Beauaraba Lodge

Performance Report

10 Weale Street   
PITTSWORTH QLD 4356  
Phone number: 07 4619 8422

**Commission ID:** 5043

**Provider name:** The Pittsworth and District Hospital Friendly Society Ltd

**Site Audit date:** 16 February 2022 to 18 February 2022

**Date of Performance Report:** 22 April 2022

# Performance report prepared by

James Howard, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* The Assessment Team’s report for the Site Audit conducted from 16 February 2022 to 18 February 2022; 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 Site Audit report received 24 March 2022.
* Other information and intelligence held by the Commission in relation to this service.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant, as six of the six specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation and risk assessments.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included:

* Applicable evidence relating to consumer examples: care plan documentation including medical information, risk assessments and dignity of risk forms.

The Assessment Team recommended Requirement 1(3)(d) as non-compliant. However, having considered the evidence presented by the Assessment Team and the service, I have determined Requirement 1(3)(d) compliant, as discussed further under ‘Assessment of Standard 1 Requirements’.

Sampled consumers provided feedback that reflected they were treated with dignity and respect, supported to maintain their identity and made informed choices about their care and services, to live the life they chose.

Review of care planning documentation and interviews demonstrated that the service understood and respected each consumers’ life journey. The service identified what was important to each consumer, consumers’ cultural background, spiritual preferences, and family relationships. Staff were able to describe the cultural, religious and personal preferences of consumers, and strategies to deliver culturally safe care based on individual requirements.

Review of care planning documentation demonstrated that consumers’ decision to include, or not to include family, friends, carers or others, in the delivery of their care and services was supported by the service. Consumers described to the Assessment Team how they make and maintain relationships of choice within, and outside the service.

The Assessment Team considered that consumers were not supported through appropriate risk based assessment to take risks, to enable them to live their best life. Having considered the Assessment Team’s findings, and the evidence submitted by the service, I decided the service addressed the points raised by the Assessment Team and demonstrated consumers were supported to take risks.

Review of care planning documentation confirmed that consumers’ communication and language requirements were considered by the service, which enabled consumers to understand information in a clear manner. Consumers and representatives confirmed that the information provided to them by the service, enabled them to make informed decisions about consumers’ care and services.

Consumers reported that their personal privacy was respected by the service. Staff described the strategies they used to maintain consumers’ personal privacy, such as knocking on a consumer’s door before entering. Consumer’s personal information was observed to be confidentially stored on a password protected electronic management system. Staff confirmed that they do not discuss consumers’ personal details in pubic settings, and conduct handover in private areas.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The Assessment Team recommended Requirement 1(3)(d) non-compliant due to 2 examples of limited record management and assessment of consumer risks.

The first example related to a consumer that required a risk assessment and revision of risk rating following a scooter crash. The service clarified in its written response, that all residents who wished to maintain their independence by using motorised scooters, were supported by risk assessments conducted with general practitioner and physiotherapist feedback and guidance from internal policies. The service held discussions with the consumer and their representative after the scooter crash about the service’s assessment and review pathway, to potentially consider use of the scooter in the future. Based on the evidence supplied by the service, at the time of the site audit, the consumer was still undergoing assessment with their physiotherapist and required general practitioner clearance for use of the scooter, hence why an updated risk rating was not completed. Care plan notes recorded the incident and the on-going actions required after the incident.

The second example related to feedback about a consolidated general risk assessment form for consumers whom wished to exit the service for social leave. In its written response, the service clarified that risk assessments were conducted on a per needed basis, and were tailored to the activity the individual wanted to undertake; the service provided supporting evidence of its risk assessment form for consumers exiting the service.

Based on the totality of the evidence, I have determined Requirement 1(3)(d) compliant, as the service demonstrated that it considered risks and supported consumers to live their best lives. In determining this Requirement as compliant, I considered that:

* Overall, consumers and their representatives reported no issues with the support provided by the service in the consideration of activities associated with risk.
* The scope of the examples provided by the Assessment Team were limited to two examples, with minimal risks identified.
* The service’s supporting evidence provided situational context, which addressed the Assessment Team’s findings from the site audit report.

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant, as five of the five specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* The service’s use and care of oxygen concentrators procedure, applicable medical information, care plan records and site audit exit meeting minutes.

Sampled consumers and representatives advised the Assessment Team that consumers were involved in the ongoing assessment and planning of their care and service delivery needs, to optimise their health and well-being.

The Assessment Team recommended Requirement 2(3)(a) as compliant, however, noted a few examples, which the service clarified in its written response as discussed under ‘Assessment of Standard 2 Requirements’.

The service demonstrated that its assessment and planning process, considered risks to consumers’ health and well-being to inform the delivery of safe and effective care and services – as discussed in further detail under Requirement 1(3)(d) and Requirement 2(3)(a).

Sampled care planning documentation demonstrated that assessment and planning identified and addressed consumers’ current needs, goals and preferences, including advance care planning and end of life planning. Consumers confirmed that they had discussions with the service about their advance care and end of life planning preferences, and as applicable, the service respected the choice to discuss the topic at a later date.

Consumers considered that they partnered with the service and with people important to them, in the planning of their care and services. Review of care planning documentation demonstrated that other organisations, individuals, and providers of care were involved in the assessment, planning and review process.

The outcomes of assessment and planning were verbally communicated to consumers and representatives, with a copy of the care plan available through electronic communication and hardcopy print. Consumers and representatives advised that staff explained relevant information to them about their care, and were aware of their care plan.

Care planning documentation demonstrated that care and services were reviewed for effectiveness when there was a change to a consumer’s condition, or incident. Review of care and services considered the consumer’s needs, goals, and preferences and included appropriate and timely referrals to health professionals as applicable, and used evidence based tools assessment to inform the delivery of care and services.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

Overall, the service demonstrated that assessment and planning considered risks to consumers’ health and well-being, to inform the delivery of safe and effective care and services. However, the Assessment Team identified the following matters during the site audit:

* 3 consumers required use of continuous oxygen, through an oxygen concentrator. The Assessment Team deemed that 2 out of 3 care plans did not include a timeframe for regular changing and cleaning of the tubing and nasal cannulas.
* The Assessment Team claimed that some consumers were administered psychotropics that did not have the appropriate documentation in place, such as a behaviour support plan and consent, or a diagnosis to rule out the psychotropic as being classifed as a chemical restraint, per restrictive practice legislation under the *Aged Care Act 1997*.

