Performance

Report

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| Name: | AnglicareSA Elizabeth East |
| Commission ID: | 6963 |
| Address: | 36c Halsey Road, ELIZABETH EAST, South Australia, 5112 |
| Activity type: | Site Audit |
| Activity date: | 30 April 2024 to 2 May 2024 |
| Performance report date: | 18 June 2024 |
| Service included in this assessment: | Provider: 1197 Anglicare SA Ltd  Service: 4371 AnglicareSA Elizabeth East |

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 AnglicareSA Elizabeth East (**the service**) has been prepared by R Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit report, which 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 23 May 2024; and
* the performance report dated 23 October 2023 for the Assessment Contact visit undertaken on 13 September 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not 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 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **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)(b): Ensure assessment and planning identifies and addresses consumers’ current needs, goals and preferences for care, including, but not limited to, preferences for personal care and mobility.
* Standard 3 Requirement (3)(a): Ensure personal and clinical care is safe, effective and tailored to consumers’ needs, best practice and optimises consumers’ health and well-being, including, but not limited to, medication management.

# 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 confirmed consumers are treated with dignity and respect and staff value their individual identity and culture. Consumers are satisfied they are supported to take risks to live their best life and confident staff manage those risks appropriately. Consumers reported having choice in the way care and services are delivered, who is involved in that process and confirmed they can make their own decisions where they wish to. Observations showed staff interacting with consumers in a respectful manner, delivery of care was done in a way that maintained privacy and dignity of consumers and information about consumers and their care and services was kept on password protected electronic care systems.

Staff were familiar with consumers’ diverse backgrounds and cultural needs, and described ways in which they delivered care and services in a safe manner to respect those needs, including specific gender staff for provision of personal care. Staff confirmed they assist consumers to understand information provided to support them make decisions about care and services, including around lifestyle for meals and activities. Consumers were satisfied with the way information was communicated to them and confirmed it enabled them to exercise choice and make decisions about their care and services.

Documentation reflected consumer choice and decision making through all aspects of care, and where consumers expressed the choice to take risks, strategies to manage those risks to keep consumers safe were recorded.

Accordingly, I find all requirements in Standard 1 Consumer choice and dignity, 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. | Not 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 service was found non-compliant in Requirement (3)(e) following an Assessment Contact undertaken in September 2023. The non-compliance was in relation to assessment and planning not being reviewed for effectiveness when changes or incidents occurred. The service has implemented actions to address the deficits identified, including providing education to clinical staff around evaluation and reassessment in relation to wound, behaviour and incident management.

At this Site Audit, the assessment team recommended Requirements (3)(a), (3)(b) and (3)(e) not met as assessment and planning processes did not consider risks to consumer health, safety, and well-being, specifically in relation to pain, falls and diabetes, care planning did not reflect consumers’ current needs, goals, or preferences and care and services were not being reviewed for effectiveness when changes in circumstances or an incident occurred that impacted the needs, goals and preferences of consumers.

**Requirement (3)(a)**

* Three named consumers did not have all assessments as part of the admission 28 day checklist completed. One named consumer, who had been at the service for one month did not have a pain, skin integrity or personal hygiene assessment, a malnutrition screening was not fully complete, and the falls risk assessment did not include the assessment of risks in relation to medications or cognitive impairment. The consumer has experienced three falls since admission at the beginning of April 2024.
* A second named consumer, who had been at the service more than two months, did not have a completed falls risk assessment or medication assessment and did not have a completed care plan in place.
* A third named consumer who lives with diabetes, requires insulin to be administered daily and confirmed they had been experiencing hypoglycaemic episodes, did not have a diabetes management plan completed on their electronic care plan or in paper form. Diabetic charting was completed and showed episodes of low blood glucose readings, but this had not been reported to the medical officer.

The provider did not agree with the findings in the assessment team’s report and included in their response additional information and commentary. In relation to assessments not being consistently completed as per the service’s admission checklist process, the provider asserts the first named consumer’s date of admission was on 14 April 2024, all assessments for that consumer were completed by their due date in early May 2024 and the provider included copies of the completed assessments, including the falls risk assessment with strategies and consideration of risks with their response. In relation to the second named consumer, the provider asserts their admission was delayed due to hospital discharge and the actual date of admission was 12 April 2024 and provided additional information, including falls risk and medication assessments completed on the date of admission.

In relation to the third named consumer, the provider asserts the consumer came to the service initially on respite and when admitted to hospital was discharged then readmission post hospital stay. The provider asserts management and staff were not aware of the episodes of hypoglycaemia the consumer described and has since had discussions with the consumer and their representative with the medical officer also notified. The provider’s response includes additional information and commentary that asserts the medical officer reviewed the consumer in early May 2024 after the Site Audit visit was completed and a diabetic management plan was developed on 10 May 2024, and a specialised nursing care plan started on 23 May 2024.

I acknowledge the information included in the assessment team’s report, however, I have come to a different view and find the service has demonstrated that risks have been considered through assessment and planning processes for consumers. In coming to my finding, I have considered for all three consumers, the additional information the provider has included in their response. The provider has included for each consumer documentation which includes completed mobility, falls risk, and skin integrity assessments, along with completed care or specialised nursing plans. The date of completion for the assessments is within the service’s admission checklist timeframes as per their processes. I have also considered for the first named consumer in relation to the falls risk assessment the additional information in the provider’s response which included the completed falls risk assessment which considers the consumers’ medication and cognition, which shows risk has been considered in developing their care and services. In relation to the management of diabetes for the third named consumer, I have considered that information in Requirement (3)(e) in this Standard.

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

**Requirement (3)(b)**

* Care planning documentation is not consistent with consumer preferences, specifically in relation to personal care. One named consumer confirmed their preference for showering is when they arise and they do not receive this care, personal care is after breakfast when staff are able to attend to assist them. There was no personal care or hygiene assessment completed and staff did not have information to guide them on the consumer’s preferences for personal care. Care staff did not have knowledge of the consumer’s preferences for personal care.
* A second named consumer confirmed their preference for personal care is to have a shower every second day. The consumer’s care plan and handover information recorded the consumer prefers personal hygiene to be attended to in the morning twice weekly.
* One named consumer who requires assistance with putting on and taking off compression stockings did not have up to date care documentation with information to direct staff to provide assistance. The consumer was observed waiting for staff assistance with their compression stockings.
* Care documentation did not include consumer preferences for care delivery and goals were generic. Of two consumer care plans sampled, one did not include preferences for mobility that were tailored to the consumer, and the second consumer did not have tailored personal hygiene goals for care delivery.
* Two named consumers did not have end of life assessments or advance care directives recorded in their care planning documentation which was not in line with service’s processes.

