Performance

Report

**1800 951 822**

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| Name of service: | Baptistcare Gracehaven |
| Service address: | 2 Westralia Gardens ROCKINGHAM WA 6168 |
| Commission ID: | 7914 |
| Approved provider: | Baptistcare WA Limited |
| Activity type: | Site Audit |
| Activity date: | 14 February 2023 to 16 February 2023 |
| Performance report date: | 4 April 2023 |

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

**This performance report**

This performance report for Baptistcare Gracehaven (**the service**) has been prepared by A. Kasyan, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 15 March 2023.

# Assessment summary

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

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

# Areas for improvement

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

* **Standard 2 Requirement 2(3)(a)** Ensure assessments and care plans are comprehensive and accurately identify each consumer’s care needs to inform strategies to manage risks. Ensure staff have skills and knowledge to correctly identify the change in skin integrity and to create a care plan specific to the type of skin injury.
* **Standard 3 Requirement 3(3)(b)** Ensure each consumer’s high impact and high prevalence risks are managed effectively including management of wounds, medications and falls. Insure falls preventive strategies include interventions to effectively mitigate potential consequences of ongoing falls, such as injuries.
* **Standard 4 Requirement 4(3)(a)** Ensure services and supports for daily living are provided to each consumer in line with their assessed needs and promote their wellbeing and quality of life.
* **Standard 7 Requirement 7(3)(e)** Ensure staff performance is effectively monitored to identify deficits in staff practice and corrective actions taken for employees who are not meeting expectations.
* **Standard 8 Requirement 8(3)(e)** Ensure the organisation’s clinical governance framework is implemented effectively, specifically in relation to minimisation of restrictive practices that must only be used as a last resort and in the least restrictive form for the shortest period of time to prevent harm to the consumer.

# 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

This Quality Standard is Compliant as six of the six Requirements have been assessed as Compliant.

Consumers and representatives interviewed confirmed consumers are treated with dignity and respect with their culture and identity valued. Consumers reported feeling well informed about their care and the services available to them and said information is provided in a timely and accurate manner. They also reported feeling supported to exercise choice and independence, with staff encouraging them to make decisions about their care and daily activities. Consumers provided examples of how the service supports them in risk taking, such as leaving the service independently and eating the foods they enjoy despite these not being recommended by a speech pathologist. Finally, consumers reported feeling that their privacy is respected, and their personal information is kept confidential.

The Assessment Team observed staff interactions with consumers to be friendly and respectful, except for one occasion when the Assessment Team observed a staff member demonstrating a lack of respect in their interaction with the consumer when they asked the consumer to stop doing what they were doing. Management were advised and made a note to address this with the staff member.

The service has policies and procedures in relation to consumer dignity and risk, privacy and confidentiality, and staff are trained it its use.

Staff were knowledgeable about how to provide culturally safe care and provided examples of how they ensure they are sensitive to the needs of all consumers, taking into consideration consumers’ specific needs, goals and preferences. The service demonstrated commitment to cultural safety by acknowledging and respecting the cultural diversity of consumers and their families, providing access to interpreters, providing culturally appropriate care that takes into consideration the unique needs, beliefs and values of consumers. Staff were able to describe how the service actively promotes awareness and inclusion for differing cultural backgrounds by adopting a series of regular programmed events, activities and themed lunches which are relevant to consumers.

The service provides timely and accurate information to consumers ensuring they are well informed about their care and the services available to them. The Assessment Team observed information provided to consumers and their families in a range of formats, including through the public announcement system, noticeboards, menu boards in the dining rooms and the activity program. One consumer advised the menu displayed on the blackboard is sometimes difficult to read but they can ask staff if they need to know the choices for the day.

The Assessment Team observed only authorised personnel had access to consumers’ personal information and medical records, keeping them secure and confidential. Policies and procedures guide staff practice in relation to maintaining consumers’ privacy and confidentiality. Staff provided examples of how they maintain consumers’ privacy by knocking on consumers’ doors prior to entering, respecting consumers’ choice to have their room doors shut, respecting consumers in a relationship right to have privacy in their rooms and ensuring dignity coverings are used when consumers are receiving personal care.

# Standard 2

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

Findings

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements 2(3)(a), 2(3)(b) and 2(3)(e) in this Standard as Not Met.

Based on the Assessment Team’s report and the provider’s response I find Requirement 2(3)(a) Non-compliant. However, in relation to Requirements 2(3)(b) and 2(3)(e) in this Standard, I have come to a different finding to the Assessment Team and have found these Requirements Compliant. I have provided reasons for my findings in the respective Requirements below.