In response to feedback about cleaning and changing of tubing and nasal cannulas, the service clarified that staff were required to follow the guidance under the service’s use and care of oxygen concentrators procedure. The procedure, upon review, confirmed nasal cannulas were to be washed weekly, and replaced if damaged or soiled, and was applicable to the care and service delivery of the 2 named consumers. The service also provided a copy of a staff training checklist, which outlined required competencies, including infection control, that staff were required to pass before they assisted with the administration of oxygen via a concentrator. Review of the 2 consumers’ care plan clinical records confirmed that directions were included for staff to follow the service’s use and care of oxygen concentrators procedure and safety instructions.

Regarding the second point raised by the Assessment Team; the service provided a copy of its psychotropic register. The psychotropic register recorded consumers’ diagnosis, which excluded the consumers identified by the Assessment Team, from being classified under a chemical restraint.

In addition to this, the service provided care plan clinical records pertaining to the named consumers which included risk assessments, consent, strategies in place to guide care and service delivery. The service acknowledged for one named consumer that there was a transcription error, due to the implementation of a new electronic records management system, and that the consumer was not prescribed or administered antipsychotic medication. The consumer’s relevant medical documention was provided, which verified the consumer did not receive antipsychotic medication that would be considered a chemical restraint. The service’s full response to chemical restraints is further considered under Requirement 3(3)(a).

The service addressed risk factors associated with the Assessment Team’s findings, through evidence based responses, which mitigated a potential finding of non-compliance. Based on the totality of the evidence, given that the service’s response demonstrated that there was minimal risk to consumers, I decided Requirement 2(3)(a) is compliant.

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Compliant, as seven of the seven specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* The service’s use and care of oxygen concentrators procedure.
* Applicable medical documentation such care plan records, risk assessments, progress notes and consent.
* A copy of the psychotropic medication register.
* Applicable staff training documentation.
* A copy of site audit exit meeting minutes.

The Assessment Team recommended that Requirement 3(3)(a), Requirement 3(3)(b), Requirement 3(3)(e) as non-compliant. However, having considered the evidence in the site audit report and the evidence provided by the service in its response, I decided that all requirements are compliant, as further detailed under ‘Assessment of Standard 3 Requirements’.

Overall, consumers considered that they received personal and clinical care that was safe, met their individual needs and aligned with their goals and preferences.

Staff provided examples of how the service’s policies, procedures and tools applied in practice in the delivery of clinical care and services. Staff interviews and review of the service’s documentation confirmed that staff had access to evidence-based work instructions, which guided personal and clinical care in a safe and effective manner to optimise consumers’ health and well-being. The service demonstrated effective management of high impact risks associated with the care of each consumer, as detailed in full under Requirement 3(3)(b).

Sampled consumers and representatives confirmed that they had discussions about end of life care and advanced health directives, as verified against review of care plan documentation.

Staff described how they recognised and responded to deterioration or changes in a consumer’s mental health, cognitive or physical function. Based on the totality of evidence, the service demonstrated how it effectively shared information about the consumer’s condition, needs and preferences within and outside the organisation through shift handovers, care plan record management and involvement of consumers, representatives and other health professionals as required.

Review of care planning documentation demonstrated that the service completed timely and appropriate referrals to other organisations and providers of care and services. Management explained that the service used a referral tool to provide relevant information to the provider, which included an introduction of the consumer, situation, background assessment and recommendation.

Staff explained how they minimised infection related risks, for example through the appropriate use of personal protective equipment and good hygiene practice. Staff demonstrated awareness of the implications of antibiotic resistance, and practices to promote appropriate antibiotic prescribing which aligned with the service’s infection control and antimicrobial stewardship policies.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Compliant

*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.*

Sampled consumers advised the Assessment Team they received safe and effective personal and clinical care that was tailored to their needs. However, the Assessment Team considered there was information missing in some consumer care plans, which indicated best practice care was not provided in relation to risk.

The Assessment Team recommended Requirement 3(3)(a) as non-compliant with consideration to potential risk associated with discrepancies in record management for restrictive practices – specifically, chemical restraint. The Assessment Team deemed there were no applicable diagnosis on file to rule out the consumers as being classified under a chemical restraint. The Assessment Team held consideration as to whether the consumers under potential chemical restraint were receiving clinical care that was in keeping with restrictive practice legislation, such as the regular assessment, monitoring and review to minimise the use of restraints.

In response to the feedback in the site audit report about chemical restraints, the service provided further context about its record management system, and the 2 named consumers under potential chemical restraint disclosed by the Assessment Team. The service advised that it moved to a new electronic records management system, and that a copy of the service’s psychotropic register was provided in its old format to the Assessment Team, hence the discrepancies. The service provided supporting evidence, such as a copy of the psychotropic register, which included relevant diagnosis that excluded consumers from being classified under a chemical restraint.

In regard to the first named consumer, as mentioned under Requirement 2(3)(a), the service acknowledged a transcription error from its old to new record management system, and that the consumer was not prescribed or administered any form of antipsychotic medication. In regard to the second named consumer, the service provided relevant evidence about the consumer’s diagnosis, excluding them from being classified under chemical restraint. The service also provided care plan records and medical information relevant to the 2 named consumers, to substantiate its claims.

