Performance

Report

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| Name of service: | Brightwater Madeley |
| Service address: | 95 Imperial Circuit MADELEY WA 6065 |
| Commission ID: | 7272 |
| Approved provider: | Brightwater Care Group Limited |
| Activity type: | Site Audit |
| Activity date: | 31 January 2023 to 3 February 2023 |
| Performance report date: | 22 March 2023 |

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

**This performance report**

This performance report for Brightwater Madeley (**the service**) has been prepared by K. Rochow, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with a sample of management, staff, consumers, representatives and others;
* the provider’s response to the Assessment Team’s report received 28 February 2023; and
* the performance report dated 8 June 2022 for the Site Audit undertaken on 19 April 2022 to 21 April 2022.

# Assessment summary

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

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

# Areas for improvement

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

**Standard 1 Requirement (3)(a):**

* Ensure each consumer is treated with dignity and respect, with their identity, culture and diversity valued with each interaction with staff.
* Monitor staff practices and interactions with consumers to ensure a culture of respect and recognition of consumers as individuals.

**Standard 3 Requirement (3)(a):**

* Ensure medication administration and management processes are implemented in accordance with consumers’ preferences and therapeutic guidelines.
* Ensure consumers’ positioning in their chairs supports their comfort and is in accordance with allied health directives and best practice.
* Ensure staff provide all personal and clinical care in accordance with consumers’ assessed needs and preferences.

**Standard 3 Requirement (3)(b):**

* Where pain is identified for consumers, ensure adequate and effective pain monitoring and evaluation, including identifying the source of pain, efficacy of pain-relieving strategies and consumer comfort levels.
* Where changes to consumers’ skin integrity are identified and nursing staff identify potential causes, ensure these clinical assessments are monitored and followed-up to ensure new risks are identified and effectively managed.

**Standard 3 Requirement (3)(d):**

* Ensure where there are changes to consumers’ skin integrity or new pain identified that these changes are monitored and assessed to ensure any deterioration or further change can be identified and acted upon in a timely manner.

**Standard 3 Requirement (3)(e):**

* Ensure that all staff are provided with comprehensive information about consumers’ needs and preferences to support effective communication and negate the need for consumers to repeat their preferences and needs.

**Standard 3 Requirement (3)(f):**

* Ensure where referrals are made, or where representatives have been asked to make appointments following referrals, that these are followed-up to ensure timely referrals, appointments and reviews occur.

**Standard 4 Requirement (3)(c):**

* Ensure consumers are supported to participate in activities of interest to them, including identifying their preferences to inform the development of an individualised activity plan.

**Standard 4 Requirement (3)(f):**

* Ensure meals provided are of suitable quality, considering consumers’ feedback.
* Implement monitoring processes to ascertain consumer views regarding meals.

**Standard 6 Requirement (3)(c):**

* Ensure that all complaints are acknowledged and responded to, including consultation and communication with the complainant.
* Ensure that all feedback is captured through the service’s complaints management system to ensure complainants are included in the investigation and outcomes processes.

**Standard 7 Requirement (3)(b):**

* Ensure workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.
* Monitor workforce interactions and ascertain consumers’ feedback in relation to workforce interactions.

**Standard 7 Requirement (3)(d):**

* Ensure key personnel are provided with incident management training and that essential training for all positions is attended to promptly.

**Standard 8 Requirement (3)(b):**

* Ensure the improved corporate supports monitor progress with improvement initiatives and regular review of progress by the governing body, including understanding consumer and representative views, satisfaction, and feedback.

**Standard 8 Requirement (3)(d):**

* Ensure incidents are investigated and managed in accordance with the service’s policy and procedure.
* Ensure incidents are finalised in a timely manner and trends are identified, analysed and any actions implemented in a timely manner.
* Ensure all staff are aware of what constitutes an incident and their role in reporting and responding to incidents.
* Ensure incidents relating to abuse and neglect of consumers are responded in a commensurate time relating to the allegation or incident, including trends to support an effective and timely response to lower the risk of elder abuse.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirements (3)(a) and (3)(e) as not met and all other Requirements in this Standard as met. In relation to Requirements (3)(a) and (3)(e), the Assessment Team found the service was unable to demonstrate appropriate action had been taken to ensure each consumer is treated with dignity and respect and that consumers were provided with consistent information to support them to make decisions.

I have come to different view from the Assessment Team in relation to Requirement (3)(e). I have provided reasons for my findings in relation to Requirements (3)(a) and (3)(e) below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(a)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard. This non-compliant finding related to the service being unable to demonstrate that each consumer was treated with dignity and respect, with their identify, culture and diversity valued.