**Requirement 2(3)(a)**

The Assessment Team found assessment and planning does not inform the delivery of safe and effective care and services. The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* Consumer A was not assessed for risks associated with the consumer’s preference of sleeping in a recliner, resulting in the consumer acquiring 2 pressure injuries and one fall when the recliner tipped over while the consumer was sitting in it.
* Staff were not undertaking reviews or assessments of Consumer B, who has high falls risk, in a timely manner following repeated falls. This consumer did not have assessments completed or a care plan to guide staff on how to care for their urinary catheter and their bowel management, despite the care plan stating the consumer requires physical assistance from staff to manage a bowel problem. Staff and management were not able to describe how to manage the consumer’s bowel problem.
* Whilst Consumer C’s tumour was bleeding at each dressing change, no risk assessment for the tumour to spontaneously bleed was undertaken.
* Two consumers did not have a care plan on how to manage their diabetes.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* In relation to Consumer A, a risk assessment was undertaken in a timely manner and the consumer was informed of the risk of developing pressure injuries. The consumer was able and still can reposition themselves in a chair and the second skin injury was not a pressure sore, but an incontinence associated dermatitis that resolved over the course of a week. The consumer was provided instructions by an occupational therapist on how to use a replacement chair when their recliner was sent for repairs. Relevant documented evidence to support risk assessment and communication with the consumer was attached in the provider’s response. The provider asserts the consumer did not fall out of the chair rather tipped the chair through error when was attempting to get up.
* In relation to Consumer C, the provider asserts bleeding of the consumer’s tumour was identified and escalated to an external palliative care team and a Residential Care Line nurse multiple times since its inception in March 2022. The provider strongly refutes the Assessment Team’s findings that the service failed to assess and plan wound care for the consumer, including risk of bleeding. The provider notes that at no stage a Residential Care Line nurse or a palliative care team expressed any concerns that the wound was/is not being managed properly. To support their assertions, the provider included a range of documented evidence to demonstrate effective assessment and planning, such as wound care charts, referrals, Residential Care Line and palliative care team progress notes, care plans and email correspondence with a general practitioner regarding dressings.
* In relation to Consumer B, the provider supplied evidence of review of the consumer’s care in relation to falls, mobility and falls risk preventative strategies 30 times since June 2022. These included reviews by a physiotherapist, general practitioner, Nurse Practitioner and a nurse from the external service provider with expertise in care for people with the condition impacting Consumer B’s gait and balance.
* The provider acknowledges some consumers did not have a comprehensive care plan and instructions to guide staff on management of diabetes, urinary catheter and bowel management noting there was no indication that consumers have been harmed as a result of these deficiencies. The above-mentioned consumers’ care plans have been updated accordingly. In addition, the provider had been in discussion since late 2022 with Residential Care Line in relation to training programs with urine and bowel management education booked for 23 March 2023.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 2(3)(a) Non-compliant.

I find at the service did not have an effective assessment and planning process to ensure assessment and planning of all risks associated with the consumer’s care was conducted in a way to inform safe and effective care, specifically in relation to diabetes management, bowel management, urinary catheter management and skin care.

I acknowledge the provider has updated the identified consumers' care plans to ensure they are comprehensive in relation to bowel management, diabetes management and urinary catheter management. However, the provider's response did not demonstrate or include evidence to support the assessment processes undertaken to update the care plans to ensure they are individualised and specific to consumers' needs. Therefore, based on the Assessment Team's report, I consider the service did not demonstrate effective assessment processes in relation to diabetes management, urinary catheter management and bowel management which inform the delivery of safe and effective care.

Whilst the provider asserts there was no indication consumers were harmed because care plans or assessments were either not completed or comprehensively conducted/completed, this Requirement expects that services’ assessment and planning processes considers risks to consumers’ health and well-being, to inform the delivery of safe and effective care and services.

Whilst the provider states in its response that Consumer A did not develop a second pressure injury, but it was an incontinence associated dermatitis which resolved within a week, I am not satisfied this statement and supporting documentation in the provider’s response demonstrate an effective assessment and planning of the consumer’s risks associated with the skin integrity. The provider’s response did not demonstrate the service identified or implemented strategies to treat the incontinence associated dermatitis in a timely manner. The provider’s response included a wound chart which demonstrates staff identified Consumer A as having a stage 2 pressure injury one month prior to the Site Audit, which demonstrated staff incorrectly identified the change in skin integrity. Additionally, progress notes show the incontinence dermatitis was disclosed to the family after the Site Audit, indicating that the incontinence associated dermatitis was not resolved for over one month.

I am satisfied assessment and planning around wound care for Consumer C was appropriate and comprehensive. I am satisfied the evidence put forward by the provider demonstrates an assessment of the risks of the wound to spontaneously bleed through a range of actions taken, including but not limited to, a review of the consumer’s medical history and medications, monitoring and documenting on the wound chart the amount of bleeding at each dressing change to determine if the bleeding was increasing or decreasing over time and escalating a change in the amount of exudate and bleeding to a wound specialist and a palliative care team to enable adjustment of the treatment plan.

I considered review of Consumer B following their ongoing falls under Requirement 2(3)(e) where it is more relevant.

Accordingly, I am satisfied Requirement 2(3)(a) is Non-compliant.

**Requirement 2(3)(b)**

The Assessment Team found the service was unable to demonstrate assessment and care planning consistently identifies and addresses consumers’ advance and end of life planning. The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* A review of six consumers’ end of life care plan showed each had the same information recorded.
* Consumer C’s palliative care was not planned in a timely manner, which could have impacted on the end-of-life experience of the consumer.
* The service could not provide evidence of end-of-life care planning for two consumers who have passed away within 2 months prior to the Site Audit.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* In relation to the 2 deceased consumers, the provider asserts individualised end of life care was planned as evidenced through referrals to palliative care services, the consumers’ and/or representatives’ involvement in the development of Goals of Care, completed End of life care pathways, communication with the appointed Guardian where appropriate.
* In relation to Consumer C and the timeliness of their end-of-life planning, the provider asserts, the service had been assessing and planning for the consumer’s palliative care since their entry into the service. The consumer’s end of life wishes in relation to medical treatment were documented by their representative in March 2022 with the representative declining to fill in the remainder of the form. The planning of the consumer’s end of life care has been complicated by the lack of engagement from the family until recently.
* In addition, the organisation has guidelines and protocols on end of life care planning including Palliative and End of Life Practice dated 2019, has a strong relationship with Metropolitan Palliative Care Consultancy Service which facilitates their timely and effective response to referrals, participation in End of Life Directions for Aged Linkages (a national project funded by the Australian Government Department of Health to develop and support palliative care and advance care planning in aged care), and has an established practice of inviting consumers and their representatives to attend case conference or care planning to discuss end of life plans.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service Compliant with this Requirement.

I accept the Assessment Team found generic end of life care plans for consumers sampled. However, I consider this does not indicate the service does not plan end of life and advance care for consumers and this does not constitute a failure of the service to demonstrate compliance in this requirement. I consider a generic care plan was used by the service as a starting point for creating individualised plans.