I have determined Requirement 3(3)(a) compliant, as the service demonstrated through its supporting evidence, overall, consumers received clinical and personal care that was best practice, tailored to needs and optimised health and well-being. I have also considered other examples, as outlined by the Assessment Team in the site audit report, to support the finding of compliance for Requirement 3(3)(a), for example:

* Management and clinical staff advised that they reviewed quality indicators and data to identify trends and required interventions to manage any gaps or concerns.
* Clinical staff were able to describe how they provided best practice, tailored care to optimise the well-being of a consumer whom required behavioural intervention support.
* Staff were supported by clinical policies and guidelines, for example restraints, skin integrity and pain management, to inform the provision of clinical care for consumers.
* Clinical staff were able to describe the processes in place for restrictive practices which aligned with the service’s policy, including involvement of the consumer, general practitioner, family and or representative.
* Care planning documentation demonstrated best practice, tailored, personal and clinical care that optimised consumers’ well-being, such as:
  + One consumer had lost weight over a period of a month, in which the service informed and addressed this with the consumer’s general practitioner, representative and family.
  + Another consumer’s care planning documentation included relevant information to support care and service delivery for mechanical restraint, with appropriate consent, risk assessment noted in the behaviour support plan.
  + Review of a third consumer’s care planning documentation demonstrated that it contained relevant information regarding the monitoring and management of their blood glucose level, which aligned with blood glucose level charts.
* Pain management: the service demonstrated through its policies and procedures, review of consumers’ care plans, the service’s Schedule 8 drug register and medication charts that consumers were supported through appropriate pain management.
  + The service used an application to assess consumers whom experienced pain, and could not communicate verbally. When a high score was noted, appropriate management was provided, including non-pharmacological interventions such as heat packs, massage or repositioning.
* Skin integrity: the service demonstrated through its policies and procedures, site observations, review of care plans and staff interviews that skin and wound care management was appropriately managed by the service.

Other matters

The Assessment Team also referred to 2 consumer interviews with feedback that indicated personal care was not tailored to their needs. However, the Assessment Team did not refer to these examples as the primary basis of their finding of non-compliance, as most interviews with consumers indicated they received the clinical and personal care and services needed.

The service addressed the 2 consumer interviews noted in the site audit report, by providing further context to the consumers specific care requirements, risk factors, consent, medical conditions, needs and preferences. Based on the supporting evidence and information provided by the service, the 2 consumer interviews do not warrant a finding of non-compliance in of itself, as the service demonstrated overall consumers received appropriate clinical and personal care in line with this requirement.

In summary, the consumer examples were:

* Consumer one: reported that their nasal cannulas were not cleaned or changed frequently. As discussed under Requirement 2(3)(a) the service provided supporting evidence, including context about the consumer’s medical condition, care plan clinical notes, and applicable care procedures which demonstrated best practice clinical care regarding the nasal canula.
* Consumer two: reported that staff sometimes intrude in the consumer’s privacy in the bathroom. The service provided context about the consumer’s medical condition, which clarified that due to the assessment of the consumer’s medical condition, staff were directed to be present in the adjacent room to support the consumer’s independence and privacy.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team considered that 3 examples highlighted in the site audit report indicated that the service did not demonstrate effective management of high impact, or high prevalence risks associated with the consumer due to incomplete or missing record management. However, based on the service’s written response, I have determined Requirement 3(3)(b) compliant as the service provided evidence that substantiated high impact, high prevalence risks were considered accordingly for consumers.

The examples considered by the Assessment Team, and reasons why I have deemed the examples compliant are outlined below:

Cleaning and replacement of nasal cannula and tubes for oxygen concentrators

As detailed in full under Requirement 2(3)(a) I have deemed this example compliant based on the supporting evidence, such as relevant medical documentation, procedures and consumer care plan records, and context provided by the service. The service demonstrated that for all consumers that required use of an oxygen concentrator, appropriate guidance was in place for staff regarding the cleaning and replacement of nasal cannulas and tubes, and was noted in the consumers’ care plans.

Restrictive practice: chemical restraint

As detailed in full under Requirement 3(3)(a) I have deemed this example compliant based on the supporting evidence, such as relevant medical documentation, consumer care plan records, risk assessments, meeting minutes, and additional context provided by the service. The service demonstrated that for the named consumers, appropriate diagnoses were recorded on the psychotropic register that ruled out the consumers being classified as under a chemical restraint. The consumers’ care plans contained information relevant to the behavioural support and strategies required to assist the consumers.

Falls management

The Assessment Team considered an example of a consumer who had repeated falls within a 6 week period, indicative of ineffective management of high impact risks. The Assessment Team reported that the consumer’s falls management interventions included close monitoring, sitting the consumer in high traffic areas, and residing in the service’s memory support unit.

In response, the service provided supporting evidence that demonstrated the consumer had several fall risk assessment reviews throughout the 6 week duration to best support the consumer’s needs and independence. In addition, the service clarified that with the consumer and representative’s consent, it used bed and chair sensors and an electronic falls prediction system to manage falls risks.

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

The Assessment Team considered Requirement 3(3)(e) as non-complaint based on the missing or incomplete records management for the examples covered under Requirement 2(3)(a), Requirement 3(3)(a) and Requirement 3(3)(b). A summary of the examples included restrictive practice, falls management, personal and clinical care. As detailed in full under the applicable requirements, the service provided supporting evidence that demonstrated, overall, information about consumers’ condition, needs and preferences were documented and communicated within the organisation, and with others where responsibility was shared. I have also considered other findings presented by the Assessment Team, that supported the determination of Requirement 3(3)(e) as complaint, such as:

* Information relating to consumers’ condition, needs and preferences were documented in handover documentation and communicated where the responsibility for care was shared.
* All sampled care plans demonstrated that the service communicated consumers’ clinical needs with other staff, providers of care and representatives.
* Sampled consumers reported that their needs and preferences were effectively communicated between staff.
* Staff were able to explain how they refer and communicate information about changes to a consumer’s condition to others where the responsibility of care is shared.
* The Assessment Team observed clinical staff handover where information and updates about consumers’ condition, needs and preferences were communicated to staff on the next shift.

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant, as seven of the seven specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team and the service’s written response to the site audit report:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation, including progress notes and assessments.
* Review of the lifestyle activity program.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* Food satisfaction surveys dated July 2020 and November 2021.
* General feedback from the resident feedback book.
* Food forum meeting action items.
* Copies of seasonal menus and dietitian review.
* Copy of food services subcommittee meeting action items dated February 2021.