The Assessment Team found the service’s plan for continuous improvement (PCI) did not include improvement actions for this area. The Assessment Team found the service was unable to demonstrate appropriate action had been taken to ensure each consumer is treated with dignity and respect. The Assessment Team provided the following information and evidence relevant to my finding:

* Four consumers and/or representatives said staff do not always demonstrate respect, recognise, or value consumers which impacts on consumers’ dignity. Specifically:
  + The Assessment Team observed a consumer (Consumer A) to be mechanically restrained. Consumer A indicated they were not sure why they had been restrained and that the restraint ‘annoys me and I can’t move’. Consumer A also indicted they do not feel valued by all staff, with some staff making them feel ignored and ‘lousy’.
    - Consumer A’s representative indicated Consumer A would not like to be restrained.
    - Staff and management were either not aware of the mechanical restraint or were unaware if the restraint had been applied on other occasions. Management confirmed Consumer A had not been assessed for equipment for the purpose of mechanical restraint and it was removed and reported as an incident during the Site Audit.
  + A consumer (Consumer B) indicated a staff member made them feel disrespected in relation to one incident associated with the provision of care.
  + A consumer (Consumer C) feels management do not show respect or value their concerns which makes them feel angry and frustrated. Consumer C indicated they have raised concerns about staff being moved from different ‘houses’ resulting in staff not knowing the care they need to provide. Consumer C indicated that while management say they will address their concerns, they have not addressed these issues.
  + A consumer (Consumer D) and their representative said the consumer can ‘never’ choose their activities. Consumer D’s representative indicated staff ‘never’ offer Consumer D support to do things of interest them. Additionally, Consumer D said sometimes staff relocate them without asking permission which they do not like.
* The Assessment Team observed staff on three occasions to enter consumers’ rooms without knocking or asking permission, including two occasions where staff did not acknowledge the consumer in their room and another occasion where a staff member interrupted a conversation between the Assessment Team and a consumer without permission to do so.
* In response to feedback from the Assessment Team, management said they are trying to change staff culture.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer A, the consumer lives with dementia and is unable to give a recount of days, dates, and times. The equipment used which caused Consumer A to be mechanically restrained, was interim replacement equipment and the attached mechanical restraint was used in error. The relevant health professional has been educated about ensuring replacements for this equipment does not have additional accessories which could be applied as an unauthorised mechanical restraint.
* In relation to Consumer B, a meeting has occurred to discuss their concerns, including the incident with a staff member which made them feel disrespected. The purpose of the meeting was to check that Consumer B felt safe and provide an opportunity to share their thoughts on what would make them feel safe. The staff member involved in the incident was interviewed as part of the incident investigation process and it was found they did not have the experience to manage the incident, but they did act appropriately to seek assistance from senior staff.
* In relation to Consumer C, therapy activity records indicate there were only three occasions in the preceding six months in which Consumer C was not able to attend activities due to personal care not being attended to. These occasions were all in October 2022 and there have been no further occasions. Additionally, the service reviewed workflows for the ‘house’ in which Consumer C resides in November 2022 and since that time the consumer has been assisted with personal care to be ready in time for activities. The service also tries to ensure a regular staff member is assigned to each ‘house’ of the service.
* In relation to Consumer D, the consumer has attended several activities that are listed as their preference and included eight examples of activities attended. The provider asserts that Consumer D choses to spend the afternoon in bed in accordance with their wishes which limits activities they can attend. Consumer D regularly watches sports when they are in season, including participating in associated tipping competitions and a party. Therapy staff also meet with Consumer D to encourage music therapy.
* The provider’s PCI actions relation to this Requirement include:
  + Feedback to be added as a standing agenda item at all staff meetings, and residents and relatives meeting.
  + Feedback training package to be developed and delivered to all staff.
  + Care plans to be printed and located in each consumer’s wardrobe. Clinical and allied health staff to have duty lists updated to include reminders to replace the care plan if changes are made to assessments/care plans.
  + Introduction of ‘get to know me’ prompt cards for consumers, associated education for staff and consent from consumers.
  + Management to ensure all feedback is logged and a weekly review of feedback to ensure feedback loop has been completed.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified, I find that the information and evidence indicates not all staff always treat consumers with dignity and respect.