I consider the service has in place guidelines and protocols for managing end of life care, including pain management, spiritual and emotional support and communication with family members. The service demonstrated in its response individualised care is planned, although not recorded necessarily on the end-of-life care plan but in other documents, which the provider attached to its response.

In relation to other elements in Requirement 2(3)(b), including that assessment and planning identifies and addresses current needs, goals and preferences, I am satisfied the service demonstrate its compliance with this as evidenced through information and evidence across Standards 1, 2 and 4 in the Assessment Team’s report, specifically that care planning process is in place to identify and address consumers’ needs and preferences. Consumers described their needs and preferences, and these were congruent with the consumers’ care plans. Care plans contained information about consumers’ history, pastoral care and leisure and lifestyle needs, personal history, preferences for care, including dietary preferences and requirements, equipment to assist consumers to maintain their independence, and activities of interest.

Accordingly, I find Requirement 2(3)(b) is Compliant.

**Requirement 2(3)(e)**

The Assessment Team found the service was unable to demonstrate care and services are consistently reviewed for effectiveness when circumstances change or when incidents impact on the needs of consumers. The Assessment Team provided the following findings and evidence to support their recommendation of not met in this Requirement:

* Consumer A’s care plan was not updated to reflect the consumer’s preference to sleep in a recliner and was not reviewed for effectiveness following the two incidents when the consumer sustained pressure injuries as a result of sleeping in the recliner.
* Consumer C’s care plans, assessments and strategies were not reviewed for effectiveness following an ongoing deterioration of their tumour.
* Staff did not undertake review of assessment and care planning when Consumer D complained of mouth ulcers, pain on chewing and biting, and ill-fitting dentures since May 2022 resulting in a weight loss.
* Staff were not undertaking reviews of Consumer B, who has high falls risk, in a timely manner following repeated falls with strategies recorded in the care plan being generic and remaining ineffective.
* The sampled consumers’ assessments and care plans sampled were overdue up to 2 months for a six-monthly review.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* The provider acknowledges Consumer A’s preference to sleep in the chair was not documented in the care plan at the time of the Site Audit. However, this preference was documented in other parts of the consumer’s care documentation and staff were aware of this preference. Additionally, this preference was discussed during a family conference and allied health professionals were involved throughout August 2022 to address pressure injury risk.
* In relation to Consumer C, the provider advised and provided documented evidence of the review of the consumer’s assessments and care planning when their general decline was noted in November 2022. This was evidenced by escalation to the service’s multi-disciplinary team in November 2022, a referral to a general practitioner and dietician for weight loss, review of nutrition and hydration plan in November 2022 and February 2023. In addition, a referral was sent to a Residential Care Line nurse in relation to wound management on 22 November 2022 and wound care management plan was reviewed for effectiveness.
* In relation to Consumer D, the provider states they were not aware of the consumer’s concerns of mouth ulcers and/or ill-fitting dentures until the consumer raised these concerns in January 2023. The provider states and provides documented evidence, such as progress notes, to show the consumer was diagnosed and treated for two specific issues, in April and October 2022, one of these being blocked salivary glands which resolved following treatment. The consumer’s weight has been stable until January 2023 and the consumer only expressed discomfort with respect to their jaw in January 2023. A care conference was held in early February 2023 where the care plan was reviewed and referrals to a dentist, speech pathologist and a dietician have been made.
* In relation to Consumer B, the provider supplied evidence of review of the consumer’s care in relation to falls, mobility and falls risk preventative strategies 30 times since June 2022. These included reviews by a physiotherapist, general practitioner and Nurse Practitioner.

Based on the Assessment Team’s report and the provider ’s response, I have come to a different view from the Assessment team’s recommendation of Not Met and find the service Compliant with this Requirement.

I have considered that the service does review care and services for effectiveness at the scheduled intervals, when circumstances change or when incidents, such as falls, pressure injuries and unplanned weight loss, impact on the needs, goals or preferences of the consumer.

I have considered information and evidence in the Assessment Team’s report demonstrating all consumer plans have an agreed review date and whilst some consumers’ care plans were noted to be behind in their 6 monthly review schedules, I am satisfied care and services are reviewed when it is necessary to ensure safe and effective care and service delivery.

In relation to Consumer B, I consider the service demonstrated ongoing review of the consumer’s care through providing documented evidence in its response demonstrating a comprehensive clinical assessment, including a review of the consumer’s gait and balance, strengths and mobility and cognitive function, development of the care plan that considered the consumer’s desire for independence whilst also addressing the risk of falls. The provider’s response included evidence of regular review of falls preventative strategies, including physical therapy and assistive devices as well as communication with the consumer and their family to ensure that the consumer’s goals and preferences are being met.

In relation to Consumer C, the provider’s response and corresponding evidence demonstrated wound management care was reviewed for effectiveness regularly and when the wound’s deterioration was noted. A review of medical records, including wound care charts, progress notes and referrals in the provider’s response shows regular review of the wound. This includes review of the wound’s repair stage, colour, odour, exudate type and amount, wound edge appearance and surrounding edges which were assessed at each dressing change with referrals and escalation made to a general practitioner, palliative care team and a residential care nurse for advice on further evaluation and treatment of the wound.

In relation to Consumer D, I consider the consumer was assessed timely when a change in condition occurred and the care was reviewed accordingly with changes made in relation to nutrition and hydration needs.

I acknowledge, some consumer care plans were overdue for their 6 monthly reviews with the provider accepting this deficiency. However, I am satisfied the provider had commenced actions prior to the Site Audit which includes an upgrade of the provider’s electronic care management system by the end of March 2023 that will ensure that care plans are automatically updated to reflect changes in assessments and interventions.