The provider did not agree with all the information in the assessment team's report and included additional information and commentary in their response. In relation to care planning documentation, the provider asserts the service uses a process to assess consumers on entry, which includes discussion about the care plan with the consumer and/or the representative to establish individual goals of care. In relation to the consumer who does not have personal care recorded in line with their preferences, the provider acknowledges the consumer feedback in the assessment team’s report, and asserts the consumer had their preferences recorded at the time of entry in their interim care plan which states everyday second after breakfast documented and is signed by the representative on 25 March 2024 which is provided with their response. The provider asserts the service has discussed preferences with the consumer post the Site Audit visit and have updated the personal hygiene care plan to reflect the consumer’s preferences of everyday showers in the morning.

In relation to the named consumer with compression stockings, the provider asserts the stockings were not clinically prescribed and the consumer’s family brought them in with staff applying as the consumer requested. The provider’s response included additional information from the physiotherapist who reviewed the consumer the day following the end of the Site Audit and prescribed a different brand of garment for the consumer’s legs and updated the care plan with instructions for staff to take off when settled in bed. In relation to generic information in care plans, the provider acknowledged the information in the assessment team’s report for the named consumer who did not have tailored goals of care for mobility. In relation to the consumer with generic goals of care for personal hygiene, the provider asserts the consumer’s cognition is a barrier to have them partner in the development of goals and their representative is not able to provide information.

I acknowledge the additional information and commentary included in the provider’s response, however, I find that assessment and planning does not always identify or address the consumer’s current needs, goals and preferences. In coming to my finding, I have considered the information about care planning documentation not being tailored to consumers’ current needs, goals or preferences for care, including for two sampled consumers in relation to mobility and personal hygiene. I find the care planning documentation did not include for either consumer tailored goals to guide staff practice in delivering care to those consumers in a way that meets their current preferences. I have also considered for the named consumer who did not have current preferences for personal care included on their care plan. I acknowledge the consumer’s personal hygiene assessment has been reviewed on multiple occasions since entry. The provider asserts the new admission note for the consumer during September 2021 records the consumer’s preferences were for personal hygiene twice weekly, however, I have not been provided information that specifically states the preferences of the consumer were recorded as twice weekly, and whilst personal hygiene is now recorded on the consumer’s care plan as every second day, this has occurred post the Site Audit visit and was not until then in line with the preferences the consumer described.

In relation to advance care planning and consumers’ end of life wishes, I have considered this information in Requirement (3)(c) in Standard 3.

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

**Requirement (3)(e)**

* One named consumer who had a hospital admission during April 2024 returned to the service with a change in health and a requirement of a 1.5L fluid restriction and daily weights. The consumer confirmed that some staff will still provide a jug of fluid in their room and other drinks throughout the day and they are not always weighed daily as per directives. The consumer’s most recent dietary assessment completed in March 2024 had not been updated since hospital admission and did not include the fluid restriction, care planning documentation did not include guidance for staff around the fluid restriction and while clinical staff had knowledge of the restriction in place, one care staff did not.
* One named consumer did not have a pain assessment completed on return to the service from hospital during April 2024. Staff completed an evaluation of pain charting when the consumer returned from hospital which stated pain management was effective.
* One named consumer who requires and is administered regular and as required oxygen has a dignity of risk in place to undertake an activity of their choice that impacts their oxygen administration. The consumer’s dignity of risk form does not include guidance for staff in removing and reapplying the continuous oxygen prior to and after the consumer undertakes their activity of risk. The dignity of risk was not reviewed post the prescription of oxygen in March 2024.
* The service has 3 systems to document and monitor diabetic management plans. Three consumers with type 2 diabetes, two controlled with oral medications and one with insulin injections, did not have consistent information recorded in each of the systems used for diabetic management to guide staff practice. One consumer did not have information about when to take blood glucose readings and each system did not record the same information, including times of readings or when a medical officer is to be notified. One consumer’s paper based diabetic management plan did not include reportable ranges and their uploaded plan recorded weekly readings but did not specify day or time of the week to guide staff.
* The service has a process to review care plans six monthly, however, one consumer’s care plan did not indicate if mobility, lifestyle, or an end of life assessment had been reviewed.

The provider did not agree with the findings in the assessment team’s report and included additional information and commentary in their response. In relation to the consumer with fluid restrictions and daily weight directions, the provider asserts when the consumer was transferred back to the service from hospital in April 2024, the provider acknowledges the consumer’s dietary assessment did not include the fluid restriction but asserts it was recorded on the seven day handover sheet and clinical staff were aware of the restriction in place. The provider asserts the assessment has also not been updated as the consumer was no longer on the fluid restriction and included additional information where the medical officer confirmed the fluid restriction was no longer in place during April 2024. In relation to the consumer with inconsistent pain assessment, the provider included additional information that records no pain assessed and, as such, pain charting was ceased. In relation to the consumer undertaking an activity of risk with oxygen administration, the provider asserts there had been no change to the way the risk activity was undertaken with the change in the way oxygen was administered, however, included additional information to show the consumer’s care plan documentation had been changed to reflect the current processes undertaken.

I acknowledge the information in the assessment team’s report and have balanced that against the additional information and commentary, however, I have come to a different view to that of the assessment team and find the service regularly reviews care and services, including when changes or incidents occur. In coming to my finding, I have considered in relation to the consumer who did not have pain charting consistently completed, the additional information included in the provider’s response indicates pain charting was completed over a number of days when the consumer returned from hospital and there was no pain recorded for the consumer during that time, and accept the provider’s assertion that pain was assessed and the charting ceased due to the consumer not displaying or verbalising signs of pain. I have also considered for the consumer who undertakes the activity of risk, whilst the current process was not documented, due to the change in the way oxygen was administered the risk to the consumer did not change and, as such, there was no impact to the consumer. I acknowledge the provider has since updated the care plan to reflect the change in administration.

