Blue Care Toogoolawah Alkira Aged Care Facility

Performance Report

2 Charles Street   
TOOGOOLAWAH QLD 4313  
Phone number: 07 5423 4200

**Commission ID:** 5150

**Provider name:** The Uniting Church in Australia Property Trust (Q.)

**Site Audit date:** 23 February 2022 to 25 February 2022

**Date of Performance Report:** 28 April 2022

# Performance report prepared by

Alice Redden, 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** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Non-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** | **Non-compliant** |
| Requirement 6(3)(a) | Non-compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Non-compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-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; 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 23 March 2022.

# 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.

Consumers and their representatives interviewed confirmed consumers are treated with dignity and respect and are made to feel valued as individuals. Consumers confirmed staff know their preferences, respect their choices and know their backgrounds and cultural needs. Consumers confirmed they are supported to maintain relationships and people important to them are involved in their decisions. Consumers confirmed they are supported to live their best life, even where risks are involved. Consumers are satisfied with the information they receive. However, two consumers stated one staff member can be rude, this issue has been relevantly addressed in Standard 7.

The service has a system supported by policies and procedures to support, identify, assess, document and communicate consumers’ choices, cultural and unique histories and preferences, privacy and information in relation to care and service delivery. Care plans reflect consumers individual life histories and cultural preferences including religious and language needs. Consumer files record others involved in decision making for the consumer. The service assesses and supports consumers to undertake activities involving risk where the consumer chooses. The service has a variety of ways, including verbally, newsletters, noticeboards, meetings and written material to communicate information to consumers and their representatives to support choice and decision making.

Staff interviewed provided examples of individual consumer’s cultural and individual preferences and choices and how they support them. Management provided examples of strategies in place to support consumer privacy, dignity and information. Staff interviewed confirmed strategies used to support consumers who choose to undertake activities involving risk. Staff and management provided examples of sharing and communicating information to consumers to support consumer choice and decision making. Staff were observed treating consumers respectfully and supporting consumer dignity.

## 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.*

### 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 NON-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 Non-compliant as three of the five specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), (3)(b) and (3)(e). Reasons for the finding are detailed in the relevant Requirements below.

Most consumers and representatives considered they are involved in assessment and planning and confirmed their awareness of the consumer’s care plan and could request access to it if needed.

Care planning documentation evidenced consumer and representative involvement in consumer care planning and assessment, for example in risk assessment discussions and consultation about the use of restraints. Sampled care plans demonstrated the outcomes of assessments and planning are generally made available to those involved in consumer care.

Staff interviews confirmed the process of referring consumers to other individuals, such as allied health professionals and outlined the process used to ensure changes made by external providers are communicated to staff. Management outlined the assessment process when a new consumer enters the service, and how the results of assessment and planning are communicated to others involved in care.

The service has a suite of policies and procedures which outline requirements for consumer and representative partnership in assessment and planning. Progress notes and care planning documentation indicated staff generally adhere to organisational requirements.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-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.*

The Assessment Team found the service does not consistently complete assessments and plans in line with consumers’ needs including consideration of risks to ensure care plans inform the delivery of safe and effective care and services. Relevant evidence included:

* At the beginning of the audit, five consumers did not have care plans accessible on the care planning system, to inform the delivery of safe and effective care. Some of the five consumers had transitioned into permanent care, after entering initially as respite consumers. When the five care plans were made available to the Assessment Team, they found that several assessments that should have been completed according the service’s ‘admission checklist’, were missing.
* One of the five consumers had been assessed as needing support with management of their stoma and indwelling catheter, however their care plan had been amended to note they were self-managing those aspects of care. There was no supporting assessment of the consumer’s capacity to do so. Furthermore, the consumer advised that they do not self-manage those aspects of care and required a hospital visit to change the catheter and support to empty the bag and manage the stoma. The consumer’s care plan was also inaccurate in relation to food and dietary preferences, some assessments were missing or had been incorrectly archived whilst some assessment information was input into the system long after the care conferences had occurred.
* Referrals to the physiotherapist were sometimes not made in a timely manner. An improvement action about the issue was included the service’s continuous improvement plan (CIP), however the planned actions had not occurred by their due date.
* The Residential Services Manager (RSM) was also acting as care coordinator, clinical staff and lifestyle staff at the time of the audit.

Other evidence put forth by the Assessment Team was not relevant to my decision and as result, has not been outlined here.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and outlined the actions that have been implemented to address the deficiencies. Actions taken to date include the introduction of additional clinical support and oversight of senior clinicians at the service, employment of a floating RSM, placement of experienced aged care nurses at the service and the temporary ceasing of all new admissions. A schedule of clinical monitoring has commenced, to be performed by onsite and offsite clinicians to improve oversight and maintain appropriate governance.

The response also outlined that consumers whose care plans were incomplete at the time of audit have had their care plans and assessments completed and updated where possible and a review of all consumer care plans and assessments has commenced. Staff education is planned to ensure the organisation’s assessment and planning procedure for new admissions is understood, and timely assessment and planning occurs. Lastly, the response confirmed that the service’s CIP has been reviewed and brought up to date with planned improvements.

The response also outlined other clarifying information relating to availability of staff for interview during the Site Audit. I acknowledge the information provided and in reaching my decision, have not considered those examples provided by the Assessment Team.

### I acknowledge the numerous actions taken to address the deficits identified by the Assessment Team. However, at the time of site audit, the service did not ensure that the documented ‘admission checklist’ was followed and relevant baseline assessments completed for each consumer entering the service. As a result, the service did not ensure that assessment and planning informed service delivery for those consumers. By failing to ensure timely referrals to the physiotherapist, the service also failed to ensure that assessment and planning addressed risks to consumers, including risks emanating from falls or lack of mobility and/or balance.

### The service also did not take into consideration risks relating to one consumer’s complex continence care, by failing to ensure the planning documentation accurately documented their need for support with their catheter and colostomy bag. The service’s monitoring systems were not effective at identifying the deficits in assessment and planning.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### Requirement 2(3)(b) Non-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.*

The Assessment Team found that although the service has relevant policies and procedures in place to guide assessment and planning, which staff understood, not all care plans contained the current and accurate needs, goals and preferences of sampled consumers. Some plans had outdated information, were missing assessments or had specified care needs that were not being provided. Relevant (summarised) evidence put forth by the Assessment Team included:

* Four consumers did not have advanced care plans or EOL care plans in place and had not been referred to the external advanced care planners used by the service.
* Four consumers had calls bells that did not work, though it was noted that these consumers were unable to use bells in any case. Three of the four consumers’ care plans had been recently reviewed and all had falls prevention or mobility plans which specified their call bells “should always be within reach.”
* A consumer had outdated information in their diabetes management plan.
* A consumer’s weight loss and deterioration were not identified as risks in their care plan.
* The service’s CIP contained an overdue action plan to address deficiencies in the service’s assessment and planning process and it noted that consumers’ current needs were not being identified or met in a timely manner.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and outlined the actions that have been implemented to address the deficits. Actions taken, or commenced, since the Site Audit include the previously outlined review of all consumer care plans and assessments for accuracy, completeness and to ensure any referrals to external services have been completed. The service has also repaired the call bell system; however, the Approved Provider reiterated that consumers whose bells did not work were not able to use and so were being more closely monitored by staff. The response noted the service is introducing call bell monitoring to ensure future maintenance issues are addressed in a timely manner.