Accordingly, I find Requirement 2(3)(e) is Compliant.

**Requirements 2(3)(c) and 2(3)(d)**

I am satisfied the remaining Requirements 2(3)(c) and 2(3)(d) in this Standard are Compliant.

Consumers and their representatives interviewed confirmed they feel like partners in the ongoing assessment and planning of their care and services and they were informed of outcomes of assessment and planning on admission and on an ongoing basis.

Documentation showed the service collaborate with organisations, individuals and providers of other care and services to ensure consumer’s needs are fully addressed. The outcomes of the assessment and planning process is documented in a care plan and other supporting documents and are shared with consumer and/or their representative through face-to-face meetings, emails, and other means of communication. A copy of the care plan is offered to a consumer on request.

Staff advised they have access to consumer care plans and follow it accordingly.

# 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. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

This Quality Standard is assessed as Non-compliant as one of the seven specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirements 3(3)(b), 3(3)(d) and 3(3)(f) in this Standard as Not Met. Based on the Assessment Team’s report and the provider’s response I find Requirement 3(3)(b) Non-compliant. However, in relation to Requirements 3(3)(d) and 3(3)(f) in this Standard, I have come to a different finding to the Assessment Team and have found these Requirements Compliant. I have provided reasons for my findings in the respective Requirements below.

**Requirement 3(3)(b)**

The Assessment Team found the service does not effectively manage consumers who have risks related to personal care or clinical care. This is in relation to falls, pressure injuries and restrictive practices. The Assessment Team provided the following evidence relevant to my finding in relation to this requirement:

* Consumer B continues to frequently fall with 25 falls reported in the last 4 months with 15 of these occurring in the last 6 weeks, with the majority being unwitnessed falls with minimal injury.
* Two consumers did not have their neurological observations completed following falls in line with the organisation’s policies and procedures.
* Consumer A was not provided with effective pressure relieving aids with a delay of 4 months since the risk assessment. As a result, the consumer developed two wounds with one remaining current.
* Two consumers’ wounds were not dressed in line with their care plans. One consumer’s pressure injury has failed to heal since December 2021.
* One consumer has been administered a sedative medication prescribed for treatment of anxiety inappropriately on 14 occasions over the 8 weeks prior to the Site Audit visit to manage the consumer’s behaviours including agitation and calling out. Staff did not record consistently strategies trialled prior to the decision to administer the medication and did not consider other factors, such as pain, contributing to the change in behaviours despite 2 recent falls where the consumer hurt their knee.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a detailed continuous improvement plan which is being implemented to address the deficits. Improvements include training for staff including in relation to management of consumers’ wounds, falls and restrictive practices and implementation of new processes. More broadly a continuous improvement activity has been developed to remedy clinical gaps identified in the Assessment Team’s report is being implemented with planned completion for 30 June 2023.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 3(3)(b) Non-compliant.

In relation to Consumer B, I acknowledge the service reviews the consumer following each fall, and reviews falls preventative strategies. In addition, the service acknowledges and respects the rights of the consumer to maintain their mobility and independence and to mobilise without staff assistance. However, I encourage the service to review the consumer’s falls prevention strategies to effectively mitigate potential consequences of ongoing falls, such as injuries.

I find whilst the service has policies and procedures and each consumer has a care plan to guide staff around management of high impact/high prevalence risks including risks associated with wound care, falls management and medication management, these are not consistently implemented in practice.

In coming to my finding, I have considered that inconsistencies in wound care provision and the delayed implementation of pressure injury prevention strategies has not effectively managed the risks of pressure injury development for one consumer and has caused delayed wound healing. Additionally, staff are not completing neurological observations in accordance with the service’s post-falls protocol to monitor and identify injury and/or changes in health status.

I have also considered that staff are not effectively managing risks associated with the use of psychotropic medication through using this medication on several occasions without considering reasons for the change in behaviour, such as pain following falls.

Accordingly, I am satisfied Requirement 3(3)(b) is Non-Compliant.

**Requirements 3(3)(d)**

The Assessment Team recommended Requirement 3(3)(d) as Not Met. The Assessment Team found the service was unable to demonstrate deterioration or change of a consumer’s physical function, capacity or condition is recognised and responded to in a timely manner. The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* The service did not recognise and did not respond to Consumer C’s general decline and wound deterioration.
* Four consumers were not referred to appropriate specialists in a timely manner.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* Consumer C’s general decline was recognised in November 2022 exhibited by the consumer’s deteriorating wound and weight loss associated with the progression of one of the consumer’s medical conditions. The service responded to this deterioration by a range of actions, including escalation to the Service’s multi-disciplinary team on 30 November 2022, referral to a general practitioner for weight loss, referral to a dietician, wound specialist and palliative care team and engagement with the consumer and their representative on the development of the consumer’s Goals of Care.
* The provider asserts appropriate referrals were sent in a timely manner and provided documented evidence of this.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service is Compliant with Requirements 3(3)(d).

I find the service demonstrates they recognise and respond to deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition in a timely manner.

I consider Consumer C’s deterioration was recognised appropriately through a change in the wound’s appearance and the consumer’s weight loss, and timely interventions were implemented, including notifying appropriate health professionals, adjusting treatment plan and involving the consumer and their representative in the development of Goals of Care and informing them of changes in the consumer’s condition.

I considered the Assessment Team’s findings in relation to lack of referrals and the provider’s response to this finding under Requirement 3(3)(f) where it is relevant.

Accordingly, I am satisfied Requirements 3(3)(d) is Compliant.