In relation to the consumer with fluid restrictions and daily weights, I have considered the service did not review fully the care documentation for the consumer to ensure the change in dietary requirements were recorded in the dietary assessment or that daily weights were occurring, however, place weight on the additional information in the provider’s response which indicates information was included on handover documentation along with feedback from staff that indicated they were aware of the directions of care for the consumer in relation to their fluid restrictions, along with information documented in progress notes from the medical officer that shows the fluid restriction had been ceased also in April 2024. I acknowledge the provider’s assertion they have implemented a new process where care staff are required report monitoring activities, they have undertaken for consumers, including fluid and weight monitoring and report to the registered nurse.

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

In relation to **Requirements (3)(c) and (3)(d),** consumers and representatives confirmed they were partners in the development of consumers’ care and services and any outcomes of those were communicated effectively and consistently. Documentation confirmed consumers had input into their own care and services through regular discussion and the outcomes of assessments were communicated to consumers and staff in various ways. Staff described ways in which they involved consumers in developing their care and services and confirmed they advise consumers and/or their representatives where appropriate, of outcomes in a timely manner.

For the reasons above, I find **Requirements (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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-compliant in Requirements (3)(a), (3)(b), and (3)(d) in this Standard following an Assessment Contact in September 2023. The non-compliance was in relation to medication, diabetes, behaviour, wound, and pain management, skin integrity and the identification and response to consumer deterioration not being timely. The service implemented several improvement actions to address the deficits identified, including providing additional education to clinical staff around wound care, escalation of consumer deterioration, documentation of vital signs and diabetic monitoring, a review of care documentation, including wound and pain assessments, review of all consumers with fluid restrictions to ensure what is recorded aligns with medical officer directives, review of all behaviour support plans, distribution of clinical risk meeting minutes to staff and a review of handover processes.

At this Site Audit, the assessment team recommended Requirements (3)(a), (3)(b) and (3)(d) not met as personal and clinical care, including medication management is not in line with best practice, personal care is not tailored to consumer needs, goals or preferences, restrictive practices are not managed effectively and staff do not monitor consumers for signs of deterioration effectively, including responding to consumers with changes in condition in a timely manner.

**Requirement (3)(a)**

* One named consumer confirmed they are not always assisted to the bathroom and has experienced episodes of incontinence as a result. The consumer has directives for care, including regular pressure area care and toileting, and has an ongoing wound chart for ongoing incontinent associated dermatitis commencing in October 2023. Staff were unable to describe how they assist the consumer with their continence needs.
* One consumer confirmed they prefer personal hygiene assistance in the mornings between 8:00am and 8:30am, however, they do not get assistance for this until later in the morning.
* Three named consumers who have fluid restrictions or directives for weight monitoring did not have charting completed consistently. One consumer advised staff do not always adhere to the fluid restriction they had in place, and they receive above restrictions. Fluid charting showed staff are not consistently monitoring as per the service’s processes, or completing progress notes where fluids are above restriction amounts.
  + For the second consumer with a 1.5L fluid restriction, charting recorded above those restrictions on two occasions in a two week period during April 2024, staff documented through progress notes on 29 April 2024 the consumer had two litres of fluid with comment stating staff to encourage fluid intake to 2L fluid restriction. Staff confirmed they would check the handover sheet, of which for this consumer stated a 1.5L restriction in place.
  + A third consumer with 1.5L fluid restriction had inconsistent charting over a two week period during April 2024, with one 24 hour period showing more than the restriction had been consumed with no documentation recorded in relation to increased fluid intake. Documentation indicated the medical officer increased the consumer’s fluid medication during April 2024 due to increased swelling in their legs.
* Three named consumers who are administered time sensitive medications to treat Parkinson’s disease, on multiple occasions did not have medications administered in line with medical officer directives. One named consumer who has time sensitive medications delivered, during a two week period in April 2024 was administered medications either late or early on 23 occasions, with two occasions where the medications were either missed or a double dose administered, and staff did not complete and incident for the error.
  + Medications for a second consumer over a two week period during April 2024 were administered either late or early on seven occasions.
  + The third consumer who has time sensitive medications administered three times daily did not have those administered on time on six occasions.

The provider did not agree with all the findings in the assessment team’s report and included additional information and commentary in their response. In relation to the consumers with fluid restrictions in place, the provider asserts the consumer who provided feedback regarding fluids being provided to them did not have a fluid restriction in place and included documentation that indicates the medical officer ceased this in April 2024. For the second named consumer, the provider included in their response documentation that indicates the consumer’s fluid restriction was ceased by the medical officer during November 2023, and asserts the directive remained on the handover sheet which is why staff were continuing to monitor and measure fluid intake. The provider acknowledges for consumer three, staff did not consistently monitor fluid through their charting process and have for this consumer requested a fluid management plan to be developed by the medical officer with the consumer based on their preferences. The provider refutes the lack of fluid charting being attributable to the consumer’s requirement for increased fluid tablets and included additional information indicating the medical officer post review in April 2024 increased the fluid medication in line with consumer’s request.

In relation to medication management, the provider acknowledges the information in the assessment team’s report for the three named consumers administered time sensitive medications and have asserted the service implemented a process following the Site Audit of having clinical coordinators checking medication administration within half an hour of when it was due to be administered.

In relation to the consumer with incontinence associated dermatitis, the provider refutes the findings in the assessment team’s report and included additional commentary in their response that for this consumer, they have had wound care specialists involved to monitor and care for the consumer’s wounds and information recorded indicates the wound is not caused by incontinence.

I acknowledge the information included in the provider’s response, however, I find the service does not demonstrate they have provided effective personal and clinical care that is best practice or optimal for consumers. In coming to my finding, I have considered for the three consumers named in the assessment team’s report who are administered time sensitive medications, the delivery of those medication is not always in line with best practice as they have experienced multiple occasions where those medications are administered late. I have also considered evidence in the previous performance report for the Assessment Contact undertaken in September 2023 which indicates medication management, specifically issues with the administration of time sensitive medications for consumers was identified at that time. I acknowledge the actions the provider has implemented in relation to medication administration in response to the previous non-compliance and the actions immediately implemented following this Site Audit in April and May 2024, however, this will need more time to achieve efficacy.