In coming to my finding, I have considered the Assessment Team’s observations of staff entering consumers’ rooms without permission and without acknowledging the consumers. I consider that this staff behaviour is indicative of staff not always respecting consumers. I have also considered comments and observations made by consumers through interviews with the Assessment Team indicates staff are not always respectful or support consumers’ dignity in their interactions. I address specific consumer comments below.

In relation to Consumer A, the provider has indicated the consumer lives with dementia and is unable to recount days, dates, and times, and that the mechanical restraint was used in error. However, I consider that by staff applying an unnecessary and unauthorised mechanical restraint demonstrates a lack of respect and dignity for Consumer A, that is, staff have not considered Consumer A as an individual when applying the restraint. I have also considered while the provider indicates Consumer A cannot recount days, dates, and times, they were able to recount to the Assessment Team that the restraint annoyed them and inhibited their movement. I have also considered their views are valid that some staff can make them feel disrespected and an inability to recount days, dates, and times, does not limit Consumer A’s ability to express how staff interactions makes them feel.

In relation to Consumer B, I acknowledge the provider’s action in response to feedback from the Assessment Team, to have a meeting with Consumer B to discuss the incident, to ensure their safety and express an opportunity to share their thoughts. However, I find that this should have occurred as part of the incident investigation process, to ensure Consumer B’s feelings of safety and respect were monitored at the time of the incident, considering the provider acknowledges the staff member involved did not have the experience to manage the incident. I consider that Consumer B felt disrespected because of this incident and while the core issue was identified and managed by senior staff at the time, the interaction between Consumer B and the staff member was not actively dealt with at the time of the incident.

In relation to Consumer C, while the provider submitted information to indicate Consumer C’s concerns have not been occurring recently, I consider that the core issue of this consumer’s concerns relates to complaints management. Please refer to Standard 6 Requirement (3)(c) for my reasoning in relation to Consumer C’s concerns. However, I do consider that a failure to adequately communicate actions, investigations and outcomes to complaints can make consumers feel they are not respected or valued, which has occurred for Consumer C.

In relation Consumer D, the provider asserts the consumer has attended several activities as listed in their preferences, and that their choice to spend the afternoon in bed limits the activities they can attend. However, I find staff have not demonstrated respect for Consumer D through relocating Consumer D without their permission and by not considering Consumer D’s participation in activities of choice in the context of their desire to rest on their bed in the afternoons.

For the reasons detailed above, I find that each consumer has not been always treated with dignity and respect, with their identity, culture and diversity valued. The observations of the Assessment Team, coupled with feedback from consumers, indicates staff culture has not always ensured consumers are always recognised and respected as individuals. While I acknowledge the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the improvement activities are mostly yet to be implemented and requiring monitoring and time to establish efficacy and improved consumer outcomes. Therefore, I find the service to be non-compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

**Requirement (3)(e)**

The Assessment Team found the service was unable to demonstrate that information is provided to consumers to enable them to exercise choice. The Assessment Team provided the following information and evidence relevant to my finding:

* Six consumers and one representative stated they do not know what is on the menu for each meal because the menu is not displayed. Staff and management confirmed the menu is not display but hospitality staff can tell consumers if they ask.
* Seven consumers and one representative said they are not offered activities to choose from which are varied or of interest to them.
* Consumers advised that after raising a query or concern at the monthly resident and relative meeting, management does not follow-up with this information. While meeting minutes show issues are recorded, these are not carried over to the next meeting.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement, which are inclusive of improvement actions from the PCI:

* The service has adjusted the way information is shared with consumers and representatives. Menus are emailed to representatives and are printed weekly for each consumer. Additionally, blackboards have been implemented in each ‘house’ to display the daily menu until television monitors are implemented.
* The service has implemented a corporate initiative to commence a ‘residents’ activity group’ to ascertain consumer feedback about activities. Additionally, consumer representatives are emailed a monthly activity planner.

Based on the Assessment Team’s report and the provider’s response I find the service to be compliant with this Requirement.

In coming to my finding, I have considered evidence presented in other Requirements which indicates information is provided to consumers which enables them to make choices. I have considered that consumers attend resident and relative meetings and actively participate in assessment and care planning processes which provides them with information to support them to make choices.

In relation to consumers’ and a representative’s concerns that they do not know what is on the menu, I consider that based on the service’s processes that consumers have been provided with information about food choices and have pre-selected their meals well in advance of being provided the meal. Therefore, the core issue is about being re-informed about their meal choices each day rather than having the information to make choices. The provider indicates actions have already been taken to ensure consumers are reminded of their meal choices each day.