The Assessment Team recommended Requirement 4(3)(f) as non-compliant. However, having considered the evidence in the site audit report and the evidence provided by the service in its response, I have deemed Requirement 4(3)(f) compliant, as further detailed under ‘Assessment of Standard 4 Requirements’.

## Overall, sampled consumers advised they received safe and effective services and supports for daily living that were important for their health and well-being, and enabled them to do the things they wanted to do. Sampled consumers reported that they felt supported to pursue activities of interest to them, which optimised their independence and aligned with their goals and preferences, for example, quiz activities and trivia nights, happy hour drinks and lunchtime outings.

## Staff explained that they supported consumers’ psychological and spiritual well-being through strategies such as:

* Facilitation of social connections with people important to consumers, through technology, staff support and pairing consumers with volunteers.
* Spiritual needs: the service organised various religious services to visit consumers.
* An on-site chapel was available for consumers to attend regular church services and bible study groups.

For consumers experiencing low mood, staff advised that they supported consumers by engaging them in conversation and listening to their concerns. The Assessment Team observed notice boards throughout the service, that provided information about a range of services to support consumers from culturally and linguistically diverse backgrounds, and information about mental health resources and spiritual care. Consumers provided examples of how the service supported them to participate in their community within and outside the service environment and maintain relationships.

Review of care planning documentation contained information about the consumer’s condition, needs and preference, and demonstrated that information was shared within the service and with others where care is shared. Staff explained the processes in place for referral to other organisations to supplement lifestyle activities offered at the service, for example the local men’s shed and pastoral care.

Based on the supporting evidence provided by the service, the service demonstrated it provided meals of a variable and suitable quality and quantity and had processes in place to address consumers’ feedback about meals. Equipment relating to lifestyle and activities of daily living, for example mobility aids, books, table games and sensory resources were observed to be safe, suitable, clean and well maintained.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team sampled 8 consumers, in which 5 reported mixed responses that ranged from complimentary, feedback for improvement, or dissatisfaction with meal quality and size portions. When queried about this during the site audit, the service acknowledged that it had received complaints and feedback in the past regarding food, and that the service added this to its continuous improvement plan. The service explained that it addressed feedback about meals through various strategies, such as the employment of a new chef, and the facilitation of consumer driven food focus groups to discuss consumers’ needs, preferences and feedback. The service also advised that it conducted surveys to monitor and track the progress of the service’s food quality and food consumption. However, the Assessment Team recommended Requirement 4(3)(f) non-complaint due to the variance in feedback from consumer interviews.

In its written response to the site audit report, the service provided specific details and context around the feedback from the named consumers, which demonstrated that the areas identified by the Assessment Team had been resolved accordingly by the service. Specifically, there was one named consumer who expressed outward dissatisfaction with the meals during the site audit to the Assessment Team.

Regarding the named consumer, the service explained that it had meetings with the consumer, representative, chef and care coordinator to address the consumer’s feedback about small portion sizes. Supporting documentation, such as care plan notes, demonstrated that the service used an open disclosure process to address the feedback, and continued to monitor the consumer’s satisfaction with the meal sizes following the feedback. The first named consumer has also been referenced under Requirement 6(3)(c) of this report.

One consumer advised the Assessment Team that if they disliked any of the dinner options they had access to alternatives. The service provided additional information about the alternatives that were available for consumers, such as the purchase of items for consumers at the local grocery store or local takeaway restaurants, or making salads and sandwiches to ensure consumers had their meal of choice.

As a result of the initiatives the service had undertaken to address the quality and quantity of food, food related feedback and complaints had decreased overtime as validated by evidence provided by the service in response to the site audit report.

Evidence received from the service included:

* Food satisfaction surveys dated July 2020 and November 2021.
* Food related complaints and feedback data.
* Copy of consumer feedback forms.
* Meeting minutes and action items arising from the service’s food focus group.
* The service’s nutritional menu review report for the summer season. This was reviewed by a dietician, dated November 2021.

In the food satisfaction survey dated November 2021, 35 consumers were sampled, with a high portion of consumers which reported positive feedback regarding meal size, quality and variability. Given that 35 consumers were sampled in the survey, comparative to the 8 sampled by the Assessment Team, I have considered that evidence from the food survey provided a more comprehensive representation of the total number of consumers at the service.

I also noted that overall, feedback provided by the 8 consumers to the Assessment Team, was either complimentary or feedback for improvement, that was not necessarily indicative of negative responses to meal quality, quantity and size. Based on the balance of evidence presented by the Assessment Team and the service, I have determined Requirement 4(3)(f) compliant, as overall, the service demonstrated that it provided varied and suitable quality meals that met consumers’ dietary needs and preferences.

I also considered other findings presented by the Assessment Team in support of the determination of Requirement 4(3)(f) as compliant, such as:

* Care documentation reflected individual dietary needs and preferences, which aligned with responses from consumers and representatives.
* Hospitality staff explained individual consumer’s dietary requirements and preferences, and used dietary charts to ensure relevant information was shared with all staff.
* Dietary charts contained information about individual consumer’s dietary needs, allergies, meal texture requirements, supplements, individual meal choices and drinks and meal preferences.

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant, as three of the three specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, such as:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff at the service.
* Review of the maintenance and cleaning logs.
* The service’s policies and procedures.
* Observations during the site audit.

Overall, sampled consumers advised that the service environment felt like home, and that it was welcoming, easy to understand and navigate, safe and comfortable. The service was observed to optimise each consumer’s sense of belonging, independence, interaction and function, for example:

* Consumers’ rooms were personalised, for example with furniture, photographs and artwork.
* The service environment reflected dementia enabling principles of design, and safe freedom of movement both indoors and outdoors.
* Communal indoor and outdoor areas had wide, flat pathways, and consumers were observed to move about the service freely.

Management advised that they knew consumers and their visitors felt welcomed, and at home in the service through the monitoring of written and verbal feedback, and surveys. The overall service environment was observed to be clean and well maintained, and consumers moved freely about. Review of the service’s preventative maintenance program and maintenance log confirmed that the service environment, including furniture, fittings, and equipment was safe, clean and maintained regularly. Staff demonstrated an understanding of how they would deal with a safety issue or hazard, to ensure consumers were safe.