I also acknowledge the additional information and commentary included in the provider’s response in relation to the issues identified in the assessment team’s report, including management of consumers with fluid restrictions and personal care, however, this Requirement requires optimal and tailored care that is best practice and effective for each consumer, and for three consumers with significant medical conditions that are dependent on medications being administered within very specific time frames, the service has not been effective in the management of that.

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

**Requirement (3)(b)**

* One named consumer with diabetes did not have their medication administered in line with medical officer directives. Documentation showed the consumer was administered their diabetes medication late on four occasions during the last two weeks of April 2024. There were no incident reports completed for the late medications.
* Three named consumers had restrictive practices, including chemical and mechanical restraints in place without valid informed consent. One named consumer was observed on multiple occasions to have a mechanical restraint in place as they were on their bed which was in the lowest position at floor level. The consumer did not have a restrictive practices assessment completed and was observed mobilising on multiple occasions. Clinical and care staff confirmed the consumer has a low low bed in place as a falls prevention strategy, and is able to mobilise independently.
* Two named consumers have psychotropic medications administered as a strategy to manage behaviours, including agitation. One consumer was administered one dose of an as required anti-anxiety medication during April 2024 and staff did not document personalised strategies, as recorded in the consumer’s behaviour support plan, were trialled. Staff recorded in care documentation that the consumer was unsteady on their feet during the night and experienced and unwitnessed fall that evening.
* For the second consumer, anti-psychotic medication was administered in an as required dose on 13 April 2024 for agitation without and the consumer was later transferred to hospital post fall on the same day.

The provider did not agree with the findings in the assessment team’s report and include additional commentary and information in their response. I acknowledge the information and findings in the assessment team’s report, however, I have come to a different view, and find the service effectively manages high impact or high prevalence risks associated with the care of consumers. In coming to my finding, I have considered the additional information and commentary included in the provider’s response and balanced that against the information in the assessment team’s report.

The provider asserts for the consumer with diabetes, information in the assessment team’s report is not accurate in relation to the timings of their medications. Documentation in the provider’s response included the consumer’s medication chart which shows medical officer directives for administration between 6:30am and 9:00am and post lunch between 12:00pm and 1:30pm, along with information that indicates medications were all administered between these times. In relation to the incorrect timing for insulin administration on 29 April 2024, the provider included additional information indicating this was an error in recording the administration time by staff and the medication was delivered as directed. I have considered the information in the provider’s response and place weight on the additional documentation included which indicates administration of medications are done so within the specific time frames as directed by the medical officer.

In relation to restrictive practices, the provider asserts the consumer observed with in their bed at the low position is not floor line and is placed at the height which enables the consumer to rise from their bed in a safe manner, that staff were trained through January and February 2024 in relation to restrictive practices and the manager residential services and clinical coordinator undertake daily walks of the service and have not identified the consumer with a floorline bed restricting their movement. For the second named consumer who was administered as required psychotropic medication on one occasion in April 2024 with staff recording agitation as the rationale, the provider asserts and included additional information, that the clinical staff administering the medication selected the incorrect category on the electronic management system as it should have been documented as the medication was not given or behaviour management. The provider acknowledges this error by staff and has implemented actions to address those through education. In relation to the fall for this consumer, the provider refutes the administration of medication at midday placed the consumer at additional risk of falls or contributed to the fall they sustained almost 12 hours later. I have considered this information and for the first consumer, I place weight on the observations undertaken daily by management across the service which have not identified any instances of the consumer being on a floor line bed unable to get up, and find the observation made during the Site Audit is one that is likely not reflective of usual practice. For the second consumer, I have not been provided information that persuades me the medication directly contributed to the fall experienced by the consumer. I also acknowledge the actions immediately implemented by the service to ensure clinical staff are recording accurate rationales for medication administration.

In relation to the third named consumer who was administered one dose of antipsychotic medication for agitation on 13 April 2024 and was later transferred to hospital after sustaining a fall. The provider refutes the information in the assessment team’s report and include additional documentation that indicates the sequence of events was the consumer sustained a fall post lunch on that day, the consumer was then reviewed by the medical officer who made the decision for hospital transfer, when the consumer was being transferred to hospital staff documentation indicates they had escalating behaviours and the ambulance officers requested administration of the medication to facilitate the consumer’s safe transfer to hospital for review. I acknowledge the information in the assessment team’s report in relation to this consumer, however, I have balanced that against the information included in the provider’s response and I am not persuaded the medication contributed to the fall as it was administered post fall, nor do I have enough corroborated information to find the administration of medication was a restrictive practice.

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

**Requirement (3)(d)**

* Neurological observations for a consumer who had a fall during April 2024 were not undertaken in line with the service’s processes. The medical officer documented on the day of the fall the consumer was complaining of being dizzy and complaining of pain. A delay of approximately four hours occurred before vital signs and pain were assessed when the consumer was transferred to hospital.
* One named consumer with diabetes reported having recently experienced episodes of hypoglycaemia mostly overnight, and confirmed they had reported this to clinical staff who advised they would refer to the medical officer for review. The consumer confirmed they had not yet seen the medical officer. Medication charting for two weeks in April 2024 indicated the consumer had insulin withheld on three occasions due to a low blood glucose level reading with no record of the medical officer being advised.
* The service’s care documentation system has alerts in place to notify clinical staff and management when consumers have observations documented outside of the consumer’s medical officer directives, but staff are not being alerted to these for review and action. One named consumer confirmed they had low blood pressure readings over a seven day period during April 2024. During this same period, blood pressure readings were not taken by staff. Documentation confirmed a delay of four days between the low blood pressure reading and the medical officer being notified for review, with staff not taking readings in line with medical officer directives. The care documentation system’s alert of low reading was not actioned in a timely manner on two occasions through April 2024. The consumer did not experience any falls during this time.