**Requirement 3(3)(f)**

The Assessment Team recommended Requirements 3(3)(f) as Not Met because it found the service was unable to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services. The Assessment Team provided the following findings and evidence to support their recommendation of Not Met in this Requirement:

* There were no appropriate and timely referrals to appropriate individuals, other organisations and providers of other care and services in relation to Consumer A’s pressure injuries, Consumer B’s ongoing falls, Consumer C’s deteriorating tumour and Consumer D’s complaints of problems with mouth ulcers and ill-fitting dentures resulting in the consumer’s weight loss.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* In relation to Consumer A, the provider asserts there were timely referrals to occupational and physiotherapist following the risk assessment of developing a pressure injury and following an incident where the consumer tipped the chair through error when was attempting to get up.
* Consumer B was referred to and reviewed by appropriate health professionals including physiotherapist and general practitioner following falls in a timely manner. Documented evidence of this attached to the provider’s response included referrals to a range of individuals and providers of specialised care and services, including Nurse practitioner, palliative care team and allied health staff.
* In relation to Consumer C, the provider asserts the service has been actively managing the consumer’s wound since its inception in March 2022 with ongoing referrals sent to a range of internal and external individuals and providers of other care and services, including a general practitioner, Residential Care Line (RCL) nurse, and palliative care team.
* In relation to Consumer D, there is no record of any complaint or expression of discomfort by the consumer with respect to recurrent mouth ulcers or ill-fitting dentures until January 2023. The consumer had blocked saliva glands in April 2022, which were treated and resolved. The consumer suffered from dental abscesses which were referred to and treated by the general practitioner and resolved in October 2022. The consumer expressed discomfort with respect to their jaw in January 2023 and referrals to a dietician, a speech pathologist and dentist were made in early February 2023 in consultation with the consumer and their representative. The consumer has had their dentures adjusted and is now very comfortable eating. The provider asserts and provides evidence of the consumer’s stable weight until February 2023.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service is Compliant with Requirement 3(3)(f). I find the service demonstrates they send appropriate and timely referrals as evidenced in the provider’s response documentation.

I consider Consumers A, B, C and D were referred to individuals, other organisations and providers of other care and services appropriately and in a timely manner.

In coming to my finding in relation to this Requirement, I considered consumers’ feedback in the Assessment Team’s report stating that all consumers and representatives interviewed indicated they were happy with the personal and clinical care they received. I accept one consumer (Consumer D) provided feedback to the Assessment Team about their weight loss due to lack of actions in response to their mouth ulcers and ill-fitting dentures. However, the provider’s response showed the consumer was referred to a general practitioner and was sent to a hospital for assessment and treatment of dental abscesses and blocked saliva glands in 2022 and these conditions resolved as a result of treatment. I consider the provider responded appropriately and sent referrals to specialists in response to the consumer’s unplanned weight loss identified in February 2023 following a monthly weighing.

I consider the provider’s response demonstrates Consumer A was referred to an occupational therapist in a timely manner. However, the implementation of a pressure relieving device was delayed which I considered under Requirement 3(3)(b).

I consider the provider’s response demonstrates Consumer B was referred to appropriately to several health practitioners in relation to their ongoing falls. However, I considered the consumer’s ongoing falls and management of risks under 3b.

I consider the provider’s response demonstrates Consumer C was referred to an external palliative care team and a Residential Care Line nurse when the wound was showing signs of deterioration.

Accordingly, I am satisfied Requirement 3(3)(f) is Compliant.

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

I am satisfied remaining Requirements, 3(3)(a), 3(3)(c), 3(3)(e) and 3(3)(g) are Compliant.

Overall, consumers and representatives confirmed they are satisfied they receive personal and clinical care that is tailored to their needs, and staff were able to describe consumers’ specific preferences and needs and how they ensure best practice personal and clinical care is provided.

Staff and management were able to describe how staff recognise consumers who are nearing the end of their life, and how they provide care that meets the consumers’ goals, needs and preferences. Documentation showed referrals are made to an external palliative care team who provide advice and support. Whilst the Assessment Team were not provided with evidence of addressing consumers’ needs, goals and preferences during the Site Audit, in its response the provider included consumers’ ‘goals of care’, ‘end of life pathway’ and progress notes demonstrating end of life care which is focused on the consumers’ comfort, and which preserves consumer dignity.

Consumers provided feedback indicating their care is consistent and they have continuity of care, and staff advised they are provided regular updates through shift handover.

The Assessment Team observed staff performing hand hygiene and cleaning of equipment. All staff were observed wearing masks to reduce the risk of COVID-19. The service has a screening process on entry to minimise the risk of COVID-19, including temperature checks and rapid antigen testing of visitors and staff. Staff were able to describe how they prevent infections through good hand hygiene and use of personal protective equipment, when required. Clinical staff were able to describe the process for ensuring that an infection is present before antibiotics are prescribed and have access to equipment to collect specimens and documentation reviewed confirmed this advice.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | 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

This Quality Standard is assessed as Non-compliant as Requirement 4(3)(a) has been assessed as Non-compliant.

The Assessment Team recommended Requirement 4(3)(a) in this Standard as Not Met. Based on the Assessment Team’s report and the provider’s response I find Requirement 4(3)(a) Non-compliant.

**Requirement 4(3)(a)**

The Assessment Team found Requirement 4(3)(a) as Not Met because three consumers who are living with a diagnosis of dementia, with two of them from linguistically and culturally diverse backgrounds, were observed through the Site Audit not being engaged in conversations, activities of their interests and not being provided any supports in line with their assessed needs, goals and preferences documented in their care plans. Activity participation records showed, the consumers were not being provided with meaningful supports tailored to the consumers’ needs, such as watching television and listening to the music of their liking, looking through photography albums, gardening, attending the park and socialising to promote their health, well-being and quality of life. Representatives of the two consumers advised they were not aware of the supports which are provided to the consumers, and they said they sit with them when they visit.