I acknowledge the actions being taken to address the deficits identified by the Assessment Team, by reviewing all consumer files and by introducing call bell monitoring. However, at the time of Site Audit, the service’s assessment and planning did not identify and address the current needs, goals and preferences of those consumers without advanced care planning or end of life plans in place. By not attending to end of life or advanced care planning in a timely manner, consumers might not have the end of life experience they want.

Additionally, by failing to accurately record consumer’s inability to use their call bells, the service’s planning documentation did not reflect the consumers’ actual capacity to summon support or attention from staff. Another consumer’s current diabetes management requirements, and risks related to a further consumer’s weight loss and deterioration, were not reflected in care planning documentation, representing further failures to effectively communicate consumers’ current needs to those delivering the care. In reaching my finding, I have also considered inaccuracies in care planning documentation relating to complex continence care, outlined in Requirement 2(3)(a) above.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### 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) Non-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.*

The Assessment Team found the service did not always complete the scheduled 3 monthly review of consumer care plans and that reviews did not always occur in response to consumer incidents or changes in circumstance. Relevant (summarised) evidence put forth by the Assessment Team included:

* A sampled consumer had several assessments that had not been reviewed as scheduled. The consumer’s elimination assessment was last reviewed in August 2021 and noted they self-managed their continence aids with stand by supervision, however recent progress notes showed the consumer now required more assistance with changing continence aids and other activities of daily living. The same consumer’s significant weight loss and deterioration had not resulted in review of their eating and drinking assessment.
* Another consumer’s weight loss and deterioration did not trigger a review of their eating and drinking assessment, which had also not been reviewed according to schedule.
* The Assessment Team also cited evidence, previously outlined in Requirement 2(3)(b), that several consumers had inactive call bells they lacked the dexterity or cognition to be able to use, however their falls assessment and/or mobility plans specified that the bells be kept within reach as a safety measure.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and outlined several improvement actions including updated eating and drinking assessments completed for the consumers identified in the site audit report. Weekly weight recording, and food and fluid charting has also been commenced and referrals to dieticians have been actioned or are planned for those two consumers.

The response also outlined other improvements to the management of weight loss generally at the service, including a process to alert Medical Officers when a consumer has lost weight, to ensure review occurs. All resident weights have been reviewed and referrals, supplementation and other forms of support have been actioned as needed. Lastly, the Approved Provider gave an undertaking that staff education would occur, to ensure staff monitor and manage consumer weight fluctuations in accordance with organisational policy and procedure.

I acknowledge the corrective actions planned and taken to date, to ensure consumer care plans and assessments are reviewed regularly and in response to changes in consumer condition and deterioration. I also note the improvements in weight loss management processes at the service. However, at the time of the Site Audit the service did not ensure consumers’ assessments and plans were regularly reviewed for effectiveness and accuracy. The service also did not ensure care plans were reviewed in response to changes and deterioration in consumer condition. Consumer assessments and plans were not completed and updated consistently or appropriately, or in accordance with organisational procedures. Strategies for meeting consumer needs and managing consumer risk were not being reviewed for effectiveness and newer, more suitable strategies were not being identified. The service’s monitoring systems did not identify that regular scheduled and reactive care plan reviews were not occurring, as required.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

# STANDARD 3 NON-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 Non-compliant as three of the seven specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), (3)(b) and (3)(f). Reasons for the finding are detailed in the relevant Requirements below.

Consumers and representatives expressed confidence in the service’s ability to provide appropriate end of life care to consumers. They considered the service would support them to be as pain free as possible and with the people important to them. Consumers said the service is generally responsive to their needs and staff know what their care needs are. Sampled consumers, representatives and staff were confident in the service’s infection prevention and control mechanisms and the precautions taken against COVID-19.

Care planning documentation review showed that some consumers had advanced health directives and/or end of life plans in place and generally showed the service identifies and responds to deterioration or changes in consumer condition. Progress notes confirmed the service engages consumers, representatives and others in consumer care and information is shared with those others when required.

Staff demonstrated they understood how to find information about consumers’ end of life preferences and how they monitor and respond to deteriorations in consumer condition. Staff understood how information is shared between those involved in consumer care, including information sharing processes between the local hospital and the service.

Other observations and document review noted the service has policies and procedures that guide staff practice in relation to end of life care, pain management and comfort care. Organisational policies and procedures also exist to guide the conduct of assessments, care planning, clinical deterioration and handover processes. The Assessment Team observed satisfactory infection prevention and control practices at the service, including staff maintaining social distancing, appropriate use of PPE and sufficient hand sanitation stations throughout the service.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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.*

The Assessment Team’s review of care plans showed not all consumers receive best practice personal and clinical care that is tailored and optimising of their health and wellbeing. Relevant (summarised) evidence put forth by the Assessment Team included:

* Consumers A and B live with diabetes and did not have their blood glucose levels (BGLs) monitored as frequently as required. Consumer’s A electronic care plan was inaccurate, and management had an incorrect understanding of how frequently checks should occur. The consumer had low blood sugar events in recent months that required treatment and monitoring.
* Consumer B and Consumer C required staff assistance with eating and drinking and personal care tasks, respectively. The Assessment Team observed Consumer B eating slowly and unassisted in a regency chair at meal time, while Consumer C advised assessors they had not had support for showering in more than two months.
* The service’s psychotropic medication register was revised during the site audit, with the number of chemically restrained consumers reduced from 3, to none.
* An allied health professional reported care staff do not monitor repositioning at the service and appeared not to be providing daily pain massage as required for some consumers. When interviewed, care staff did not have a shared understanding of how to monitor and record repositioning.
* The service did not have a wound management policy and procedure which stipulates when to measure or photograph wounds, or how often wound reviews should occur. These decisions are based on Register Nurses’ clinical judgement.
* Consumers D and E had pressure injuries and review of care planning documentation identified multiple deficiencies in the management, review and charting of their wounds, including no depth, length and width measurements. Their wounds were not being reviewed according to the review dates nominated by RNs, with reviews and dressings occurring up to a week late. The consumers required regular repositioning, however there was no repositioning charts and no evidence repositioning regularly occurred. Consumer E’s wound had to a Stage 3 pressure injury with full thickness skin loss between October 2021 and January 2022, but the consumer had not been referred to a wound specialist.
* A monthly clinical monitoring report for January 2022 incorrectly stated there were no consumers with pressure injuries in the identified month.
* The Assessment Team identified deficiencies in pain management, including for Consumer D, who was palliative and received pain medication through a syringe driver. The consumer had experienced a blockage in their infusion line, and their analgesia was eight hours behind when it was discovered, indicating the tubing had not been checked as frequently as required. The consumer’s pain chart was largely incomplete. A Serious Incident Reporting Scheme (SIRS) report was lodged regarding the incident.
* Consumer F complained of new pain in their groin and had an imaging request made by the Medical Officer in a review six days prior to Site Audit. The referral had not progressed as the service had not booked an ambulance to transport the consumer.
* The service’s CIP contained overdue improvement action plans relating to the above, and other related, deficiencies.