The provider did not agree with the findings in the assessment team’s report and included additional information and commentary in their response. In relation to the consumer who sustained during April 2024, the provider asserts monitoring of the consumer post fall was undertaken in line with the service’s procedures and expectations and included evidence of those. The provider’s response includes the progress note from clinical staff of the head to toe assessment undertaken, including assessment of pain and falls risk assessment that occurred immediately following the fall with a referral to a locum medical officer for review. The medical officer reviewed the consumer and a decision for transfer to hospital was made and actioned. The provider asserts the second set of observations was not undertaken as per policy due to the consumer already being transferred to hospital. The provider also included in their response a statutory declaration from the clinical staff that records they completed the neurological observations as required by the service’s procedures.

In relation to the consumer with diabetes, the provider asserts they were not made aware of the consumer’s hypoglycaemic episodes and provided the actions taken immediately following the information being provided, including relaying the information to the consumer’s medical officer for review. In relation to the consumer experiencing episodes of low blood pressure, the provider asserts the readings taken were within normal limits for the consumer and included additional information to show blood pressure readings were taken by staff for two days when the low reading was identified. The consumer was reviewed by the medical officer two weeks later who ceased the additional monitoring.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find deterioration, or signs of change are recognised and responded to in a timely manner. In coming to my finding, I have considered for the consumer who sustained a fall additional information in the provider’s response demonstrated clinical staff followed the service’s procedures to undertake observations of the consumer, including vital signs, the consumer was referred to and reviewed by the medical officer and transferred to hospital, at which point is why a set of neurological observations were not undertaken as the consumer was not at the service to have them taken. In relation to the consumer with diabetes, I have considered the information in the assessment team’s report and provider’s response that acknowledges the consumer did not report their episodes of hypoglycaemia. I have also considered that as soon as this information was provided to the service, staff acted on this and the medical officer was informed, and care was adjusted to accommodate additional monitoring for the consumer which reflect staff have responded to the identified changes in a timely manner.

In relation to the consumer with low blood pressure readings, I have placed weight on the information in the provider’s response which includes documentation of blood pressure readings taken following the low blood pressure reading which shows staff responded to the change identified in that consumer.

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

In relation to **Requirements (3)(c), (3)(e), (3)(f) and (3)(g),** consumers and representatives confirmed staff knew consumer’s’ needs and preferences for care and service delivery and were satisfied this was shared with those that delivered care to them. Consumers were satisfied staff referred them to other providers of care, including allied health and medical officers when required and in a timely manner. Infection control protocols were in place throughout the service, including hand sanitiser and surgical masks. Consumers were confident staff were knowledgeable and practice safe infection control prevention.

Documentation confirmed referrals to other providers of care are actioned in a timely manner when required for consumers, and where reviews had occurred, outcomes of those reviews with recommendations for consumer care were captured in care documentation. Staff were knowledgeable of infection control practices and described ways in which they support the minimisation of antibiotic usage for consumers.

For the reasons above, I find **Requirements (3)(c), (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

The service was found non-compliant in Requirement (3)(f) in this Standard following an Assessment Contact in September 2023 in relation to consumer feedback about the quality of meals provided and there not being choice. The service implemented several improvement actions to address the deficits identified, including reviewing the meal selection process and changing from weekly to daily for consumers, monitoring of meal services to ensure consumers are receiving their choice of meals, appointment of a new head chef, and implementation of a new menu with surveys to gain consumer feedback.

Consumers and representatives confirmed consumers’ independence is supported through care and services that considered their needs, goals, and preferences. Consumers were satisfied with the lifestyle program and provided examples of how they provide input to the program to do the things they want. Consumers reported they had choice over meals, input into menu development and were satisfied with the quality and quantity of meals provided. Consumers confirmed the service had improved the menu choices and staff asked for their meal choice daily.

Consumers were confident their information was communicated appropriately and in a timely manner, and confirmed referrals to other providers of lifestyle services were actioned when they requested, or the need identified. Staff described how they provided additional emotional support to consumers if they identified they were low mood at any time and described the services in place to support consumers’ emotional, spiritual, and psychological needs, and the ways in which they supported consumers’ lifestyle preferences, including activities. The service has a consumer friendship group and staff described the ways in which they support consumers to participate in that group to maintain their social and personal relationships.

Consumers confirmed they are provided equipment to use to participate in lifestyle services and activities and were satisfied they were safe to use and cleaned regularly. Equipment for lifestyle services was clean and well maintained and used by consumers to access the lifestyle program or support their independence.

Care planning documentation reflected consumers’ needs, goals and preferences for lifestyle supports, including activities of interest and dietary likes and dislikes. During the admission process, consumers have a personal profile completed that assists staff tailor lifestyle services for consumers. Maintenance records reflected regular checks are conducted on equipment and where issues are identified they are resolved in a timely manner.

Consumers were observed participating in the lifestyle program through various group and individual activities, along with spending time with other consumers or visitors in communal or outdoor areas.

For the reasons detailed above, I find 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 confirmed the service environment is welcoming, clean, and well maintained. Consumers confirmed they can personalise their rooms with items of importance, including photographs, artwork, and furniture. Consumer rooms were decorated with personal items, including paintings and pictures. Navigational items were displayed to enable consumer movement throughout the service environment, including within the memory support unit, and consumers were observed engaging with other consumers and visitors in various communal and smaller areas.

Consumers and representatives confirmed consumers felt safe living at the service, and said If any issues requiring maintenance arose, staff, including maintenance staff, responded to and resolved those in a timely manner. Observations showed consumers moving freely indoors and outdoors and the garden area was well maintained and free from debris.

Documentation showed the service has systems and processes in place for reactive and preventative maintenance. Staff described the process of escalation for all maintenance issues and the ways in which they assist consumers to have those issues resolved in a timely manner.

For the reasons above, I find 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 confirmed they know how to provide feedback, including complaints and are comfortable and supported to do so. Consumers provided examples of how their feedback has been used to make improvements, including to the quality and variety of meals provided. Information, including pamphlets about advocacy services and raising complaints was displayed throughout the service for consumers to access. Consumers confirmed advocacy services are discussed at regular resident meetings.

Documentation confirmed the service maintains a feedback register to monitor complaints. Whilst the register did not have all the actions recorded, management provided documentation that included all the actions taken and updated the register to reflect where each complaint was accurately.

Staff demonstrated knowledge of the service’s feedback and complaints processes and described the ways in which they support consumers to make complaints about care and services, and how they escalate those for resolution.