The Assessment Team observed that furniture, fittings and equipment were safe, clean and well maintained. Sampled consumers and representative confirmed that furniture, fittings and equipment were clean, well maintained and suitable for the consumer. Staff could describe the storage, and cleaning processes for shared equipment, and daily cleaning tasks required for furniture, fittings and other equipment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant, as four of the four specific requirements have been assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of care planning documentation.
* The service’s policies, procedures and guidance materials.
* Observations during the site audit.
* Review of the service’s feedback and complaints register.
* Review of meeting minutes.

The service’s written response to the site audit included evidence such as:

* Information relating to the service’s staff orientation pack.
* A copy of the service’s training course attendee sheet, covering topics such as:
  + open disclosure
  + dignity and respect
  + complaints diversity
  + charter of rights
  + mission and values
  + procedures and forms.
* The service’s employee handbook, covering the topic of open disclosure, and records of staff whom had reviewed the handbook.
* Copy of complaints register, including outcome of 2 complaints noted by the Assessment Team.

The Assessment Team recommended Requirement 6(3)(c) as non-compliant. However, having considered the evidence from the site audit report and the service’s response, I have determined Requirement 6(3)(c) compliant, as discussed under ‘Assessment of Standard 6 Requirements’.

Sampled consumers advised the Assessment Team that they felt supported to give feedback and make complaints. Based on the evidence presented by the Assessment Team and the service, overall, consumers and representatives were engaged in processes to address their feedback and complaints, with appropriate action taken. Consumers and representatives were aware of the advocacy services and other methods for raising and resolving complaints. Staff advised that if there was a consumer with culturally and linguistically diverse needs, they would support the consumer through interpreter services to lodge feedback and complaints. The Assessment Team observed information about consumer rights and advocacy pathways on noticeboards throughout the service, and in the service’s newsletter and resident handbooks.

In response to the Assessment Team’s finding of non-compliant for Requirement 6(3)(c) the service provided evidence that demonstrated appropriate action in response to complaints was taken, though an open disclosure process. Review of the service’s complaints register, provided as supporting evidence, confirmed that the 2 consumer examples noted by the Assessment Team were resolved to the consumer’s agreement.

The service demonstrated that it incorporated consumers’ feedback and complaints to improve the quality of care and services. For example, in response to consumers’ food related complaints and feedback the service employed a new chef, facilitated food forums to discuss consumers’ food preferences and needs, analysed complaints trends and conducted consumer surveys to monitor and track the progress of consumers’ meal satisfaction.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team recommended Requirement 6(3)(c) as non-compliant on the basis of feedback from consumer and representative interviews, review of the service’s complaints register and the purported absence of open disclosure training. Based on review of the service’s response, including supporting evidence, and findings presented by the Assessment Team, I have determined Requirement 6(3)(c) compliant. As discussed below, the service provided context to the Assessment Team’s findings, backed by evidence, which demonstrated that the service responded to complaints through an open disclosure process to resolve matters.

Consumer and representative feedback

Three consumers and representatives advised the Assessment Team they did not consider their feedback was taken on board concerning food.

In relation to the first named consumer, the service advised that the consumer had not previously provided feedback to the service about their bedding preferences, and have addressed the consumer’s feedback following the site audit. The first consumer also noted feedback about the lack of follow through regarding feedback and suggestions regarding the food focus group, however, advised they had no criticism about the food.

In relation to the second named consumer and representative, the service provided supporting evidence, such as meeting minutes, care plan records which demonstrated feedback about small food portions was addressed in a manner agreeable to the consumer and representative. The supporting evidence substantiated that an open disclosure process was utilised to resolve the matter, and involved relevant persons such as the chef, care coordinator, consumer and their representative.

A third consumer advised the Assessment Team that they felt like they had not seen any change from the food focus meetings. In response, the service provided supporting evidence in way of food complaints data, consumer food surveys, meeting minute action items which demonstrated that food related complaints had decreased overtime. The service advised that they have addressed the consumer’s feedback following the site audit.

Complaints scenarios discussed with the service

To test the service’s understanding of the open disclosure and complaints resolution process, the Assessment Team asked about 2 complaints lodged by consumers in relation to call bells. The Assessment Team considered that the service could not demonstrate an outcome of the complaints.

In response, the service provided additional context about the complaints and circumstances. A new staff member had responded to call bell alarms for 2 consumers during the same shift, turned off the alarms, and went to go get their shift buddy to help with two to one person body positioning transfers. The new staff member did not effectively communicate with the consumers and other staff about the support that was required. To address the consumers’ feedback, the service informed the consumers and the applicable staff member that the call bell would be left on until assistance was provided, to ensure care was delivered. Overall, it was noted consumers agreed with the outcome.

Open disclosure process

The Assessment Team questioned staff about their understanding of open disclosure and demonstrated that they understood the underlying purpose and process of open disclosure. However, the Assessment Team considered that the service could not demonstrate how, and when staff were trained about open disclosure. An internal audit from the service noted that it would be beneficial if the open disclosure process was more readily documented to demonstrate the process. The Assessment Team found that outcomes of complaints were not always documented, and did not demonstrate the application of open disclosure.

In response, the service clarified that the Assessment Team received a print out of the complaints register, however, did not include entire details relating to the complaints. As supporting evidence, the service provided a detailed report of the complaints in question, which demonstrated the application of open disclosure and noted outcome.

The service clarified that internal the audit noted by the Assessment Team, occurred in November 2020, in which the response was to add information and training about open disclosure in the staff orientation, resident and staff handbooks and in the clinical governance policy. The service also provided supporting evidence such as staff training records, employee handbook, which demonstrated staff had been educated about the open disclosure process.

In conjunction to the service’s response, I have also considered other evidence presented by the Assessment Team, that was supportive to the decision of compliance for Requirement 6(3)(c), such as:

* The service’s open disclosure policy provided guidance for staff to implement open disclosure against the service’s expectations and in line with the quality standards. The policy also provided information on how to identify indicators of systemic problems.
* As abovementioned, staff demonstrated an understanding of open disclosure in practice.
* The site audit reported noted an example that transpired during the site audit of a consumer complaint, and how the service used an open disclosure process to resolve the matter.