The Approved Provider’s response acknowledged the deficits identified by the Assessment Team and outlined several improvement actions to address the deficiencies. In relation to diabetes management, actions taken or commenced since the site audit include the review and updating of diabetes management plans for Consumer A and commencing BGL charting and offsite clinical monitoring for Consumers A and B. In relation to personal care, the response outlined the service has completed workplace observations to confirm Consumer B is now receiving support with eating and drinking and has apologised to Consumer C for the inconsistent hygiene support and updated their care plan.

The response described numerous actions taken to address the deficits in skin integrity and wound care identified by the Assessment Team, including specialist review of Consumer E and D’s pressure wounds. Improvement actions have also been planned or taken at the staff level, including, but not limited to, further staff training on repositioning and wound care, ongoing monitoring of repositioning and a review of all consumer care plans to identify consumers at high risk of pressure injuries. A wound specialist has been engaged and a local procedure for wound assessment, photography, documentation and review is being drafted.

In relation to pain management, the response confirmed Consumer F’s imaging referral has been actioned and outlined improvement actions taken to address system level deficits including, but not limited to, pain charts and syringe driver observations checks being implemented, monitoring of massage provision and education for staff on recognising, reporting, managing and documenting pain. The response also contained clarifying information about other evidence put forth by the Assessment Team. I acknowledge that information and have not considered the examples in my decision. Other information provided in the response has not been relevant to my decision and is not outlined here.

I acknowledge the many steps taken by the Approved Provider to address the deficits identified in relation to restrictive practices, wound and skin management, pain management, personal care provision and diabetes management. However, at the time of the Site Audit the service’s systems were not effective at ensuring each consumer receives clinical care that reflects best practice, is in line with their needs and which optimises each consumer’s wellbeing.

Two consumers with diabetes did not have their BGLs monitored as frequently as required, despite one of those consumers experiencing recent low blood sugar level events. Two consumers did not receive the personal care support they needed to bathe, eat and drink and a consumer receiving palliative care was without pain relief for eight hours when the tubing on their syringe driver was occluded and staff failed to identify this. The source of another consumer’s pain was not investigated in a timely manner. Skin integrity and wound care management procedures at the service were inadequate and wound assessment, documentation and care for two consumers with pressure injuries was not to standard. One consumer’s wound deteriorated significantly without review by a wound specialist. The service failed to rectify the issues, despite CIP items which identified the deficits.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### Requirement 3(3)(b) Non-compliant

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

The Assessment Team found the service did not effectively manage high impact or high prevalence risks associated with the care of several consumers. Relevant (summarised) evidence included:

Weight loss

* The service has not been properly managing risks associated with consumer weight loss, including Consumer F, who lost 15kg in 6 months and Consumer G, who lost 15 kg in 5 months. Neither consumer was referred to a dietician or nutritionist and there were no reviews of their nutrition risk and needs or their eating and drinking plans. The consumer’s food and fluid intakes were not monitored. Their Medical Officers were not informed of their weight loss.
* The service did not have a policy or procedure outlining when weight loss in a consumer should trigger a review or follow up action.
* The service’s CIP had overdue improvement items to address the fact there were identified consumers with unplanned weight loss who had not commenced supplements and others whose eating and drinking plans had not been reviewed in over 3 months. No actions had been recorded against those items.

Behaviour and mental health

* The service failed to properly manage risks associated with Consumer G’s challenging behaviours and overall mental health. Documentation review showed a recent referral to an older person’s acute mental health team who recommended the service contact a dementia support service for guidance on medication and non-pharmacological behavioural strategies to implement with the consumer. The service did not follow the recommendation and no other actions were taken to manage the consumer’s mental health and behaviour risks. A care staff member considered the consumer’s behaviour and cognitive skills had declined.
* The CIP listed an improvement item for consumers with major signs of depression, who had not had reviews of their spiritual care assessments or any relevant referrals. No actions had been recorded against those items.

### The Approved Provider’s response acknowledged the Assessment Team findings and included specific steps taken to address the deficits in weight loss management identified for Consumers F and G, which were previously outlined in Requirement 2(3)(b). The response also listed planned and implemented actions to address deficits in the management of challenging behaviours and mental health, including commencement of behaviour charting for Consumer G and use of behaviour support interventions. Other improvement actions planned or implemented include, but are not limited to, care plan reviews for consumers using a screening tool for depression in people living with dementia, staff training on recognising and responding to deterioration and clinical monitoring to ensure follow up of consumers displaying signs of deterioration.

I acknowledge steps taken by the service to rectify the deficits identified by the Assessment Team. However, at the time of Site Audit the service was not effectively managing the high impact and high prevalence risks associated with consumer care. Two consumers experienced sustained and significant weight loss over periods of five and six months, respectively. Neither consumer received referrals to medical officers, dieticians or nutritionists in response to the weight loss, although the issue had been identified by staff at the service. The service’s system, unsupported by any relevant procedure, was ineffective in identifying and responding to risks associated with consumer weight loss. The service also failed to follow up and implement the risk reducing measures specifically recommended by a specialist outpatient mental health unit and no alternative behaviour management strategies were implemented. The service failed to rectify the issues, despite CIP items which identified issues relating to weight loss and depression in the consumer cohort.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### 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.*

### Requirement 3(3)(f) Non-compliant

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

The Assessment Team found the service did not refer consumers to other individuals, organisations or providers of care and services in a timely manner. The Assessment Team found that consumers had deteriorated while not receiving appropriate referrals. Relevant (summarised) evidence put forth by the Assessment Team included:

* Review of care planning documentation showed that appropriate and timely referrals were not always made in response to consumer deterioration. The Assessment Team put forth consumer examples already outlined in previous Requirements, including:
  + Consumer E who was not referred to a wound specialist for their deteriorating pressure injury (refer to Requirement 3(3)(a)).
  + Consumers F and G who were not referred to a Medical Officer, dietician or nutritionist following significant weight loss and deterioration in mental health and behaviour.
  + The five consumers, identified in Requirement 2 (3)(b), who had not been referred to the external palliative care team for advanced health care planning.

In their response, the Approved Provider noted that consumer feedback for this Requirement was positive but acknowledged the need for improvements to address the deficits identified by the Assessment Team. The response outlined the steps already taken to address the deficits outlined above, which I have previously outlined in Requirements 2(3)(b), 2(3)(e) and 3(3)(a). Other relevant improvement actions have been outlined in relation to Requirements 2(3)(e) and 3(3)(a), and include, but are not limited to, renewed clinical monitoring, staff training on wound management and deterioration and the introduction of a weight loss work instruction for the service.