In relation to consumers’ and a representative’s concern they are not offered activities to choose from which are varied and of interest to them, I consider the core issue relates to Requirement (3)(c) in Standard 4 Services and supports for daily living. I consider that consumers are provided with choices to participate in activities, however, there are deficiencies relating to the activities offered being reflective of consumers’ interests and preferences. Please see this Requirement for further information and consideration of evidence.

In relation to management not following-up consumers’ concerns raised at the monthly resident and relative meeting, I find the core issue relates to Requirement (3)(c) in Standard 6 Feedback and complaints, that is, appropriate action is taken in response to complaints. Please see this Requirement for further information and consideration of evidence.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in Standard 1 Consumer dignity and choice.

**Requirements (3)(b), (3)(c), (3)(d) and (3)(f)**

In relation to the Requirements (3)(b), (3)(c), (3)(d) and (3)(f) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Management demonstrated processes to identify consumers’ cultural information and staff were able to describe how they support consumers who do not speak English as their first language. Staff indicated various cultural days are celebrated and supported.

Consumers and representatives said consumers can make their own decisions and have these communicated to the service. Consumers also indicated they are able to maintain relationships and friendships. Staff described ways they assist and support consumers and care records include consumers’ preferred contacts.

Consumers indicated they can choose to take risks and staff were able to describe how they support consumers to engage in activities of their choosing while implementing strategies to mitigate risks. Care plans for sampled consumers reflected consumers’ choices to take risks, with risk mitigation strategies included.

Consumers are satisfied their personal information is kept confidential and said their privacy is respected. The Assessment Team observed consumers’ documents to be kept safe and confidential.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(b), (3)(c), (3)(d) and (3)(f) in Standard 1 Consumer dignity and choice to be compliant.

# Standard 2

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

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard. This non-compliant finding related to the service being unable to demonstrate that assessment and planning processes informed the delivery of safe and effective care and services.

At this Site Audit, the Assessment Team have recommended all Requirements in this Standard as met. The Assessment Team found the service had implemented improvement actions in relation to Requirement (3)(a), including undertaking a review of the admission process and monitoring that assessments and planning are completed within timeframe. The Assessment Team found these improvements to be effective and have recommended Requirement (3)(a) met.

The Assessment Team provided the following information and evidence relevant to my finding:

The service has an admission process which includes the completion of several risk assessments to inform the development of the care plan. Eight consumer records were reviewed, and all risk assessments were completed with relevant risks identified. Consumers and representatives confirmed assessment processes are commenced from entry and includes the identification of risks.

Consumers were overall satisfied with assessment and planning processes identifying their current needs and preferences, including end of life wishes. Consumers’ documentation included information about their preferences in relation to end of life care.

Overall, consumers were satisfied they are involved in assessment and care planning processes. Consumers and representatives are invited to care conferences to discuss consumers’ care needs and to be included in assessment processes. Eight consumer records reviewed demonstrated most preferences are identified and input from other service and care providers are included in the plan of care.

Consumers and representatives indicated they had the outcomes of assessment and care planning discussed with them, even though four had not seen a copy of the care plan. Documentation supports that consumers and representatives participate in care conferences which includes discussing outcomes of assessment and care planning.

Seven consumer files reviewed demonstrated care plans had been reviewed following incidents, including a review of strategies. Consumers and representatives stated that generally when incidents occur, the service informs them about the strategies they will use to prevent further reoccurrences.

For the reasons detailed above and based on the evidence in the Assessment Team’s report, I find the service to be compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) as not met and all other Requirements in this Standard as met. In relation to Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) in this Standard, the Assessment Team found the service was unable to demonstrate:

* each consumer gets safe and effective personal and/or clinical care;
* effective management of high-impact or high-prevalence risks associated with the care of consumers’ pain;
* deterioration or change of a consumer’s physical health is recognised and responded to in a timely manner;
* information about consumers’ condition, needs and preferences is documented and effectively communicated to agency staff; and
* timely and appropriate referrals are made to other individuals, organisations and providers of other care and services.

I have provided reasons for my findings in relation to the above Requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(a)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard. This non-compliant finding related to the service being unable to demonstrate that each consumer was provided with safe and effective personal and/or clinical care that was best practice, tailored to their needs and optimised their health and well-being.

