a new lifestyle coordinator. It is my decision, Requirement 4(3)(a) is Compliant.

*In relation to Requirement 4(3)(b)*

Consumers considered they received services and support which met their emotional, spiritual, and psychological needs. Care documentation included information relating to consumers background, life story and spiritual and cultural needs and preferences. The Assessment Contact Report evidenced the service has taken action to improve its performance under this requirement, for example the commencement of a diversional therapist, review of consumers care plans to include emotional well-being assessments, and the provision of activity resources to all areas of the service for staff to utilise for small group activities. The service has an intergenerational program with visits by a preschool group, and observations showed consumers interacting with the pre-scholars in art activities. It is my decision, Requirement 4(3)(b) is Compliant.

*In relation to Requirement 4(3)(c)*

Consumers considered they are supported to participate in their community in and outside the service, to maintain their personal and social relationships, and do things of interest to them. One consumer spoke of weekly outings with a ladies group and other special activities through the church. Consumers spoke of being supported to provide feedback and suggestions and new activities are trialled for consumer feedback prior to being added to the activity calendar. Example of new activities include men’s group, scrapbooking, pamper sessions, cooking classes and happy hour. Observations showed consumers participating in activities in various areas of the service. It is my decision, Requirement 4(3)(c) is Compliant.

*In relation to Requirement 4(3)(d)*

Consumers confirmed they had discussions with the service in relation to their care, preferences, needs and interests on entry to the service and ongoing via care plan reviews. Staff described how they communicated information about consumers condition, needs, and preferences through verbal and documented processes. Care documentation included ‘About Me’ information which included consumers’ interest, values and people of importance; and this aligned with consumer and staff feedback. It is my decision, Requirement 4(3)(d) is Compliant.

*In relation to Requirement 4(3)(f)*

Overall consumers were satisfied with the meal service and spoke of recent improvements including being provided choice and an increase in the quality of the meals provided. Catering staff spoke of improvements made including a seasonal menu (changed 3 monthly) and described how consumer feedback is considered in the menu design. Menus are reviewed by the dietitian prior to implementation, and the electronic care documentation includes information related to consumers allergies, intolerances and preferences. Improvement actions included implementation of an electronic documentation system including tablet computers, education and training for staff about correct meal serving and use of food warmers, and the recruitment of a new chef. It is my decision, Requirement 4(3)(f) is Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

The performance report dated 06 March 2023 found the service non-compliant in Requirement 5(3)(b). Deficiencies related to some areas of the service environment which presented areas of unmitigated risks to consumers’ safety and ineffective cleaning and maintenance. The Assessment Contact Report contained information that consumers and representatives considered the service environment to be safe, clean, well maintained, enabling consumers to move freely both indoors and outdoors. Consumers described how they informed the service of any maintenance issues or repairs required, and confirmed their requests are followed up promptly. The service has implemented a 3 monthly cleaning schedule, and consumers confirmed that their rooms are cleaned each day and they are satisfied with the cleaning. Interviews with staff and service documentation confirmed the service has preventative and routine maintenance schedules and monitoring in place, and a process to complete reactive maintenance requests are addressed in a timely manner. The Assessment Contact Report contained information that some doors throughout the service are open and accessible to consumers, whilst others are locked. I have considered this under Requirement 3(3)(a). It is my decision, Requirement 5(3)(b) is 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. | Not 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The performance report dated 06 March 2023 found the service non-compliant in Requirements 7(3)(a); 7(3)(c); 7(3)(d) and 7(3)(e). Deficiencies related to insufficient numbers of staff to consistently deliver safe and quality care and services; staff not having the skills, qualifications and knowledge required to effectively perform their roles with some staff undertaking tasks outside their scope of work; consumers and representatives expressed concern that staff were not well trained and not able to provide effective personal care; the service did not demonstrate that staff performance is regularly assessed, monitored and reviewed or that performance management occurs when deficiencies in staff performance were identified.