Management confirmed they use consumer feedback collected through written and verbal feedback or the consumer focus group to improve care and services, providing specific examples of projects that have been implemented directly from consumer feedback, including more frequent meal selections for consumers and creating family friendly areas for consumers, including a private dining area.

For the reasons above, I find 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

The service was found non-compliant in Requirement (3)(c) in this Standard following an Assessment Contact in September 2023. The non-compliance was in relation to staff competency for pain, medication, falls, wounds, behaviours and clinical deterioration. The service implemented several actions to address the deficits, including, but not limited to, implementing a competency program with a suite of toolbox training sessions for staff, competency assessments being completed by staff for wound and pain management and education for clinical staff in relation to wound care and pain management.

At the Site Audit, the assessment team recommended Requirements (3)(a), (3)(c), (3)(d), and (3)(e) not met. The assessment team were not satisfied the service had the right number and mix of staff to deliver effective and safe care, staff demonstrated competency in relation to fluid monitoring, medication management and assessment and planning, and the training and monitoring of staff was not effective.

**Requirement (3)(a)**

* Six consumers and/or their representatives were not satisfied with the number of staff to deliver care and services to consumers in a way they preferred and needed. Two consumers described the extended waits they had for staff assistance, including for personal care and hygiene, or to be taken to have their meals. One consumer described waiting for 45 minutes during the night in the days before the Site Audit visit for staff to attend to provide assistance. Management acknowledge an issue with call bell response times and had implemented a system to monitor them.
* One consumer was observed in bed earlier at approximately 3:00pm in the afternoon and not after the evening meal service as they preferred and is recorded in their care documentation. Staff stated it was easier for them to put the consumer to bed prior to the evening meal service, as it was too hard to do after.
* Two staff advised staff who are rostered do not always present for their shift and the roster is not changed to reflect the absences. The stated when they work short, they do not always have enough time to get consumers dressed before breakfast, and consumers walk around in their night clothing. Management confirmed they were aware of this occurring and were working towards getting dedicated staff to work in the memory support unit.
* Lifestyle staff confirmed an additional resource had been recruitment which made delivering lifestyle activities for consumers easier.
* Documentation sampled for one week during April 2024 indicated there were 16 unfilled clinical shifts which included three nurse in charge shifts, eight unfilled care shifts and two unfilled servery shifts.

The provider did not agree with all the finding in the assessment team’s report and included additional information and commentary in their response. In relation to consumer feedback, the provider included call bell data that indicates call bells are responded to within the organisation’s expectations on almost all occasions, where they have been over 15 minutes the provider included the actions taken with staff. In relation to the feedback provided by two staff around not always having enough staff, the provider asserts since the previous non-compliance in September 2023, the service did not take any new admissions and did not decrease the hours or numbers of staff. The provider also asserts where staff do not attend for their rostered shift or there are unfilled shifts on the roster, hours for current shifts are extended to cover those gaps.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service has demonstrated it has the correct number and mix of staff. In coming to my finding, I have considered the additional information the provider has included in their response which indicates assistance is provided to consumers in a timely manner when they request or require it, and most staff interviewed, including lifestyle staff, indicated they were well supported and had enough staff to deliver care in a way consumers preferred. I have also considered half of the consumers sampled provided feedback that indicated they were satisfied with staffing numbers and felt there were enough to deliver care and services.

In relation to the consumer who confirmed they did not receive their shower in line with the preferences, I don’t not have any information before me that indicates this is due to the mix or number of staff. I have considered this evidence in Requirement (3)(a) in Standard 3. In relation to the consumer who had specific requests for the gender of staff delivering personal care to be female only, the provider acknowledges the statement by the consumer and indicated the consumer is also comfortable with male care staff that are regular staff at the service and included the personal hygiene care plan which records this information. I have considered this evidence further in Requirement (3)(a) in Standard 3.

In relation to the consumer who was observed in bed prior to the evening meal which was not their preference and the staff feedback confirming this is the practice they undertook, the provider asserts this is not in line with the expectations the organisation has of their staff and the service’s manager undertook a performance management for both staff involved post the feedback received during the Site Audit. I acknowledge the observation of the assessment team and the care not being optimal for this consumer, however, I have no corroborated evidence to indicate the two staff undertake this practice due to not having enough staff to deliver the care.

For the consumer who indicated staff rush them during personal care delivery, I have considered this evidence in Requirement (3)(d) in Standard 8.

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

**Requirement (3)(c)**

* One consumer described an incident where a male care staff left them undressed and sitting in the shower during personal care alone and did not return to finish assisting them. The consumer confirmed they had been left naked sitting waiting for a shower which on this occasion did not occur, and stated it made them feel awful. The consumer described another occasion where a staff member was rough during personal care which they did not report, and confirmed staff get the hose and let it run over them and do not use a flannel or soap to wash them.
* One named consumer confirmed having to repeat their needs for personal care multiple times and said staff do not respect privacy and staff of various designations walk into the bathroom when they are having their shower.
* Staff did not demonstrate understanding of restrictive practices for one consumer who two staff confirmed a low low bed was in place for them to prevent falls. The consumer was observed in the low low bed on day two of the Site Audit. The consumer, who is two staff assist, was also observed being transferred into a chair with only one staff.
* Staff did not demonstrate they were competent in monitoring hydration for consumers with a fluid restriction in place.
* Management confirmed competencies had been added to the service’s plan for continuous improvement as part of the previous non-compliance, and documentation confirmed competencies for wound management and pain assessment had been undertaken.

The provider did not agree with all findings in the assessment team’s report and included additional information in relation to the deficits identified by the assessment team in their response. The provider asserts the organisation has a comprehensive recruitment process in place and members of the workforce are recruited with the appropriate qualifications to undertake their designated role. In relation to hydration monitoring for consumers with fluid restrictions in place, the provider acknowledges some gaps in the forms completed, however, asserts completing the forms is not a competency assessment and they had no indication or evidence staff did not know how to complete the forms. In relation to staff entering one consumer’s room when they have personal care delivered, the provider refutes this finding and asserts the consumer remains very independent and is supported in this manner. The provider included additional information which shows the consumer does not wish for anyone to knock on their door and has signage on their door to advise when personal care is being undertaken.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service demonstrated staff are competent and have the qualifications and knowledge to undertake their roles effectively. In coming to my finding, I have considered for the consumers with fluid restrictions in place, the gaps is in the completion of charting and there has been no negative impacts to consumers, including consistently receiving fluids above their restriction directives in place. I have considered this information further in Requirements (3)(a) in both Standard 2 and Standard 3 and have no evidence before me that persuades me staff competency is not effective when completing forms incorrectly.