While I acknowledge the steps taken by the service to address the deficits identified during the Site Audit, I find the service did not ensure the identified consumers received the necessary referrals they needed to address significant weight loss, deteriorating behaviour and mental health and to address end of life and advanced care planning. Three consumers experienced identifiable deterioration in the time they were waiting for the necessary referrals to Medical Officers, dieticians or nutritionists and to a relevant dementia support service and five consumers end of life planning discussions were delayed. In reaching my decision, I have also considered the example of Consumer F (previously outlined in Requirement 3 (3)(a)), whose referral for imaging to investigate the source of new pain, was not actioned in a timely manner. I find that four consumers, overall, did not have referrals actioned in a timely manner.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

### 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.

Most consumers interviewed considered they are supported to do things they want to do, including participating in activities at the service and socialising with other consumers, however one representative considered lifestyle staff have difficulty catering to all consumers. Overall however, consumers considered their emotional, spiritual and psychological wellbeing is supported and described ways the service supports them to maintain their relationships external to the service and practice their faith. Consumers and representatives felt staff know consumers well, including the activities they like and dislike. Most consumers confirmed they enjoy the meals provided and their dietary needs and preferences are met. Consumer feedback indicated equipment is sometimes cleaned by staff.

The service has effective processes for identifying and documenting consumer preferences for daily living, with sampled care plans listing consumers’ preferred pass-times and stating how staff can support them to maintain their wellbeing. Care plans reflected consumers’ important relationships and contained lifestyle assessments which identified consumers’ current needs, goals and preferences for daily living. Consumer dietary requirements are recorded in consumer care plans and available to food services staff.

The service has a preventative and reactive maintenance system in place, with document review showing regular equipment maintenance occurs at the service.

## 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.*

### 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.

Consumers and their representatives interviewed confirmed the service is safe, clean, well maintained and that consumers can move about freely. Consumers confirmed the service environment is a nice place to live and is very welcoming. Consumers confirmed they have access to indoor and outdoor living areas which they utilise.

The Assessment Team observed consumers, including those using mobility aides, moving freely about the service, however due to heavy rain during the audit period, consumers were not observed in outdoor areas. The service had signage throughout the service to assist consumers in navigating the service and personalised bedroom doors to assist in recognition.

The service appeared generally clean and well maintained with furniture in the common areas being clean and in good condition. Consumers were observed using a range of aids and equipment, including walking frames, wheelchairs and regency chairs. The service has preventative maintenance programs in place, with external contractors used as needed. Staff understood how maintenance requests are made and maintenance logs and schedules confirmed timely action is taken in response to maintenance requests. Planned maintenance is regularly completed.

## 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 NON-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 Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), and (3)(c). Reasons for the findings are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement (3)(d) was not met. However, my finding differs from the recommendation and I find this Requirement to be Compliant. Reasons for the finding are detailed in the relevant Requirement below.

Sampled consumers did not remember being offered access to advocacy services or being informed of external complaints mechanisms, however information about the Commission and some well-known advocacy services was on display throughout the service. Staff were aware of referral processes for outside services, including advocacy services, however had not supported any consumers with the process. The admission pack also included information for consumers about internal and external complaints processes, translating and interpreting services and advocacy services.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Non-compliant

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

The Assessment Team found the service did not encourage or support consumers and others to make complaints or provide feedback. Relevant (summarised) evidence included:

* Consumer feedback demonstrated sampled consumers do not feel safe in raising concerns. For example, two consumers were concerned about ramifications of making complaints. A representative said their family member does ‘not want to bring things up’ with management.
* Consumers sampled were not confident action would be taken in response to feedback or complaints. One consumer considered that raising concerns with management was a ‘waste of time’ and a representative said that they had concerns about boredom in residents. The representative felt comfortable to raise their concerns but said they had not done so as they had been informed that lifestyle supports are minimal due to staff shortages.
* Management advised the Assessment Team that feedback can be provided via feedback forms (amongst other mechanisms) however the Team observed that there was no suggestion box on display in the service, preventing consumers and others from submitting anonymous complaints or feedback. Feedback forms had not been copied doubled-sided, so return address and reply-paid information was not included on the form.
* Other evidence relating to the capturing and recording of consumer and staff complaints and feedback are more relevant to Requirements 6(3)(c) and 6(3)(d) and have been considered under those Requirements.

In their response, the Approved Provider acknowledged the consumer feedback and outlined several actions taken to address the deficits identified, along with relevant supporting evidence. Relevant improvement actions outlined in the response included individual discussions with consumers and representatives to address the concerns outlined and to remind consumers of internal and external complaint avenues. The response included evidence that complaints, feedback and compliments lodged before and after the Site Audit have been entered into the service’s electronic feedback system. The service’s interim leadership team is maintaining visibility in the service to improve confidence in local management and properly copied feedback forms and suggestions boxes have been placed in accessible areas around the service. The service plans to provide education to staff on open disclosure and the organisation’s feedback and complaints organisational procedures. The Approved Provider also gave an undertaking to monitor the service’s feedback system closely to ensure it is used by the service.

I acknowledge the improvement actions implemented by the Approved Provider and welcome the undertaking to increase oversight of the service’s complaints handling. However, at the time of Site Audit, the service did not support consumers to provide feedback and make complaints. Consumers said they did not feel safe in making complaints and considered complaints would not result in any improvements to care and services. I find the service had barriers in place preventing consumers from making anonymous complaints, including the lack of an accessible suggestions box and the lack of a return address for feedback forms. I find this deprived consumers, representatives and others from making complaints anonymously, or simply at a time and in a manner, which suited them. Consequently, consumers were neither encouraged, nor supported to provide feedback and make complaints to the service. As a result, I find the service is Non-compliant with this Requirement.

### 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) Non-compliant

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

Although the service could demonstrate that an open disclosure process is used when things go wrong, the Assessment Team found the service did not record complaints and feedback from all sources in the electronic feedback system, according to organisational policy. As a result, the service could not demonstrate that appropriate action is consistently taken in response to complaints. Relevant (summarised) evidence included:

* The organisation’s feedback management framework contains a detailed user guide and set of instructions for complaint handling and a policy which emphasises blame free resolution of problems. Complaints and feedback handling at the service did not occur in line with the procedure.
* Management advised there was no complaints folder as the service had received only one complaint in the previous six months, via the organisation’s customer service centre. This complaint had been recorded along with follow up actions, but no others were recorded.
* The minutes from a recent staff meeting contained discussion of consumer complaints made to staff about toileting, lack of sensitivity in the provision of personal care, leaving pans and bottles in consumer rooms and consumers feeling pressured to finish their first course meal before receiving their second. The Assessment Team’s review of the electronic feedback system showed these complaints were not recorded.
* The service also could not demonstrate that complaints and feedback submitted through consumer surveys are captured in the electronic system and actioned.