Based on the balance of evidence presented by the service and the Assessment Team, the service demonstrated that it implemented an open disclosure process to address complaints and feedback and is Compliant with this Requirement.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant, as one of the five specific requirements have been assessed as Non-compliant, informed by the evidence from the Assessment Team, and the service’s written response:

The Assessment Team’s evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff and management at the service.
* Review of staff rosters, orientation program, training records and appraisal schedule.
* The service’s policies and procedures.
* Observations during the site audit.

The service’s written response to the site audit included evidence such as:

* Copy of the service’s call ball report.
* Continuous improvement plan actions and processes document.
* Relevant medical documentation and care plan records.
* The service’s employee handbook, covering the topic of open disclosure, and records of staff whom had reviewed the handbook.
* A copy of the service’s training course attendee sheet.
* Copy of the service’s performance review template – appraisal tool.

The Assessment Team recommended Requirement 7(3)(a), Requirement 7(3)(b), Requirement 7(3)(d) and Requirement 7(3)(e) as non-compliant. However, having considered the evidence from the site audit report and the service’s response, I have deemed Requirement 7(3)(e) non-compliant, and all other Requirements compliant, as discussed under ‘Assessment of Standard 7 Requirements’.

Overall, sampled consumers advised they received care and services from staff who are knowledgeable, capable and caring and felt confident that the workforce was appropriately staffed. Workforce interactions with consumers were observed to be kind, caring and gentle. The service demonstrated that they used an open disclosure process to address consumer and representative feedback, and to deliver care and services in a manner that respected each consumer’s identity, culture and diversity.

All staff interviewed reported that they understood their role, responsibilities and accountabilities at the service, and were supported to participate in development opportunities. Agency staff were required to complete staff orientation training, and all staff were required to hold up to date registration and appropriate qualifications. Agency staff and new starters were accompanied by a buddy staff member, until they have reached the required competency to work unsupervised. Staff were supported in their roles by the service’s policies, procedures and guidelines.

However, based on the evidence presented by Assessment Team and the service, not all staff members had received regular performance appraisals. Performance appraisal documentation reviewed by the Assessment Team demonstrated that these were conducted in a timeframe outside the service’s guideline and services.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

The Assessment Team recommended 7(3)(a) as non-compliant due to feedback about call bell response times, and feedback about the service’s continuous improvement plan, as detailed below. Based on the weight of evidence presented by the Assessment Team and the service, I have determined Requirement 7(3)(a) compliant, as the service demonstrated that it had a sufficient number and mix of staff to deliver safe and quality care and services.

Call bell times and consumer feedback

The Assessment Team reported that call bell records indicated that 125 call bells were attended to in over 10 minutes, with a majority between 20-40 minutes within a 3 day period. The Assessment Team considered that the lengthy wait times indicated there were insufficient staff available to provide quality and safe care and services.

In response, the service provided the call bell report reviewed by the Assessment Team, which demonstrated that a majority of call bells were answered within 0-5 minutes. As discussed under Standard 6, the service provided further context around the interpretation of call bell data. In regard to ‘presence indicators’ noted in the call bell report: a staff member would attend to the call bell, however the call bell would be left on when another staff member was required to assist with delivery of care, for example, two to one person transfers.

In addition, the site audit report noted feedback about a consumer’s call bell wait time, one representative stated, ‘That’s not a reflection of the staff, mum just won’t let them turn it off’. In response, the service clarified there was no fault with the call bell.

Based on the further information provided by the service, I have determined matters relating to call bell response times as compliant, as the service demonstrated it delivered safe and quality care and services.

Continuous improvement plan

The Assessment Team reviewed the service’s continuous improvement register, which recommended that junior staff should be supported to transition into senior clinical duties, allowing for the leadership to focus on clinical and governance outcomes, with leadership being called onto the floor to assist with care provision.

In response, the service provided further context around its continuous improvement plan and its mentorship initiatives. The service advised that it worked within a service delivery model that included members of the leadership team mentoring clinical staff, and being part of the clinical team, hence why leadership assisted with care provision. The service advised that it had a new graduate program and career pathway for staff to progress in their clinical career, which aligned with staff feedback in the site audit report about career progression and job upskilling.

Based on the further information provided by the service, I have determined matters relating to the service’s continuous improvement plan and care delivery as compliant. The service demonstrated that leadership was involved in the care and service delivery, from a mentorship perspective, and not as an indicator of a gap in staffing levels.

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

The Assessment Team recommended Requirement 7(3)(b) as non-compliant, due to feedback from 3 named consumers. With consideration to the balance of evidence presented by the Assessment Team and the service, I have determined Requirement 7(3)(b) as compliant. Overall, the service demonstrated that workforce interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity.

In regard to the first named consumer, their representative provided feedback that the consumer did not like that staff were sometimes present when showering. The service provided context around the consumer’s care needs; as verified by review of supporting documentation, the consumer required physical assistance when showering due to their medical condition and mobility. As noted in the site audit report, the representative advised that overall the care, respect and treatment of the consumer was appropriate, and as stated, the consumer was happy.

Regarding the second and third named consumers, feedback was overall complimentary. However, one noted sometimes staff did not understand them, and another advised that sometimes staff forgot to shut their door at night.

Feedback regarding the closing of a consumer’s door at night, and communication barriers is acknowledged. However, given that the evidence on the whole demonstrated that interactions with consumers were kind, caring and respectful I have determined Requirement 7(3)(b) complaint. I also considered other findings presented by the Assessment Team in support of the determination of Requirement 7(3)(b) as compliant, such as:

* Observations of staff interactions with consumers were caring and respectful, and demonstrated understanding of each consumer’s individual needs and preferences.
* Staff education records demonstrated that staff were trained to provide kind and respectful and care and services, with consideration to each consumer’s identity, culture and diversity.
* Staff demonstrated knowledge of each consumer’s individual needs and preferences.