I have considered in relation to the consumer who confirmed they have to repeat instructions on multiple occasions and described how staff of various designations enter their room when they are in the shower not respecting their privacy or dignity, information in the provider’s response that includes the wishes to remain independent of the consumer and the signage they have in place about not entering the room, and notice when personal hygiene care is in progress. Whilst staff may enter the consumer’s room when they are not requested to, I do not find this to be an issue of competency.

In relation to the consumer with low low bed in place, I have considered this information in Requirement (3)(b) in Standard 3 as this is where it is better aligned. In relation to the consumer who described being left in the shower without clothing on by a male care staff member, and being rushed by staff when having personal care is being delivered, including the use of a hose without soap or a flannel for showering, I acknowledge the information in the assessment team’s report that the consumer had not reported this and the provider’s assertion this is now an ongoing investigation,. I have considered this evidence in Requirement (3)(d) in Standard 8 in relation to recognising and responding to elder abuse and incident management.

In relation to medication management and the evidence in the assessment team’s report that includes staff are administering time sensitive medications not in line with medical directives and in some instances late. Whilst I do not find this is an issue of competency of the staff and more one of monitoring performance as staff were not following directives, I have considered this further in Requirement (3)(e) in this Standard and Requirement (3)(a) in Standard 3.

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

**Requirement (3)(d)**

* Some consumers stated staff did not always provide care that was tailored to their needs and needed more training.
* One consumer and representative said staff needed more training in communication as language is often a barrier to understand how consumers would like care delivered.
* Management confirmed staff undertake mandatory and non-mandatory training modules in various ways, including online face to face and toolbox sessions. Management confirmed the service has a process in place to identify where staff have not undertaken required training so it can be followed up.
* Documentation confirmed at the end of April 2024, almost three quarters of all staff had completed critical training and 70 per cent had completed essential training.
* Management confirmed some clinical staff had undertaken re-education for the delivery of time sensitive medications, managing risks and deterioration and this had all been discussed at clinical staff meetings. Three consumers were identified as not receiving time sensitive medications as per directives.
* Three agency staff confirmed the service had induction and orientation processes when they commenced. One staff who regularly worked shifts at the service confirmed they complete a checklist when they commence their shift.
* The service has formal recruitment processes in place and are managed at both the service and head office which includes checks to ensure staff have required and appropriate qualifications, registrations, and vaccinations.
* The service maintains a training calendar which was observed to be updated with training scheduled for the remainder of 2024.

The provider did not agree with the findings in the assessment team’s report. The provider asserts the organisation has a comprehensive training needs analysis matrix which identifies role specific training needs at the service to roll out to staff regularly. In relation to staff communication skills and consumer feedback of staff needing extra training, the provider asserts the service has a language proficiency assessment as part of their workforce screening processes and the service has a training calendar with scheduled training for all staff regularly throughout the year. The provider asserts where training gaps are identified through observation staff are provided additional support.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service has processes in place to effectively recruit, equip and support their workforce to deliver the outcomes required by the Quality Standards. In coming to my finding, I have considered the information included in the assessment team’s report which indicates staff undertake orientation and induction prior to working at the service and non-regular staff must undertake a checklist each time they complete a shift. I have also considered the additional commentary and information from the provider that indicates the organisation has an embedded process to identify any skills gaps and address those through regular scheduled and ad hoc training and education, along with embedded organisational process for recruitment and pre-employment checks which included checking potential staff employment qualifications, registrations, ability to work, and police clearances and balanced this against the information in the assessment team’s report that confirms the service has formal recruitment process in place. I have not been presented with information that indicates training is not effective and feedback from two consumers and one representative does not indicate a systemic risk with the recruitment and training processes.

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

**Requirement (3)(e)**

* Management confirmed performance appraisals that were outstanding for 2023 had, as part of the previous non-compliance, been finalised without completion and the service would move forward to restart the process and complete all performance appraisals for 2024.
* Staff performance is monitored through internal audits, including competency checklists, serious incident response scheme (SIRS) reporting and complaints.
* Four staff confirmed annual appraisals had not been completed in the previous year. One staff stated they were aware of goal setting conversations occurring at the service.
* Management stated clinical staff have oversight of care staff and personal care provided to consumers. Personal care is reported through progress notes for consumers.

The provider did not agree with the findings in the assessment team’s report. The provider in their response acknowledged the staff performance appraisals for 2023 were not fully completed. The provider asserts the decision to close 2023 appraisals off without completion and move to do 2024 was made during the previous period of non-compliance with a priority on those appraisals where a risk was identified with staff performance. The provider asserts the organisation has a process in place to track performance appraisals which is managed corporately, as well as by the service’s management team.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service monitors its workforce through regular assessment and review. In coming to my finding, I have considered the additional commentary in the provider’s response that indicates they have various ways to measure staff performance. I have also considered the provider’s decision to close off 2023 performance appraisals and commence with a new process for 2024 and place weight on the information that indicates staff are aware of this and of the new process in place for 2024. Further to this, I have considered and placed weight on the information in the assessment team’s report that although behind for 2023, documentation confirmed staff performance appraisals had been completed, which indicates there is a system in place and I do not have any evidence before me that staff performance has led to negative impacts for consumers.

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

In relation to **Requirement (3)(b),** consumers and/or representatives confirmed staff are kind, caring and treat consumers in a respectful manner. Interactions between staff and consumers were observed throughout the Site Audit visit to be respectful. Staff demonstrated knowledge of consumers’ needs and preferences, likes and dislikes and provided examples of how they provide care in a way that is respectful to consumers.