The provider responded to the Site Audit report and acknowledged the concerns raised by the Assessment Team and supplied evidence to demonstrate the actions that have been taken to address the issues raised. The provider created a specific action plan in relation to ensuring that all consumers living with a diagnosis of dementia are having their activities and well-being needs met and the needs and preferences of consumers from culturally and linguistically diverse backgrounds are reviewed and addressed.

Whilst the provider asserts, there is verbal evidence from clinical and care staff that the service’s lifestyle team is engaging consistently with the three consumers in accordance with their care plans, it acknowledges, the service cannot demonstrate this in its documentation as the lifestyle team has not been charting or otherwise consistently reporting its activities. In addition, the provider’s actions include comprehensive review of the consumers’ needs and a referral to an external organisation for specialised advice on appropriate supports for consumers living with dementia.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 4(3)(a) Non-compliant. I find the service did not demonstrate they provide each consumer with effective supports and activities of daily living in line with the consumers’ needs, goals and preferences. In coming to my finding, I have relied upon the Assessment Team’s observations during the Site Audit where three consumers were observed not being engaged and had limited opportunities for socialisation. Documentation reviewed indicated that there was minimal provision of such supports and representatives of the three observed consumers indicated that they were not aware of any supports provided to the consumers.

While I note the provider has acted in response to the information raised in the Assessment Team’s report, I was not provided sufficient evidence in the provider’s response to satisfy me that the service has addressed all the deficiencies identified in the Site Audit.

Accordingly, I find the service is Non-compliant with this requirement.

**Requirements 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g)**

I am satisfied the remaining Requirements 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g) are Compliant.

Consumers provided feedback indicating staff at the service provide them with assistance when they are feeling down, and they can attend one of the church services offered, as well as to meet and connect with family and friends. Most consumers stated the staff knew them very well and offered supports and services that meet their emotional, spiritual, and psychological well-being. Consumers reported being able to participate in activities they were interested in, with staff understanding their routines and preferences for care.

Lifestyle staff provided feedback that the service offers one-on-one volunteer support for consumers who are feeling isolated. Volunteers visit each day of the week and offer conversation and trishaw rides. The service also provides "isolation packs" with games, quizzes, and suggestions for activities that can be done alone, including during COVID-19 outbreaks.

The service has a lifestyle program, which is run six days a week and is supplemented by community visitors, pastoral care workers and external providers. The program offers a range of activities based on consumer interests and feedback, such as exercises, music, quizzes, games, bus rides, trishaw rides, and special and cultural events.

Menus are set by the organisation, reviewed by dietician, and rotated seasonally. Most consumers provided positive feedback regarding the quality and variety of meals, although some had mixed feelings. However, all consumers stated that the quantity was sufficient. Following feedback with management, a food improvement project was added to the Plan for Continuous Improvement, which focuses on food temperature and ongoing engagement with the Chef.

Equipment provided to consumers is assessed for suitability to their individual needs and preferences, and regular maintenance is performed to ensure safety and effectiveness. Observations of the equipment in use by consumers demonstrated that it was generally clean, well-maintained, and functioning effectively. However, three walking aids were found to be stained with food and food crumbs on the seat area. In response to the feedback, management advised they will create a cleaning schedule for night staff to clean consumers' equipment.

# 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

This Quality Standard is Compliant as three of the three Requirements have been assessed as Compliant.

Consumer feedback was positive overall, with most consumers and representatives feeling welcome, safe, and expressing a sense of belonging. Consumers also confirmed they feel safe living at the service, are satisfied with cleaning and maintenance services and they can access outdoor areas freely, including the park across the road.

Observations of the nursing home demonstrated a welcoming environment that optimises each consumer's sense of belonging, independence, interaction, and function. The service is separated into two larger areas, with communal areas furnished with comfortable and suitable furniture. Consumer rooms were observed to be clean and personalised with various items, including photographs, pictures, plants, and ornaments.

Some consumers in the memory support area were observed requiring assistance to access the outdoor area, and some areas were initially found to be cluttered with equipment not in use, impacting on consumers' ability to interact and function. Following feedback, the areas were cleared of equipment, and a continuous improvement action was added to the service Plan for Continuous Improvement to remind staff to store equipment appropriately.

Staff interviewed demonstrated their knowledge of how to report hazards, and a schedule for maintenance demonstrated preventative and reactive maintenance. A designated maintenance officer ensures routine and preventative maintenance schedules are conducted. The service also has a centralised process for scheduling routine and preventative maintenance and ensuring the work is prioritised and completed in a timely manner.

Documentation review confirmed that the organisation conducts audits of the environment, and cleaning staff confirmed they have cleaning schedules which include completing consumer room and communal area cleans. There is a preventative maintenance schedule for large equipment items such as beds and hoists. All medical equipment is maintained and calibrated by an external contracted company.

# 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

This Quality Standard is Compliant as four of the four Requirements have been assessed as Compliant.

Consumers and representatives advised they were aware of mechanisms available to make a complaint, give feedback and suggestions and felt supported by management to give feedback. They also confirmed they have access to interpreters, advocacy and external complaint handling services and are aware of external agencies who could assist them in raising concerns. All consumers and representatives interviewed were satisfied with the way in which management respond and act on complaints and feedback to improve the quality of care and services.

Staff could describe how they support consumers who wish to make a suggestion, compliment or a complaint, and were aware of the organisation's complaints handling processes. Staff interviewed confirmed they use communication cards to communicate with consumers who cannot speak English and they can engage language services if it is appropriate. Staff understood the importance of transparency and apologising when things go wrong and provided examples of how they applied open disclosure in their role.

The organisation has processes to ensure all feedback is captured, monitored, analysed, trended and reviewed for areas of continuous improvement with improvements logged on their Plan for Continuous Improvement.