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team recommended Requirement 7(3)(d) non-compliant, as there was a purported lack evidence for training in open disclosure, which was identified in the service’s internal audit.

The service clarified that internal the audit noted by the Assessment Team, occurred in November 2020, in which the response was to add information and training about open disclosure in the staff orientation, resident and staff handbooks and in the clinical governance policy. The service provided supporting evidence such as staff training records, employee handbook, which demonstrated staff had been educated about the open disclosure process. Given that the recommendation of non-compliance was based on the purported lack of open disclosure training, and the service has provided evidence of the open disclosure training, I have determined Requirement 7(3)(d) compliant.

However, I acknowledge the Assessment Team’s feedback regarding overdue training, and considered this evidence under Requirement 7(3)(e).

### Requirement 7(3)(e) Non-compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

During the site audit, it was identified that staff performance appraisals were overdue, in addition to staff training, therefore the Assessment Team recommended Requirement 7(3)(e) as non-complaint. Staff interviews and review of documentation confirmed that staff performance appraisals were overdue, which was not in line with the service’s guidelines.

In its written response the service explained that not all performance appraisals had been completed due to COVID-19 related delays. The service’s response did not demonstrate that all performance appraisals were completed after the site audit. Given that the service, could not demonstrate that regular assessment, monitoring and review of each member was undertaken, due to the outstanding appraisals and staff training, I have determined Requirement 7(3)(e) non-compliant.

I acknowledge the service provided on the job training and feedback to staff. However, as an area for improvement, the service was unable to demonstrate how it formally monitored and reviewed staff performance in practice, and assessment of staff competency against training modules.

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant, as five of the five specific requirements were assessed as Compliant, informed by the evidence from the Assessment Team, and the service’s response to the site audit report.

The Assessment Team evidence included:

* Interviews with a sample proportion of consumers and their representatives at the service.
* Interviews with staff, management and board members at the service.
* Observations during the site audit.
* Review of staff rosters, training records and performance appraisals.
* Review of care planning documentation, including risk assessments and consent forms where applicable.
* Risk management systems and documented risk management framework.
* Draft clinical governance framework and policies relating to antimicrobial stewardship, minimisation of restraint and open disclosure.

The service’s written response to the site audit included evidence such as:

* Finalised copy of the clinical governance framework.
* Clinical governance policy and infographics.
* A copy of the psychotropic medication register.
* Applicable staff training documentation.

The Assessment Team recommended Requirement 8(3)(c), Requirement 8(3)(d) and Requirement 8(3)(e) as non-compliant. However, having considered the evidence from the site audit report and the service’s response, I decided the service is compliant with all Requirements, as discussed under ‘Assessment of Standard 8 Requirements’.

Overall, sampled consumers and their representatives reported the service was well run, and their input was used to improve care and service delivery. The service demonstrated that its governing body promoted a culture of safe, inclusive, quality care and services accountable for its delivery through interviews with management, staff and review of the service’s documentation.

Based on the totality of evidence presented by the Assessment Team and the service, the service demonstrated it had effective organisation wide governance systems. The service demonstrated its risk management systems accounted for the management of high impact risks associated with care, identified and responded to abuse and neglect, managed and prevented incidents, and used its incident management system accordingly to report matters to the Serious Incident Response Scheme. The service demonstrated that it had a documented clinical governance framework in place, relating to antimicrobial stewardship, minimisation of the use of restraint and open disclosure.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

The Assessment Team recommended Requirement 8(3)(c) non-compliant due to issues in the following areas:

* Requirement 8(3)(c)(i) information management.
* Requirement 8(3)(c)(iv) workforce governance.

However, based on the totality of evidence presented by the Assessment Team and the service, I have determined Requirement 8(3)(c) compliant, as specified below:

Information management

The Assessment Team recommended the service’s information management governance system as non-compliant due to purported information gaps in consumers’ care plan documentation, as detailed in full in this report, under Requirement 2(3)(a), Requirement 3(3)(a), Requirement 3(3)(b) and Requirement 3(3)(e).

The Assessment Team also recommended the service’s information management governance system as non-compliant, due to a lack of information relating to open disclosure as covered under Requirement 6(3)(c) and Requirement 7(3)(d).

Based on the service’s written response and supporting evidence, which clarified the points raised under the other applicable requirements, I decided Requirement 8(3)(c)(i) is compliant. With due consideration to the balance of evidence, overall, the service demonstrated that it had effective governance systems for information management.

I have considered the Assessment Team’s feedback regarding the service’s clinical governance framework, as appropriate, under Requirement 8(3)(e).

I have also considered other findings presented by the Assessment Team, which demonstrated that the service had effective governance systems for information management, such as:

* Sampled staff advised that they could access the information they needed through the service’s electronic management system and the service’s intranet, such as consumer care plans, policies, procedures and online training relevant to their role.
* Staff were provided personal communication devices during their shift to allow for effective communication between staff, for example, to request assistance.
* QR codes were located on consumers’ doors to allow staff to record care information onto the electronic system in an efficient manner.

Workforce governance; including the assignment of clear responsibilities and accountability

The Assessment Team deemed that the service’s workforce governance was non-compliant, with due consideration as to whether staff were appropriately trained, based on some consumer feedback about their individual care and services preferences. The Assessment Team also considered that leadership staff that assisted in the delivery of care and services may have indicated a gap in staffing levels.

As detailed in full under Requirement 3(3)(a), the service provided supporting evidence which provided further context to the consumers’ care and services feedback. Based on the additional information, and low risk presented I have determined the consumers’ feedback, in relation to workforce governance, including the assignment of clear responsibilities and accountability as not indictive of non-compliance in of itself.

As covered under Requirement 7(3)(a), the service explained that leadership staff offered assistance for other staff as a mentorship initiative, rather than an indicator of inadequate staffing levels or performance of activities beyond managerial roles.

Based on review of the examples presented under Requirement 3(3)(a) and Requirement 7(3)(a), I have determined that the service demonstrated compliance through effective management of workforce governance, including the assignment of clear responsibilities and accountability.