For the reasons above, I find Requirement (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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. | 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 service was found non-compliant in Requirement (3)(d) in this Standard following an Assessment Contact during September 2023. The service did not demonstrate it had an effective risk management process, specifically in relation to managing high impact or high prevalence risks, identifying and responding to abuse and neglect of consumers and effective use of the incident management system to manage and prevent incidents. The service implemented actions to address the deficits identified, including updating handover sheets to include high risk consumers, implementation of a quality audit assurance program, and additional training for staff in incident management.

At this Site Audit, the assessment team have recommended Requirements (3)(c) and (3)(d) as not met. The assessment team was not satisfied the organisation’s governance was effective in relation to information management, workforce governance and risks management.

**Requirement (3)(c)**

Information management issues identified included:

* Discrepancies in relation to the documenting of diabetes management for consumers, including diabetes management plans being completed across three different systems containing different information which was not identified through the diabetes audit undertaken in March 2024.
* Dignity of risk assessments for consumers undertaking activities of risks did not contain accurate information.
* Feedback and complaints information is not always recorded in the service’s register which provided challenges to determine if complaints had been completed.
* Staff reported they were able to access information to provide care, including consumer information and policies and procedures to guide practice.

Workforce governance issues identified included:

* Consumers reported not receiving care in line with their preferences, being rushed and indicated there was not enough staff.
* Deficits identified in clinical areas indicated a lack of staff knowledge and competency, specifically in relation to fluid monitoring, medication management and assessment and planning.
* Staff performance appraisals were not conducted in accordance with organisational policies and a number were outstanding for the previous year.

The provider did not agree with the findings in the assessment team’s report. The provider asserts feedback and complaints are gathered through a variety of means from consumers and their representatives, including regular resident and relative meetings, direct feedback from consumers and the complaints made through the complaints system, all of which are input into the organisation’s feedback management system and a report is generated regularly. The provider asserts in relation to the way information about consumers with diabetes is captured is not three separate systems and the included the audit information with the actions identified and taken. In relation to workforce governance, the provider refutes the information in the assessment team’s report and asserts they did not take new admissions between October 2023 and March 2024 and in that time had a decrease in consumers at the service but staffing hours remained the same. The provider asserts in relation to the qualifications of staff and competencies the issues identified with medication management relates to staff practice and, as such, education has been provided to all staff responsible for the administration of medications.

I acknowledge the information in the assessment team’s report, however, I have come to a different view and find the service has effective organisational governance. In coming to my finding, I have considered in relation to information management, evidence in Standard 6 indicates feedback and complaints are actioned appropriately and consumers reported satisfaction, and whilst not all complaints were recorded on the register there was no indication of impact to the resolution of complaints. I have also considered evidence in Standards 1, 2, 3 and 4 that indicates information is communicated effectively with other providers of care, as well as consumers and is accessible.

In relation to dignity of risk assessments containing inaccurate information, I have considered this evidence in Requirement (3)(e) of Standard 2 which indicates even though a consumer’s risk assessment did not have a change to the way oxygen was administered, this did not change the way the activity was undertaken, there was no impact to the consumer or the activity and the provider included additional information to show the information was updated immediately. I have also considered the feedback provided by staff that indicated they had access to information to support them to deliver care and services in line with consumers’ needs and preferences.

In relation to workforce governance, I have considered the information in Standard 7 and placed weight on that, along with the additional information and commentary in the provider’s response and I don’t not have evidence before me that indicates the organisation has ineffective workforce governance. The service has a system and processes in place to monitor recruitment and the skills and qualifications of staff. Competencies are undertaken when required and further education is provided where gaps in staff practice are identified. Whilst appraisals for 2023 were not completed, the service had already identified an implemented an improvement process to ensure they are completed for 2024.

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

**Requirement (3)(d)**

* Management self-identified the processes in place for recognising, assessing, mitigating and monitoring risks even with policies and procedures in place were inadequate for managing high risks for consumers, including medication management, fluid monitoring and restrictive practices.
* Time sensitive medications and insulin were not being administered in line with medical directives.
* Fluid monitoring for three consumers was not always conducted leading to adverse impacts for one consumer who had an increase in fluid medication.
* Two consumers had chemical restraint in place without showing it was a last resort, one consumer sustained a fall after medication was administered.
* Weekly high risk meetings are conducted discussing consumers with risks, however, did not include consumers with time sensitive medications or fluid monitoring.
* A high risk register is not maintained, instead minutes of high risk meetings are used to indicate high risk consumers.

The provider did not agree with the findings of the assessment team’s report. The provider in their response included additional information and commentary in relation to the organisation risk management system. The provider acknowledges the gaps in staff practice in relation to the administration of time sensitive medications and provided actions planned and implemented to address that deficit. The provider asserts the service has processes in place to identify, monitor and manage consumers at risk, including a weekly clinical risk meeting that identifies consumer at clinical risk and strategies to manage those, reporting on issues identified through complaints data, with the care manager reviewing the service’s clinical quality indicator data.

I acknowledge the information in the assessment team’s report, however, have come to a different view and find the service’s risk management system is effective. In coming to my finding, I have considered and placed weight on the additional information included in the provider’s response which describes the systems and processes in place which indicate consumer risks are discussed regularly, with clinical indicator data and incidents collected, analysed, and used to implement improvements. I have no evidence before me that indicates there is a systemic issue with the risk management system and processes.

I have also considered information included in Standards 2 and 3 that indicates consumer risk is identified and managed effectively. In relation to the management of time sensitive medications, I have addressed this under Requirement (3)(a) in Standard 3, issues identified with staff not monitoring fluid restrictions has been addressed under Requirements (3)(e) and (3)(b) in Standards 2 and 3, and the issues in relation to restrictive practices information included in Requirement (3)(e) in this Standard indicates the organisation has processes in place to monitor restrictive practices and they are effective.

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

In relation to **Requirements (3)(a), (3)(b) and (3)(e),** consumers confirmed they are included in the development, evaluation and delivery of care and services and described the various ways they do so, including through resident relative meetings, the consumer advisory body and consultation about meals and menu development. The organisation is guided by a strategic plan with a number of committees and sub committees with oversight for operational activities. The Board is included in the performance of the service, including complaints and incidents through regular reporting. The organisation has policies and procedures to guide effective care and services, including antimicrobial stewardship and open disclosure with processes in place to minimise the use of restraint.

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

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