In their response, the Approved Provider acknowledged the deficits identified by the Assessment Team and referred to the improvement actions previously outlined in relation to Requirement 6 (3)(a). The Approved Provider also gave undertakings to ensure feedback from all sources is entered into the service’s feedback system and to monitor the system closely to ensure it is used by the service.

I welcome the Approved Provider’s undertaking to provider greater oversight of the feedback and complaints handling at the service. I also acknowledge their commitment to provide further training for staff in the organisation’s feedback management system, and the steps they have taken to ensure all historical complaints from various sources have been entered into the feedback system and actioned appropriately. However, at the time of the Site Audit, evidence clearly demonstrated the service was not consistently recording consumer complaints and not gathering evidence of actions taken in response. While I note there was one complaint, with actions recorded, in the feedback register, the weight of evidence indicates other complaints, such as those recorded in staff meeting minutes, have been made, but there is no evidence of any actions taken in response. In reaching my finding, I have also considered consumer feedback evidence provided in other Requirements, which reflect lack of action in response to complaints at the service.

Based on the summarised evidence above, I find the service Non-compliant with this Requirement.

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

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

The Assessment Team found the service did not review complaints and feedback and use them to improve the quality of care and services delivered. Relevant (summarised) evidence included:

* Most sampled consumers and representatives could not provide examples of changes made at the service as a result of feedback and complaints.
* Management contended there had been only one complaint to enter into the feedback management system and as a result, they were not able to identify any complaint trends.
* Management was not able to be interviewed at the time of Site Audit, to provide direct feedback in relation to this requirement.
* The service has continuous improvement plans which list various issues identified through internal audits in November 2021 and January 2022. The items align with the Quality Standards and while 42 of 77 action items had no outcomes actioned at the time of site audit, most were assigned to the RSM who, as noted previously, was fulfilling multiple roles at the time of Site Audit.

The remaining evidence put forth by the Assessment Team indicated that continuous improvement actions had occurred in response to complaints and feedback made directly to staff and via the consumer meetings. Relevant (summarised) evidence included:

* A representative reported new pillows were purchased for consumers and raised garden beds were installed, both in response to feedback. The same representative said changes were made in response to issues raised at consumer meetings, though sometimes this did not occur quickly.
* A staff member referred to a garden patio being installed, to support consumers to maintain their gardens.
* A lifestyle staff member described seeking direct feedback on the activities schedule each fortnight and said they had run activities at different times in response to this feedback. The staff member noted they had also used surveys to gather feedback on the program.
* A hospitality staff member said that consumer food wastage showed consumers preferred savoury over sweet options for morning and afternoon tea. The menus were changed to include more savoury options and savoury supplies were placed in lodge kitchens.
* Consumer meeting minutes show food options are discussed, and a Food Focus group is planned. Food audits are conducted to seek consumer input to the menu.
* Review of consumer meeting minutes showed that consumer requests and preferences are actively canvassed and discussed. The meeting minutes evidenced an initiative, in response to feedback from consumer families, to move the purchasing of medication to a local pharmacy.

In their response, the Approved Provider referred to the improvement actions outlined in relation to other Requirements in this standard. I acknowledge the provider’s response and willingness to address the identified deficiencies. However, I also note the Assessment Team’s evidence in this Requirement reflects that despite the service failing to properly document and record all consumer complaints and subsequent continuous improvement actions, the service does have a continuous improvement process in place and staff are actively making changes in response to consumer feedback. The service has not adequately recorded and documented those efforts, however I consider this to be a function of staffing numbers and mix at the service, rather than relating to a lack of willingness to implement improvements in response to feedback. As a result, I have reached a different decision than the Assessment Team.

Issues relating to the recording and capturing of complaints and feedback have already been assessed in relation to Requirement 6(3)(c), where it is more relevant. I consider there is evidence in this Requirement, and others, which demonstrates complaints and feedback are used to improve quality of care, to the extent staff can do so within the limits of their roles. The effectiveness of the feedback and complaints governance arrangements and the impact of staffing numbers and mix on feedback and complaint handling, will be addressed in Standards 7 and 8 below.

Based on the evidence and reasoning summarised above, I find the service is Compliant with this Requirement.

# 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 three of the five specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(a), (3)(b) and (3)(e). Reasons for the findings are detailed in the relevant Requirements below.

Consumers and representatives considered staff are effective in their roles and have the skills they need to deliver care and services.

Staff described the corporate orientation to the service and the onsite training and buddy support provided to new employees. Position descriptions for the service show core competencies and requirements for roles, including essential qualifications, registrations, skills and worker screening checks. Staff confirmed they are provided with sufficient training in relation to mandatory and additional topics such as elder abuse reporting, fire safety and food safety. Staff training modules were largely complete, though some deficits in the content of training modules was noted. Additional staff training needs had been identified by the service and included in a continuous action plan.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-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 found the workforce at the service is not planned to enable, and the service did not have a number and mix of staff deployed to facilitate, the delivery and management of safe and quality care and services. Relevant (summarised) evidence included:

* At the time of site audit, the RSM had been filling the Clinical Coordinator position since November 2021 and was completing RN and care staff shifts to fill unplanned leave shifts. The RSM was also acting as the site IPC lead while the assigned staff member was on planned leave.
* A staff member considered the RSM position does not receive adequate support from the wider organisation.

Consumers and representatives

* Most consumers considered the service is short-staffed and said this leads to poor consumer outcomes. For example, one consumer described having a fall after care staff assisted them to the toilet but then left to assist another consumer. Another consumer described waiting up to an hour for medication and hearing other consumers repeatedly calling out for help until they received assistance.

Staff

* Interviewed staff said that there are either not enough staff, or that existing staff did not want to work afternoon shifts.
* One care staff member said they were not able to complete two-person assisted transfers when there is no second staff member available.
* A staff member advised that the RSM also recently obtained a bus license to drive the service bus after a volunteer driver left.
* A lifestyle staff member said they sometimes fill care staff shifts and when this occurs, they are cannot host lifestyle activities.
* Two staff said that additional duties had been added to their roles in recent years. One staff member said they now cannot complete all their daily tasks, while a lifestyle staff member said rostered hours had recently been decreased, but duties were not reduced.
* Management confirmed the service was experiencing staff shortages on a daily basis, including the lack of a Clinical Coordinator since November 2021. The RSM confirmed they will attempt to fill unplanned leave shifts through an agency, but when this is not possible, the RSM will fill the shift, which results in there being only one RN on site.
* There has been a recent increase in consumers at the service, with 14 new consumers entering the service since December 2021.

Other documents, observations and evidence

* Review of rosters and allocation sheets showed the service had no unfilled shifts in the previous fortnight however the RSM had filled a night shift.
* Meaningful call bell data could not be extracted due to system limitations and the Assessment Team were unable to analyse recent call bell patterns.
* The service’s continuous improvement plan contained an overdue action item to address concerns that members of the workforce were working double shifts.

The Assessment Team put forth other evidence which was not relevant to my decision and is not outlined here. I have not taken these examples into consideration. However, I considered evidence put forth by the Assessment Team in other Requirements, including first hand observations of consumers not being supported to eat as specified in care planning documentation, clinical documentation not being completed appropriately or accurately and evidence to suggest that consumers have not been receiving appropriate and regular pressure area care, including repositioning and regular wound care.