*In relation to Requirement 7(3)(a)*

Overall, consumers and representatives were satisfied with the care consumers receive and spoke of staff having time to deliver care and not being rushed. Consumers said there had been improvement in staffing levels. However, one consumer representative advised whilst there have been improvements in staffing, new staff are often left unsupervised and as a result the representative had needed to advise new staff member on the consumers’ preferences and needs for personal care. Consumers and staff reported a high turnover of management staff at the service in the last 12 months. Staff provided mixed feedback, some staff spoke of not having time to complete documentation, being left unsupervised whilst more experienced staff attend to other consumers and waking consumers to enable showering. Interviews with staff and review of service documentation identified deficiencies in workforce coverage, with the roster for the fortnight before the Assessment Contact showing 25 care staff or other nurse shifts unfilled, 9 registered nurse shifts left unfilled, and agency registered nurse utilised on 12 occasions. Call bell reports reviewed identified an average response time of over 10 minutes, and up to 20 minutes on occasion. The response submission provided clarifying information relating to the workforce roster, ongoing recruitment, and actions in response to delays in response to call bells reports. I acknowledge efforts taken by the service in the recruiting of staff, and the commitment to embedding a stable leadership team including the supported handover period for the new residential care manager commencing in December 2023. The response submission contained commentary on how staff who require support or supervision are to request assistance, including through formal education, on the floor mentoring and coaching, however, evidence to support this was not provided. In coming to my decision, I acknowledge to efforts of the service in improving its performance under this Requirement, however, consumer, representative and staff feedback evidenced that consumers do not receive quality care and services as the and could provide examples of how consumers’ care had not received care in accordance with their needs and preferences. It is my decision that Requirement 7(3)(a) is Non-Compliant.

*In relation to Requirement 7(3)(c)*

Overall consumers and representatives considered the most staff know what they are doing and are competent in providing care and services. However, one consumer and one representative spoke of needing to guide newer staff in personal care needs and preferences. I have considered this under my decision for Requirement 7(3)(a). Staff spoking of working within their scope of their role and are satisfied with the supervision and support they receive from the service’s management team. Care coordinators regularly observe staff practices and in areas for further training are identified, additional education is provided. It is my decision Requirement 7(3)(c) is Compliant.

*In relation to Requirement 7(3)(d)*

Consumers and representatives spoke of most staff know what they are doing, however, advised extra training would be beneficial. The service is supported by an organisational clinical education specialist and the service education calendar identified education and training are offered face to-face and through online learning modules. Staff confirmed having received training in several areas including the Serious Incident Response Scheme, continence management and manual handling. New staff to the service complete a 5-week induction period which includes the completion of training and buddy shifts, after which they are allocated with experienced staff. However, the Assessment Contact Report contained information that staff did not demonstrate understanding of policies and procedures, including open disclosure and antimicrobial stewardship. Whilst training for staff had been provided in dementia care, observations of staff and care documentation evidenced episodes of consumers changed behaviours are not consistently documented including implemented strategies to support consumers. Although deficiencies in medication management were identified, including practices of supervised administration of medication to consumers, appropriate storage and gaps in interim medication charts, the service did not evidence further education or training was provided to staff. The response submission included information demonstrating immediate and planned actions to the deficiencies including the learning pathway which new staff to the organisation complete with mandatory education modules; ‘Infection Prevention & Control (IPC) & Antimicrobial Stewardship (AMS) Lesson Plan’ and the approved provider advised a new module is due for release in early 2024; and the ‘Medication Session Lesson plan’ and a review of competency assessments have been undertaken and currently being implemented by the service. In coming to my decision, I acknowledge the approved providers committed to continue to enhance the training of staff to ensure the workforce is recruited, trained and equipment and the immediate and planned actions taken. However, I am of the view that the actions being taken will take some time to fully implement and evaluate for effectiveness. It is my decision, Requirement 7(3)(d) is Non-Compliant.

*In relation to Requirement 7(3)(e)*

The Assessment Contact Report contained information that staff annual performance reviews were not current, with only approximately 50% of staff completed and this was acknowledged by service management. Regarding monitoring and review of staff performance, the Assessment Contact Report contained information relating to staff performance not being actioned as a result of medication incidents; and 2 Serious Incident Response Scheme notifications relating to rough handling by staff and neglect. The response submission included commentary in relation to the planned completion of staff performance reviews by 15 December 2023, and the actions undertaken as a result of the 2 Serious Incident Response Scheme notifications, including the processes of investigation, internal review, file notes and in 1 instance the staff member was stood down and being managed by the organisation’s human resources team. However, no evidence to support this commentary was not provided. I am not satisfied the service has demonstrated processes are in place to monitor and review staff performance, nor the effectiveness of these. From the evidence before me, it is my decision Requirement 7(3)(e) is Non-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. | Not 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. | Not 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. | Not Compliant |

Findings

The performance report dated 06 March 2023 found the service non-compliant in Requirements 8(3)(a); 8(3)(b); 8(3)(c); 8(3)(d) and 8(3)(e). Deficiencies related to mechanisms to engage consumers in the development, delivery and evaluation of care and services; the governing body did not demonstrate it had not promoted a culture that ensures safe and quality care and services or ensured mechanisms are in place to ensure it is accountable for their delivery; the organisation did not demonstrate effective organisation wide governance systems in place relating to information management, continuous improvement, workforce governance, regulatory compliance, risk management and clinical governance.