Other matters

The service demonstrated effective governance systems in relation to other matters covered under Requirement 8(3)(c):

The service demonstrated that it identified opportunities for continuous improvement from various avenues such as consumer feedback, consumer forums, surveys, internal audits and data. For example, in response to consumer feedback, the service purchased exercise equipment to allow for physiotherapists to conduct exercise activities with consumers. Meeting minutes verified that continuous improvement was consistently discussed during meetings with the leadership team, board and chief executive officer.

The service reported that it ran financial reports against the budget every month, as well as prior to the service’s board meeting, to ensure that any additional expense requests or issues were raised with the board. The service advised that its financial committee meets on an annual basis to review financial audits and submit the budget.

Job responsibilities and accountabilities for the leadership team and staff were set out in position descriptions. Staff were required to have a current police certificate and registration as applicable to comply with the requirements of their role, which was validated by the Assessment Team.

The service demonstrated how it tracked changes to legislation, and communicated updates to staff to meet regulatory compliance through evidence, such as:

* The service’s implementation of the Serious Incident Response Scheme.
* The service’s implementation of behaviour support plan requirements under restrictive practices.
* COVID-19 vaccinations for consumers and staff.

The service’s feedback and complaints governance system demonstrated that it effectively supported consumers and representatives to lodge feedback and complaints, and that data and trends were discussed during the monthly board meeting to identify areas for improvement.

Therefore, having considered the available evidence presented by the Assessment Team and the service, I decided the service is compliant with Requirement 8(3)(c).

### Requirement 8(3)(d) Compliant

*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.*

The Assessment Team claimed that risk assessments were not completed for some consumers, indicative that consumers were not supported to take risks to live their best life. However, the specific examples noted by the Assessment Team were addressed by the service, which demonstrated consumers were supported to take risks, by way of assessment, to live their best life – as detailed under Requirement 1(3)(d), Requirement 3(3)(b) and Requirement 2(3)(a) of this report. The Assessment Team also considered that there was no evidence of a system that monitored psychotropic medications with applicable diagnosis, indicative that the service was unable to manage risks. However, as covered under Requirement 3(3)(a), the service provided supporting evidence, such as its psychotropic register, which included relevant information to manage risks, including consumers’ diagnosis.

Based on the supporting evidence supplied by the service, which addressed matters raised by the Assessment Team, I decided Requirement 8(3)(d) is compliant.

I have also considered other evidence presented by the Assessment Team, that demonstrated the service had effective risk management systems to manage high impact risks associated with care of consumers, identifying and responding to abuse and neglect, supporting consumers to live their best life and managing and preventing incidents, such as:

* The service’s risk management system and framework, which identified risk by level and impact, organisational and governance risks, workforce risks, consumer risks and environmental risks.
* Risk was documented by likelihood, consequence, priority ratings, current controls, residual risk and person responsible.
* Review of the service’s incident management system demonstrated incidents were documented, with evidence of referral to relevant parties, such as representatives, medical professionals, and notification to the Serious Incident Response Scheme.

### Requirement 8(3)(e) Compliant

*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.*

During the site audit it was identified that the service had commenced work on draft documentation for its clinical governance framework, as a result of an internal audit dated January 2022. The service advised that the clinical governance framework had been added to its continuous improvement plan, and that staff had access to policies, guidance, processes and procedures relating to clinical care. The Assessment Team reviewed the draft version of the clinical governance framework, and policies relating to antimicrobial stewardship, minimising the use of restraint and open disclosure. As the service did not have a clinical governance framework that was finalised and approved by the board, the Assessment Team recommended Requirement 8(3)(e) as non-compliant.

In its written response, the service advised that it worked to a clinical governance framework, and that staff were guided by the policies, processes and procedures as reviewed by the Assessment Team. The service explained that it had attended an aged care industry meeting about the Aged Care Standards before the site audit and identified that it needed to expand upon its policies, procedures and guidance documents to provide staff more in depth documentation. The service provided an endorsed copy of its clinical governance framework, that covered the topics of antimicrobial stewardship, minimising the use of restraint and open disclosure.

Based on the weight of evidence presented by the Assessment Team and the service, I have determined Requirement 8(3)(e) compliant. It is acknowledged that the service did not have an endorsed clinical governance framework document in place at the time of the site audit. However, as evidenced from the finding of compliance under Standard 3, there was low consumer risk identified; indicative that the service implemented effective clinical care in its day to day practice, and that staff worked to a clinical governance framework that was informed by cumulative guidance from the service’s policies, processes, procedures and staff training.

Given that the non-compliant finding was based on the absence of an approved clinical governance document, rather than the lack of a clinical governance framework, and there was limited correlation to absence of the document and adverse clinical outcomes, Requirement 8(3)(e) is deemed complaint.

I have also considered other findings presented by the Assessment Team, which demonstrated that the service had an effective framework in place that guided clinical care, such as:

* The Assessment Team reviewed policy documentation that provided guidance on how the service should achieve safe, quality clinical care and outcomes for each consumer. The documentation also included information about how other topics intersect with the delivery of clinical care, such as: leadership and culture, consumer partnerships, organisational systems, monitoring and reporting, effective workforce, communication and relationships.
* Staff were able to explain what the service’s policies meant to them in a practical way. For example, staff demonstrated knowledge of restrictive practices, how restrictive practice can impact on consumer well-being and the different types of restrictive practice.
* Staff were able to explain what the open disclosure process meant to them and how they implemented it in the delivery of care and services.
* The service had policies and procedures to support the minimisation of infection related risks through infection control principles and promotion of antimicrobial stewardship. The service demonstrated that it applied its policies and procedures in practice, based on evidence provided in response to previous infectious disease outbreaks at the service.
* Staff demonstrated awareness of the implications of antibiotic resistance, and practices to promote appropriate antibiotic prescribing which aligned with the service’s infection control and antimicrobial stewardship policies.

# 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.

* As detailed under Standard 7, Requirement 7(3)(e), the service was unable to demonstrate how regular assessment, monitoring and review of the performance of each member of the workforce is undertaken, as a result of outstanding staff performance appraisals and training.