The Approved Provider’s response partially acknowledged the deficits identified by the Assessment Team, however emphasised the industry-wide staff shortage in their response. The provider outlined a range of actions the service and the organisation have taken to address the deficits in workforce planning identified during the audit. The service has ceased taking on new admissions and have a regional recruitment drive in place. The organisation has introduced temporary staff, including two senior clinical specialists and four registered agency staff. The response outlined that existing staff are being asked to increase shifts and to work more shifts where possible and that existing casual staff are being converted to permanent positions. The organisation is providing clinical monitoring and weekly call bell monitoring has been introduced. The response also outlined steps the service plans to take to monitor consumer satisfaction with staffing levels.

I acknowledge the service, and the organisation, has taken appropriate steps to address the staffing deficits and to recruit and deploy an adequate number of staff at the service. However, at the time of Site Audit and for some time prior, the service did not have sufficient staff to deliver safe and quality care. There has been no Clinical Coordinator for some months, and those duties appear have been added to the Residential Service Manager’s role. Unplanned care and clinical staff shifts, planned leave for the IPC and volunteer bus driver duties were also being filled by the RSM at the time of audit.

The Assessment Team found various examples of consumer impact and risk because of the short staffing and inappropriate mix of staff, including consumers being left unassisted during personal care and falling, consumers with swallowing risk being left to eat unassisted and consumers receiving inadequate repositioning and wound care resulting in deterioration of pressure injuries. Deficiencies in recognition of and response to significant consumer weight loss were also identified. Staff interviews confirmed additional duties had been added to their roles or their hours reduced, and others said that lack of staff meant they were at times unable to provide personal care to consumers requiring a two-person assist. Other staff indicated they were unable to provide lifestyle activities as a result of being redeployed to fill care staff vacancies. The Non-compliant outcomes previously outlined in Standards 2 and 3 demonstrate the detrimental impact to consumers, as a result of the lack of staff and appropriate mix of staff, at the service.

Based on the evidence and reasons summarised above, I find the service Non-compliant with this Requirement.

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

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

The Assessment Team found the service did not demonstrate workforce interactions with consumers are kind, caring and respectful. Relevant (summarised) evidence included:

* Three consumers reported that one care staff member was disrespectful toward them. Consumers said the staff member had been dismissive of a consumer seeking emotional support, making them cry and that they been overhead speaking to consumers in a disrespectful way and ‘very rude’ way. One consumer said that had not raised a complaint about the consumer because they did know if complaining would ‘make it worse’ for them.
* When the issue was raised with management, their response was not consistently respectful of the consumers who had raised concerns. Management said they had not received any complaints about the worker.
* A care staff member said they heard the same care worker yelling ‘shut up’ at consumers and displaying generally unpleasant behaviour. The staff member said they had been aware of the behaviour for almost a year and had reported it to clinical staff and management but no follow up occurred.
* Records showed that a complaint had been raised about the staff member in December 2020, but no details of the complaint were recorded. The RSM at the time had a verbal discussion only with the staff member, 3-4 months after the complaint was made. The staff member’s most recent individual development plan did not mention the complaint.
* The Assessment Team viewed minutes from the most recent staff meeting which noted that staff were asked to conduct themselves professionally in front of consumers, who were concerned about a lack of sensitivity from staff when delivering personal care.

In their response, the Approved Provider did not acknowledge the deficiencies identified by the Assessment Team but referred to the organisation’s Code of Conduct which requires staff treat consumers with dignity and respect. The response advised the service met with the consumers who raised their concerns with the Assessment Team and issued apologies to them. The complaints have been documented in the service’s feedback system and actioned accordingly. The response did not however, state if there would be an investigation into the alleged conduct or provide any details as to next steps to be taken in response to the complaints. The response did confirm the service has scheduled education for all staff at the service to ensure there is ‘consistent understanding’ of organisation values and expectations.

I acknowledge the steps taken by the service to meet with and apologise to the consumers who raised concerns about disrespectful staff conduct. However, the Approved Provider’s response did not provide clarity or confirmation that a robust inquiry would take place into the allegations. The Approved Provider did not acknowledge or address evidence that staff had previously complained about the staff member or evidence that a previous complaint was not responded to for 3-4 months. I find the service did not take steps to ensure the staff member had consistently kind, respectful and caring interactions with consumers. Multiple consumers experienced poor outcomes as a result, including feelings of emotional distress. Management’s response to the December 2020 complaint was not sufficient and also reflects Non-compliance with this Requirement.

Based on the evidence summarised above, I find the service is Non-compliant with this Requirement.

### 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.*

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

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

The Assessment Team found the service did not regularly assess, monitor and review workforce performance, despite having an established framework for doing so. Relevant (summarised) evidence included:

* The service did not effectively monitor the performance of a care staff member after a complaint was made about them. Refer to evidence previously outlined in relation to Requirement 7 (3)(b).
* The individual development plan for the staff member who had been complained about did not reference the complaint.
* Care and clinical staff performance was not consistently monitored resulting in consumers not always receiving safe and effective pain and wound management.
* Evidence of annual performance appraisals for staff was not provided to the Assessment Team as requested, and the RSM was not available to speak the Assessment Team regarding the status of performance appraisals.
* A continuous improvement plan item identified gaps in staff practice from January 2022. The planned actions to rectify the gaps included re-educating staff on reporting of incidents, infections and wound care and were due in March 2022, but had not been actioned at the time of Site Audit.

In their response, the Approved Provider acknowledged the deficits identified by the Assessment Team and conceded that the organisation’s staff performance framework was not consistently implemented at the service. The Approved Provider committed to embedding the framework by ensuring all staff performance reviews were completed and the performance appraisal register updated within 3 months. The Approved Provider gave an undertaking that management would use feedback and complaints data, clinical indicators, clinical monitoring and observations to inform staff monitoring in future.

I acknowledge the improvement actions the service has planned to ensure staff performance is adequately monitored in future and the undertaking they have provided to ensure management properly reviews all sources of evidence to monitor staff performance. However, I find the service failed to properly monitor and review the performance of one staff member, despite previous complaints against them concerning rude, verbally aggressive behaviour toward consumers. The failure to adequately monitor the staff member’s performance resulted in three consumers experiencing emotional distress. The service also failed to complete staff performance appraisals and to provide education for staff in response to identified deficiencies in incident reporting, infections and wound care. Other deficits in staff practice, relating to weight loss management and recognising consumer deterioration were also not identified to ensure staff performance review and management occurred.

Based on the evidence summarised above, I find the service Non-compliant with this Requirement.

# STANDARD 8 NON-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 Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

The Non-compliance is in relation to Requirements (3)(b) and (3)(c). Reasons for the finding are detailed in the relevant Requirements below.

The Assessment Team also recommended Requirement (3)(a) was not met. However, my finding differs from the recommendation and I find this Requirement to be Compliant. Reasons for the finding are detailed in the relevant Requirement below.