*In relation to Requirement 8(3)(a)*

The Assessment Contact report contained information the organisation did not have a framework to actively engage consumers in the development, delivery and evaluation of care and services. Management advised, and the service’s plan for continuous improvement confirmed that a consumer engagement framework was in development including an advocacy committee with an elective representative from each service. The due date for completion was 1 November 2023. I have come to a different decision following the response submission which evidence of how consumers are supported to engage in the development, delivery and evaluation of care and services including copies of consumer meeting minutes, the organisation’s ‘Engagement with People we Support Framework’, organisational governance charter, terms of reference for the Consumer Advisory Board and policies. I have also placed weight on positive consumer and representative feedback under other requirements, that spoke of being involved in discussions about consumer care and services and updated about outcomes of assessments and care plan evaluations. For the reasons detailed, it is my decision Requirement 8(3)(a) is Compliant.

*In relation to Requirement 8(3)(b)*

The Assessment Contact report contained information that the organisation’s governing body was unable to demonstrate accountability for the delivery of safe and quality care and services due to gaps in collating, trending and analysis of clinical data, requested meeting minutes not been provided and organisational policies and procedures are not contemporaneous. I have considered this information alongside the Approved Provider's response, which provided information including meeting minutes of the governing body which evidenced information provided from various subcommittees, with evaluation and actions documented. For example, meeting minutes for 4 September 2023 evidenced review of the National Quality Indicator Program data and the progress to the establishment of the Aged Care Quality Care Advisory Board and Consumer Advisory Boards. The meeting minutes for the organisation’s Care Governance committee (a subcommittee to the governing body) evidenced the reporting, analysis, trending and evaluation of clinical incidents at a service level. I am satisfied the organisation does promote a culture of safe, quality care. Therefore, it is my decision Requirement 8(3)(b) is Compliant.

*In relation to Requirement 8(3)(c)*

The Assessment Contact report contained information that the organisational governance systems of information management, continuous improvement, workforce governance, and regulatory compliance were not embedded and operating effectively at the service level:

Information management

* Deficiencies were identified in the organisation electronic care management system, including a recent change (the previous fortnight) to the incident management system resulted in the service needing to develop manual reports for clinical incidents. Due to time required to do this, incident data was not consistently current and not all clinical incidents (refer to medication incidents under Requirement 3(3)(b) were not consistently reported.
* While the organisation had policies and procedures, these were not contemporaneous, and the organisation was currently in the process of reviewing these. I have also considered this under my decision for other Requirements in Standard 8.
* Deficiencies in consumer care documentation including assessments, charting, and recording of incidents. I have considered this information under Requirement 2(3)(a), Requirement 2(3)(e), Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(e). My decision is that Requirement 3(3)(b) is Non-compliant, with evidence that medication incidents were not consistently reported.

The response submission stated the organisation ‘recognises the deficits associated with client management system’ and advised a staged approach to improving this is being developed via a business care and implementation plan. In relation to policies and procedures, the organisational has established an organisational policy development workplan which details the implementation of the policy and procedure developments, reviews, and updates throughout the organisation.

Continuous improvement

The Assessment Contact report contained information that the organisation did have a continuous improvement system which included audits, feedback and observations which are fed into a continuous improvement plan for all services within the organisation. However, the service did not evidence a plan for continuous improvement, and while numerous improvement activities were initiated (and completed) at a service level these were not consistently documented. The response submission included a copy of the organisation’s ‘Plan for Continuous Improvement Work Instruction’ that outlines the functions of the organisation’s electronic platform for development of a plan for continuous improvement. However, this did not provide information related to specific organisational and/or service improvements, including relation to the previously non-compliant requirements. I acknowledge the efforts made by the service in improving their performance as evidenced in my decisions of a return to compliance in 20 of the 28 Requirements. However, the service remains Non-compliant in Requirements 3(3)(b), 3(3)(g), 7(3)(a), 7(3)(d), 7(3)(e), 8(3)(c), 8(3)(d) and 8(3)(e).

Workforce governance

The Assessment Contact report contained information that the organisation did not have effective workforce governance systems in place including a sufficient mix of staff and skills, staff trained and equipped to deliver the outcomes of the Standards, and the review and monitoring of staff performance. The Approved Provider’s response acknowledges the challenges experienced in the recruitment of staff; I acknowledge the approved providers immediate and planned actions to the deficiencies identified, including ongoing strategies the organisation is taking to attract and retain more staff and the stated committed to continue to enhance the training and performance of the workforce.

Regulatory compliance

While the organisation had systems for receiving information about regulatory obligations, systems and processes to ensure the service is complying with all relevant legislation and regulatory requirements was not consistently evidenced. The Assessment Contact report contained information which identified:

* Ineffective incident management, including gaps in the reporting of clinical incidents.
* While the organisation had policies and procedures, these were not contemporaneous, and the organisation was currently in the process of reviewing these to align to current legislation. For example, the organisation’s policy and procedure has not been updated regarding approved provider governing body and key personnel obligations and about the aged care worker code of conduct, which both took effect in December 2022. In addition, the organisation’s complaints policy did not include information relating to open disclosure, and staff did not demonstrate a shared understanding.
* The service did not have an appointed infection prevention and control lead.
* The organisation has not ensured the service implements the requirements for minimising the use of restrictive practices under the Quality-of-Care Principles 2014.