Advocacy and external complaint information is provided within the admission information pack. Posters and pamphlets were observed to be displayed throughout the service detailing mechanisms for raising complaints. The service’s feedback register showed where complaints were made, they were actioned in a timely manner and open disclosure was applied appropriately.

# 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. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement 7(3)(e) as Not Met. The Assessment Team found the service was not able to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. The Assessment Team provided the following evidence relevant to my finding in relation to this requirement:

* Ten staff members from various roles advised they had not had a performance discussion with the management team in more than 12 months.
* Management advised there had been no performance appraisals completed with any staff member for approximately 2 years.
* Clinical staff performance was not always monitored, and corrected actions were not taken in relation to the inappropriate use and documentation of chemical restraint.
* Lifestyle staff performance was not effectively monitored to ensure all consumers are provided meaningful supports and engagements in line with their assessed needs.

The provider responded to the Assessment Team’s report and acknowledged the concerns raised by the Assessment Team. The provider supplied evidence to demonstrate the actions that are planned to address the issues raised which include, but are not limited to the following:

* weekly audits of activities by lifestyle team leader, monthly reports by the lifestyle team leader on all consumer engagements to service’s leadership and to the provider’s Allied Health management team;
* monitoring of restrictive practices; and
* heads of service lines will be trained to conduct performance reviews which will then be delegated to them for completion.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 7(3)(e) Non-compliant. I find the service is not undertaking regular assessment, monitoring and review of the performance of each member of the workforce. I have considered lack of documentation related to regular performance appraisals, staff reports of not receiving regular performance evaluations and no evidence of corrective actions taken for employees who are not meeting expectations specifically in relation to the appropriate use of chemical restraint and implementation of lifestyle supports for each consumer.

Accordingly, I find the service Non-compliant with this Requirement.

**Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(d)**

I am satisfied the remaining Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(d) are Compliant.

Consumers expressed their satisfaction with the quality of care provided by the staff. They commended staff for their friendly and caring attitude towards them. Overall, most consumers and/representatives stated they were happy there were enough staff to deliver safe and quality care and services. However, one consumer and three representatives expressed their feeling that there are not enough staff, with one representative stating there are not always enough staff to attend to a consumer who calls out and becomes disruptive and one consumer stating they often have to wait for assistance to use the bathroom. Management advised they roster and allocate based on consumer needs and monitor incidents and review consumer and staff feedback to ensure they have the right mix and number of staff allocated across each of the house. Documentation showed where a shift was vacant due to unplanned leave, it was filled with staff from the casual pool or regular staff who may not have been rostered that day. The scheduling officers advised they allocate staff based on the needs of consumers and where there are higher needs, they will allocate staff accordingly.

Staff said whilst they were busy, they usually are able to complete their allocated tasks and provide safe and quality care to consumers. Staff members were generally aware of the individual needs and preferences of each consumer and were able to describe steps they take to ensure they provide person-centred care. Staff also confirmed they received regular training opportunities to improve their skills and knowledge, which helped them to deliver quality care.

Documentation showed staff have relevant qualifications and skills appropriate to their role and the service provided regular training opportunities to staff including mandatory and role specific training. However, documentation showed deficiencies in staff completion of mandatory manual handling and infection control competencies for more than 12 months. Management advised they were aware of this and advised they will be working towards having these competencies completed and up to date soon.

Staff were observed to be caring and attentive to the needs of the consumers and competently providing care and support to consumers.

# 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. | Non-compliant |

Findings

This Quality Standard is assessed as Non-compliant as one of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirements 8(3)(d) and 8(3)(e) in this Standard as Not Met. Based on the Assessment Team’s report and the provider’s response I find Requirement 8(3)(e) Non-compliant. However, in relation to Requirement 8(3)(d) in this Standard, I have come to a different finding to the Assessment Team and have found this Requirement Compliant. I have provided reasons for my findings in the respective Requirements below.

**Requirement 8(3)(d)**

The Assessment Team recommended Requirement 8(3)(d) Not Met**.** They found the service has a risk management framework that is supported by policies and procedures to guide staff practice in assessing and mitigating risks including supporting consumers to live the best life they can. However, the risk management framework was found to be not effective in relation to the management of high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect or managing and preventing incidents. Staff and the service did not always recognise and respond to allegations of elder abuse in a timely manner, the service’s incident management system had not identified delays in the reporting of serious incidents and some incidents under Serious Incident Response Scheme were not reported. Other evidence included the following:

* Consumer B continues to frequently fall with 25 falls reported in the last 4 months with 15 of these occurred in the last 6 weeks, with the majority being unwitnessed falls with minimal injury. The consumer continues to fall, despite being moved to a different house for increased monitoring and supervision. In addition, the service did not consider the prescription of daily psychotropic medication may contributed and to the ongoing falls or mobility.
* Three incidents of unreasonable use of force between two consumers since September 2022 have not been reported within required time frames and two allegations from a consumer/representative of rough handling or verbal aggression were not reported.
* During the Site Audit, a consumer advised the Assessment Team they were recently pushed by another consumer and fell, as a result. An incident form was not completed.

The provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s recommendation. The provider submitted the following information and evidence to refute the Assessment Team’s recommendation and demonstrate the service’s compliance with this Requirement:

* In relation Consumer B, the medication the Assessment Team referred to in the report was prescribed in 2018 to treat one of the consumer’s diagnoses, was regularly reviewed by a general practitioner who did not make the decision to cease it. The provider asserts the consumer had not experienced drowsiness and their falls preventative strategies have been regularly reviewed and new interventions trialled. The consumer was supported with their choice to mobilise without assistance.
* In relation to a consumer/representative’s allegations of staff rough handling and/or verbal aggression, the first allegation was reported to the Commission within the required timeframe and after the service became aware of the allegations. The second allegation was also reported within required timeframe, investigated and the consumer was reviewed and monitored for any signs of distress.
* In relation to the fall incident where the consumer alleged, they were pushed by another consumer, the provider asserts at the time of the incident the consumer did not make any allegations that they were pushed. The incident report was completed on the same day. The service was not aware of the allegation until was informed by the Assessment Team during the Site Audit and lodged the incident report with the Commission within required timeframe.
* In relation to three incidents of unreasonable use of force, only one of the three was reported with the delay and one was reported as a priority one by mistake.
* The provider acknowledges there have been delays with reporting of incidents under Serious Incident Response Scheme on two occasions over the last 6 months, which constituted 10% of total number of reported (2 out of 19).