The service has processes supported by the wider organisation to engage consumers in the planning and delivery of care and services. The service has organisational wide systems to direct care and service delivery and guide the management and oversight of staff, complaints, improvements, legislative requirements and improvements. However, these organisation wide governance systems are not always effective at the service as they are not consistently implemented or monitored.

The service demonstrated the presence of a risk management system with policies setting out how high impact and high prevalence risks should be managed at the service, how abuse and neglect should be identified and responded to, how consumer quality of life is supported, and incidents managed and prevented. Staff could demonstrate the practical application of these policies, including identifying signs of abuse and how dignity in risk is afforded to consumers. Management were aware of the key risks at the service, and the service had an incident management system where incidents are captured. However, at times the service does not implement incident and risk management procedures including in relation to risks associated with weight loss and behaviours. The Assessment Team reviewed two recent SIRS reports lodged by the service.

The service demonstrated the presence of a documented clinical governance framework that contains antimicrobial stewardship policies, and policies concerning the minimisation of restrictive practices. Open disclosure principles are incorporated into the service’s quality framework and the policy on feedback management.

## 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.*

The Assessment Team found the service does not engage consumers and representatives in the development, delivery and evaluation of care and services. Relevant (summarised) evidence included:

* A representative considered they are not involved in the care planning process but the service rings to ‘ask permission for things.’
* A representative said they were not consulted regarding personal care and eating times for the consumer.
* Although consumers and representatives provide the service with feedback and complaints about care and services, the service does not use that feedback to evaluate the care and services delivered and to drive improvements. Refer to Requirement 6(3)(c) for detailed information outlining consumer complaints regarding a lack of sensitivity when providing care.
* Consumer meeting minutes indicate that while consumers are informed of issues relating to the running of the service, the meeting minutes did not show that consumers were supported to contribute to discussion.

In their response, the Approved Provider stated their commitment to ensuring consumers and representatives are active in the development, delivery and evaluation of the service and to ensuring the service can evidence that participation. The provider referred to the improvement actions they previously outlined in relation to Standards 2, 3 and 6. I acknowledge the service’s commitment to improving the assessment and planning process, personal and clinical care outcomes and feedback and complaints handling at the service.

In reaching my decision, I have had regard to evidence outlined throughout this report and I find there is there is evidence to show the service engages consumers in the development, design and evaluation of care and services through surveys and consumer meetings. There is evidence (outlined previously in relation to Requirement 6 ((3)(d)) to show that the information provided by consumers through those mechanisms is used to evaluate care and services provided. The Assessment Team put forth specific evidence to show that staff at the service were making changes in response to consumer feedback and survey results. I find this evidence, along with the fact of consumer attendance at consumer meetings, is sufficient to find the service is compliant with this Requirement.

The service has an established organisational framework for eliciting consumer participation in service design, delivery and review and there is sufficient evidence that the framework is implemented. In reaching my decision, I have also had regard to the Assessment Team’s finding that Requirement 2(3)(c) was met. Evidence under that requirement indicated that a majority of representatives said they were involved in care planning processes, which is sufficient to displace the evidence outlined under this Requirement. Lastly, I consider that the service’s failure to effectively learn from consumer complaints and feedback has already been assessed in relation to Standard 6, where the information is more relevant. The service uses standard evaluation tools, namely, surveys and it supports participation with the provision of consumer meetings. The evaluation of services using systematic survey tools is not to be conflated with a complaints and feedback system, which serves a different purpose.

For the reasons outlined above, I have reached a different finding than the Assessment Team and find the service to be Compliant with this Requirement.

### Requirement 8(3)(b) Non-compliant

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

The Assessment Team found the governing body does not promote a culture of safe, inclusive and quality care and services, and had failed to address systemic deficits at the service. Relevant (summarised) evidence included:

* At the time of the site audit, the RSM was fulfilling multiple roles, as previously outlined in Requirement 7(3)(a). The RSM did not have adequate leadership support and was not able to fully participate in the audit as necessary.
* There are two continuous improvement plans at the service and the most recent has approximately 48 entries, with 42 currently open and most are assigned to the RSM for action.
* When requested, the service did not provide examples of governing body meeting minutes to confirm the reporting requirements outlined by management.
* The organisation has a quality framework which described how the reporting and quality governance structure channels information from the service to the governing body, however the Assessment Team found this was ineffective. While the organisation employs internal auditors and other supports to ensure compliance with these Standards, numerous deficits in the provision of care and services were listed in continuous improvement plans. The deficits identified put consumers at risk, but no additional resources had been provided by the governing body to ensure the service could implement the required improvements.

Other evidence put forth by the Assessment Team was not relevant to my decision and has not been outlined here.

The Approved Provider’s response did not acknowledge the specific deficits identified by the Assessment Team, including the finding that the organisation had not provided sufficient resources to address the deficits identified in the CIP. The Approved Provider referred to the planned improvements previously outlined in relation to Standard 7 and stated that the service’s CIP had been updated to reflect the Assessment Team’s recommendations. The response contended the service has made progress in implementing the continuous improvement plan.

I acknowledge the steps taken to improve oversight of the service and the extensive improvement efforts planned and already implemented. However, the governing body either failed to identify that the service was inadequately resourced to address deficits in care and service delivery which placed consumers at risk, or, it did identify this but failed to ensure the resources were provided. In reaching my decision, I have considered the numerous identified deficiencies recorded in the service’s CIP in January 2022, which remained unactioned at the time of site audit. By failing to mobilise resources to address these identified deficiencies in care and services, the governing body failed to promote a culture of quality, safety and inclusion at the service.

For the reasons outlined above, I find the service is Non-compliant with this Requirement.

### Requirement 8(3)(c) Non-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 found the service did not demonstrate effective organisation wide governance systems in place in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Relevant (summarised) evidence included:

Information Management

* Staff did not consistently record timely, accurate or reliable information in consumer care plans, assessments and handover information. The Assessment Team found that consumer documentation did not always accurately reflect care preferences or recent changes in consumer condition and needs. Refer to previous examples outlined in Requirement 3 (3)(a).
* Information was not always contained in the electronic care management system and some consumer files contained outdated information or was missing whole assessments. Refer to previous examples outlined in Requirement 2 (3)(a).
* Assessments were not regularly reviewed or when circumstances changed. as previously outlined in Requirement 2(3)(e).
* Consumers unable to use care bells did not have this information recorded in their care plans, as previously outlined in Requirement 2(3)(e).
* The deficiencies outlined above reflect repeated failures to comply with the organisation’s records management policy.

Continuous Improvement

* The service did not provide the Assessment Team with a copy of the feedback and complaints register, so found no evidence that feedback and complaints were recorded and reviewed by the service to drive continuous improvement.
* There were two Continuous Improvement plans for the service that contained numerous items aligned to the Quality Standards.

Financial Governance

* The Assessment Team was unable to gather evidence in relation to financial governance, as the RSM was not available to be interviewed to confirm how changes are made to the service budget or how they seek additional expenditure to meet changing consumer needs.