The response submission under this and other requirements included clarifying information and evidence:

* Immediate and planned actions to address the deficiencies in reporting of clinical incidents, including staff training and weekly audits and implementation of the new electronic incident management system.
* In relation to policies and procedures, the organisational has established an organisational policy development workplan which details the implementation of the policy and procedure developments, reviews, and updates throughout the organisation. The response submission included commentary in relation to the implementation of the Aged Care Code of Conduct to all staff in December 2022, however, no evidence to support this commentary was not provided. The organisation’s open disclosure policy was evidenced, as a separate policy to the organisation’s complaints policy.
* Two registered nurses form the service have now been enrolled to the Infection Prevention and Control Lead course.
* The organisation recognised deficits relating the implementation of restrictive practices, with a new policy due approved on 11 December 2023. I acknowledge that the service does have assessments, consents, and authorisations in place for consumers subject to restrictive practices, as evidenced under Requirement 3(3)(a).

I have also considered information contained under Requirement 8(3)(e) which identified that on review of Serious Incident Response Scheme incidents, the service did not comply with all of key elements of an incident management system, including investigating and/or analysing how and why the incident happened in alignment with the Quality of Care Principles 2014.

Feedback and complaints

I find the feedback and complaints system is effective, consumers are supported to provide feedback through various avenues, and feedback and complaints used to improve care and services for consumers.

In coming to my decision in relation to this Requirement, I acknowledge the approved providers committed to establishing effective organisational systems as evidenced in the response submission, including the immediate and planned actions taken. However, I am of the view that the actions being taken will take some time to fully implement and evaluate for effectiveness. It is my decision, Requirement 8(3)(c) is Non-compliant.

*In relation to Requirement 8(3)(d)*

The organisation had a documented risk management framework, which sets out clear responsibilities of key personnel, the governing body and organisational committees. However, the Assessment Contact report contained information that the organisation’s risk management systems and processes are not effective resulting from deficiencies in the clinical care, incident management and workforce impacts. Deficits included:

* While the organisation has policies and procedures in high-impact and high-prevalence risks, these were not contemporaneous. In the response submission, the organisational evidenced planned actions to address this through the established an organisational policy development workplan which details the implementation of the policy and procedure developments, reviews, and updates throughout the organisation.
* The service maintains a high-impact and high-prevalence risk register, however, risks for consumers are not consistently responded to in relation to medication management and changed behaviours. I have considered this information under Requirement 3(3)(b) and organisational processes of clinical governance under Requirement 8(3)(e).
* A review of Serious Incident Response Scheme incidents, identified the service did not comply with all of key elements of an incident management system, including investigating and/or analysing how and why the incident happened in alignment with the Quality of Care Principles 2014.

In the response submission, the approved provider acknowledged (under this and other requirements) deficiencies related to organisational policies and procedures and that the incident management system, including consistent reporting of incidents. I acknowledge the immediate and planned actions taken by the service, and the commitment to improvements. However, I am of the view that the actions being taken will take some time to fully implement and evaluate for effectiveness. It is my decision, Requirement 8(3)(d) is Non-compliant.

*In relation to Requirement 8(3)(e)*

The organisation had a documented clinical governance framework, however information contained in the Assessment Contact report identified the framework has not been fully implemented at the service.

While the organisation had policies and procedures relating to clinical governance, including but not limited to, antimicrobial stewardship, restrictive practices and open disclosure these were not all contemporaneous and did not consistently reflect current legislation. Staff did not consistently demonstrate understanding of processes in relation to the clinical governance framework, implementing antimicrobial stewardship strategies and open disclosure. Clinical risks to consumers have not consistently been addressed in relation to medication management and changed behaviours and evidence of this was included in the Assessment Contact Report. As a result, of these, the service has ongoing Non-compliance with Requirement 3(3)(b) and Requirement 3(3)(g).

In the response submission, the approved provider acknowledged (under this and other requirements) deficiencies related to organisational policies and procedures, medication management and consumers with changed behaviours, consistent reporting of incidents and staff knowledge and understanding of antimicrobial stewardship. While I acknowledge the immediate actions taken by the service and that a clinical governance framework is being developed. The ongoing non-compliance found in Quality Standards 3, 7 and 8, including in relation to consumers clinical care, workforce and organisational systems, it is my decision that Requirement 8(3)(e) is Non-compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)