After reviewing the evidence and information presented in the Assessment Team’s report in this and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of Not Met and find the service Compliant with Requirement 8(3)(d).

In coming to my finding, I have considered evidence presented in the Assessment Team’s report that demonstrates the service has risk management systems and practices with a risk management framework being supported by policies and procedures to guide staff practice in assessing and mitigating risks. Consumers interviewed indicated that they feel safe and enjoyed living at the service. Consumers interviewed said they can make choices about how they live their lives and are supported by the service to do so.

Risk assessments are completed and strategies to mitigate the risk are implemented to ensure consumers’ wellbeing and safety. A review of the service’s training matrix showed staff have completed online module training run in a range of topics, including in relation to Serious Incidents Response Scheme. The service monitors effectiveness of its systems with the service’s plan for continuous improvement identifying through audits the lack of staff knowledge for reporting incidents under Serious Incidents Response Scheme (SIRS) with training being provided to all staff that occurred prior to the Site Audit.

I consider the evidence presented does not indicate ineffective risk management systems. However, the Assessment Team did find there are some high impact or high prevalence risks associated with personal and clinical care which have not been effectively managed for some consumers, which I have addressed in Standard 3 Requirement (3)(b).

Whilst 10% of SIRS incidents were not reported within required timeframe, evidence put forth by the provider demonstrates all incidents requiring reporting were reported to the Commission. The provider acknowledged reporting within legislative timeframes requires improvement which was identified prior to the Site Audit and the provider has taken actions to improve timeliness of incident reporting falling under SIRS category.

I am satisfied the service identified and is addressing systemic issues that can contribute to delayed reporting and is planning a range of continuous improvement initiatives to be completed by 30 April 2023.

Accordingly, I am satisfied Requirement 8(3)(d) is Compliant.

**Requirement 8(3)(e)**

The Assessment Team recommended Requirement 8(3)(d) as Not Met. The Assessment Team found while the organisation has a clinical governance framework that is supported by policies and procedures including for open disclosure and antimicrobial stewardship, they were unable to demonstrate they effectively minimise the use of restrictive practices, specifically in relation to chemical and environmental restraint.

For two consumers the administration of ‘as required’ or regular doses of psychotropic medications was not performed in line with legislative requirements. Staff did not consistently document alternatives trialled prior to administration of medications, did not always document the effectiveness of the medications and the service could not demonstrate strategies were reviewed when medications were not effective. The service could not demonstrate understanding of environmental restrictive practices and for one consumer who are subject to environmental restraint there was no evidence of appropriate consent, authorisation or assessment.

The provider’s response acknowledged the deficits identified by the Assessment Team and provided a detailed continuous improvement plan with actions that either have already or are in the process of being implemented to address the deficits, including completing an incident for an inappropriate use of restrictive practices, using open disclosure with the families, completing an environmental risk assessment and obtaining an informed consent. More broadly, a continuous improvement activity has been developed to improve on reviewing restrictive practices. The service’s clinical team has already started and will be delivering regular educations and training to staff through daily huddles.

After reviewing the evidence and information presented in the Assessment Team’s report and the provider’s response, I find Requirement 8(3)(e) Non-compliant.

The service has taken appropriate actions to address the deficits identified. However, I was not provided sufficient evidence in the provider’s response to satisfy me that the service has addressed all of the deficiencies identified in the Site Audit to ensure clinical governance framework for minimisation of the use of restraint is effective and results in actions in line with legislation in relation to assessment, informed consent and documenting alternative strategies.

Accordingly, I find Requirement 8(3)(e) Non-compliant.

**Requirements 8(3)(a), 8(3)(b) and 8(3)(c)**

I am satisfied remaining Requirements 8(3)(a), 8(3)(b) and 8(3)(c) are Compliant.

Consumers interviewed confirmed they are involved in the development and delivery of their care and can suggest improvements about their care and services by providing feedback verbally and through feedback forms, through surveys and attending resident meetings. Consumers and representatives interviewed confirmed they are encouraged to participate in continuous improvement initiatives.

The organisation invites consumers and representatives to care conferences to discuss and evaluate care and services. The organisation also engaged consumers in the current food improvement project to gather their feedback on the things they like and dislike to develop a new menu that reflects their choices.

The organisation has policies and procedures in place to promote safe, inclusive, and quality care and services. The chief executive officer (CEO) of the organisation is a member of the Board and various committees, which provide information to the Board. The Board meets monthly, and the customer experience committee reports to the CEO, who reports to the Board on service performance.

The organisation has governance wide systems, including a governance framework, monitoring systems, assigned delegations and accountabilities and policies and procedures. Information systems and processes are in place to ensure staff and management have ready access to relevant and up-to-date information to perform their role. Management described the annual financial planning process and financial delegation systems for out of budget expenditure, with examples, including equipment and new furniture provided.

Processes are in place to support the service to ensure staff are selected, trained and supported to meet the organisation’s values and job specifications of each role. The organisation has memberships with peak bodies to monitor changes to aged care law to ensure regulatory obligations are met and regularly monitor communications distributed by the Aged Care Quality and Safety Commission. Feedback and complaints are managed at a site level and reported at relevant leadership and Board meetings and monitored by the Quality and Safety Team.

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