Workforce governance

* Consumer, representative and staff feedback provided to the Assessment Team indicated a lack of adequately skilled and qualified staff leading to detrimental consumer outcomes. Refer to deficits previously described in relation to Requirement 7 (3)(a).
* As outlined in relation to Standards 2 and 3, the service did not demonstrate effective clinical oversight of staff.
* The governing body failed to mobilise adequate resources to address the systemic human resources and staffing issues outlined in Standard 7.

Regulatory Compliance

* The organisation’s care and governance quality team disseminates information on regulatory changes to the member services. However, the Assessment Team could not interview the RSM to confirm steps taken to implement changes as a result of those updates.
* CIPs at the service stated that under reporting of incidents had been identified as an issue in June 2021. CIP items to address this deficiency had not be actioned at the time of Site Audit.

Feedback and Complaints

* As previously outlined in Standard 6, the service could not evidence that all feedback and complaints are recorded, and action taken as a result.

Other evidence put forth by the Assessment Team was not relevant to my decision and has not been outlined here.

The Approved Provider’s response provided clarifying information regarding some findings put forth by the Assessment Team, which they considered inaccurate. I acknowledge those clarifications and have not considered that example in my decision.

The response also referred to the organisation’s ‘industry-leading’ governance arrangements and outlined the steps the service has implemented or has planned, to address the deficiencies in management of consumer information. The provider supplied the Commission with some evidence of steps already taken, including the review of all consumer care planning and assessment documentation to ensure it is accurate, complete and current. The Approved Provider’s response also referred to other planned or implemented actions to address deficits in continuous improvement and feedback and complaints at the service. These improvements have been previously outlined at Standard 6, so are not repeated here.

Finally, in relation to the identified deficiencies in workforce governance, the Approved Provider’s response referred to the improvements they have commenced implementing to address workforce shortages and deficiencies in staff performance monitoring, review and assessment. These improvements have been previously outlined at Requirement 7(3)(a), so are not repeated here.

While I acknowledge the steps taken in response to the Assessment Team’s findings and the existing governance framework the organisation employs, I find the framework was not effective at remedying significant deficiencies at the service level, particularly in relation to information management, continuous improvement, feedback and complaints and workforce governance. In reaching my decision, I have considered the lack of clarifying information included in the Approved Provider’s response, regarding financial governance at the service. As there is insufficient evidence or contextual information about the effectiveness of financial governance arrangements at the service, particularly as it relates to expenditure on staffing, I have not reached any decision regarding financial governance. I accept the evidence relating to the remaining governance systems and find they were ineffective at the time of site audit.

Information about consumer care preferences and needs was not consistently assessed, gathered, accurately recorded or kept up to date and was not always available to those involved in the provision of care and services. Pressure injuries, weight loss and changes in consumer condition were not sufficiently monitored and documented and management strategies such as repositioning were not recorded. Continuous improvement processes used in the wider organisation were effective at identifying deficiencies in practice at the service, however there is no evidence those processes were effective at leveraging organisational resources to ensure planned actions were able to be implemented.

Complaints about a staff member using disrespectful and aggressive language toward consumers was not adequately responded to and resulted in consumers experiencing emotional distress. Finally, identified deficiencies in personal and clinical care, assessment and planning and numerous other areas, did not result in extra resources being directed to the service to bolster staff numbers.

Finally, there is no evidence of action taken by the organisation’s governing body prior to the Site Audit, to address deficits identified during internal audits in June 2021 and January 2022. The provider’s response did not demonstrate the governing body is accountable for the deficits identified.

Based on the evidence summarised above, I find the service to be Non-compliant with this Requirement.

### 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.*

### 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.*

# 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 Ongoing assessment and planning with consumers

* Requirement (3)(a) Ensure assessments and plans are completed, current and in accordance with the organisation’s procedures for consumers newly admitted to the service. Ensure monitoring of assessments and plans identifies and addresses deficits in assessments and planning and risks to consumer health and well-being.
* Requirement (3)(b) Ensure assessments and plans are current and reflect consumers’ current needs, goals and preferences including advanced care planning where requested. Ensure monitoring identifies deficits in assessment and planning, and that assessment and plans reflect the current needs and capacities of consumers.
* Requirement (3)(e) Ensure assessments and care plans are reviewed regularly for effectiveness and when incidents or changes occur. Ensure care plans are updated to reflect the most recent assessed needs, to ensure consumers’ changed needs are met.

Standard 3 Personal care and clinical care

* Requirement (3)(a) Ensure each consumer gets safe and effective personal care and clinical care which is in line with best practice and the consumer’s needs. Ensure staff practice in relation to diabetes management, personal care, complex continence care, wound care, skin care and pain management are in line with best practice and the service’s policies and procedures.
* Requirement (3)(b) Ensure high impact and high prevalence risks associated with the care of the consumer are managed effectively. Ensure risks associated with weight loss and behaviour are managed with best practice strategies to minimise the risks to consumers. Ensure monitoring of staff practice is effective to ensure consumers risks are managed effectively.
* Requirement (3)(f) Ensure referrals made are actioned and follow through is attended to in a timely manner. Ensure referrals to the physiotherapist are actioned in a timely manner.

Standard 6 Feedback and complaints

* Requirement (3)(a) Ensure consumers, representatives and others feel safe and are supported to provide feedback and make complaints. Ensure a feedback form and return box is always displayed in an accessible location, and that action is taken in response to complaints.
* Requirement (3)(c) Ensure feedback and complaints from all sources is recorded in the feedback system in line with organisational procedures, to ensure action is taken and improvement opportunities are identified, monitored and actioned.

Standard 7 Human resources

* Requirement (3)(a) Ensure sufficient staff and mix of staff are deployed to support care and service delivery in line with consumers’ needs and to meet these Quality Standards. Ensure organisational support and adequate resourcing for recruitment and rostering purposes.
* Requirement (3)(b) Ensure all staff interactions with consumers are kind, caring and respectful. Ensure monitoring of staff interactions with consumers is effective at identifying deficits in staff practice and that any complaints about staff conduct are addressed using appropriate human resources processes.
* Requirement (3)(e) Ensure ongoing monitoring and review of staff practice and performance occurs to identify deficits, areas for improvement and opportunities for further training and support. Ensure staff performance appraisals are kept up to date and ensure performance appraisal processes are meaningful opportunities for staff reflection and identification of further training and development opportunities.

Standard 8 Organisational governance

* Requirement (3)(b) Ensure the governing body promotes a culture of safe, inclusive and quality care and services and that the governing body is accountable for their delivery. Ensure adequate resources are deployed to support the service in implementing improvement actions and ensure that sufficient resources are devoted to workforce planning, recruitment and retention of staff. Ensure reporting processes identify and address deficits at the service level.
* Requirement (3)(c) Ensure the organisational governance systems relating to information management, continuous improvement, workforce governance and regulatory compliance and feedback and complaints are effectively implemented and monitored at the service.