The Assessment Team found the service has provided education and training to staff and reassessed staffing levels but still found the service was unable to demonstrate that each consumer was provided with safe and effective personal and/or clinical care, which was best practice, tailored to their needs and optimised their health and well-being. The Assessment Team provided the following information and evidence relevant to my finding:

* Six consumers/representatives stated they were not satisfied with personal and clinical care.
  + A consumer (Consumer E) has not been provided their medication in accordance with their preference or therapeutic guidelines in relation to administration times, to ensure efficacy of the medication. Consumer E indicated they are not getting a medication in accordance with their preference or their previous medical officer’s directive. Management stated they were aware Consumer E was not getting their medication at the correct time but were reminding and monitoring staff. The Assessment Team showed management the document which demonstrated Consumer E was not being administered their medication at their preferred time or in accordance with therapeutic guidelines. On further investigation, management found directions for the medication administration times to be not in accordance with Consumer E’s preference or therapeutic guidelines.
  + One representative, who did not want to be identified, was not satisfied with the provision of personal care. The representative had not raised this with staff or management.
  + Consumer C is not satisfied with the timing of their shower which impacts their attendance at activities. While this issue has been raised it has not been resolved.
  + A consumer (Consumer F) requires the administration of time-sensitive medications for their condition. Documentation demonstrates these medications are not administered in accordance with therapeutic guidelines or in accordance with the consumer’s preference which has caused negative physiological outcomes. In a 12-day period Consumer F was administered their medication outside therapeutic guidelines on five occasions, and in six-day period there were six occasions another medication was administered outside therapeutic guidelines. Consumer F’s representatives indicated Consumer F takes medications better with thicker fluid/consistencies than water. However, Consumer F is provided with water to swallow their medications.
  + Consumer F’s representative indicated the consumer’s dentures have not been in on several occasions when they have visited after lunch, even though this issue has been raised on several occasions. Management investigated this issue during the Site Audit and found that staff indicated Consumer F does remove their own dentures.
  + The Assessment Team observed Consumer F to be leaning to the left in their wheelchair with their body twisted in the chair on all four days of the Site Audit. When staff were alerted to Consumer F requiring repositioning, this was not attended to but rather a rug placed between Consumer F’s leg and the bar.
  + A consumer’s representative said they are not confident their family member receives the care they would want, specifically, positioning while sitting in the comfort chair. Staff said the representative is very particular about how they like the consumer to be positioned and seat them in the lounge area so they can monitor when the representative is not visiting. The Assessment Team observed the consumer when the representative was not visiting to have their head slumped to one side.
  + A consumer (Consumer G) is not satisfied that consumers who reside in their wife’s ‘house’ are supported with their continence needs because at lunchtime, they have at times been put off by the smells of consumers who may have been incontinent and on one occasion, one consumer sat with a puddle or urine under their chair.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer E, the consumer’s concerns were raised with the medical practitioner and progress notes indicated that on 18 November 2022 and 2 December 2022, the medical officer issued directives for Consumer E to have their medication in accordance with their preference and therapeutic guidelines. Since the Site Audit, the medical officer has met with Consumer E and the administration times of the medication were updated with specific instructions and discussions were also had regarding the amount of another medication. The provider asserts that staff were administering medications in accordance with the medical officer’s directive which is in accordance with their scope of practice.
* In relation to Consumer F, a review of medication administration times for an approximate seven-week period indicates that medication for the consumer’s condition was administered at correct times 90 per cent of the time for a specified administration time and 88.5 per cent for another specified time.
* In relation to Consumer F’s position in the wheelchair, the provider states the consumer has a preference for sitting in a wheelchair so they can self-propel, which has created some challenges for the consumer to sit comfortably. The occupational therapist has reviewed the consumer for seating on six occasions since admission and the service worked to secure a suitable chair and equipment which was made harder due to the Christmas/New Year period. However, a suitable chair was obtained but an additional cushion had been ordered prior to the Site Audit which was not available. Since the Site Audit, the cushion has been delivered and is now in place.
* In relation to Consumer C, therapy activity records indicate there were only three occasions in the preceding six months in which Consumer C was not able to attend activities due to personal care not being attended to. These occasions were all in October 2022 and there have been no further occasions.
* In relation to Consumer G, the consumer presents with a cognitive impairment and mental health concerns and is not the substitute decision maker for their family member. A recent assessment indicated Consumer G has significant short term memory loss and a decline in recall. There have been no other reports from other sources about urine-related smells.
* The provider’s PCI actions in relation to this Requirement include:
  + Consumer and representative feedback about personal and clinical care to be added as an agenda item at the next staff meeting and the resident and relative meeting.
  + Training package to be developed and delivered.
  + In response to specific feedback, care review meetings to be held and care plans updated to reflect individual preferences.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified, I find that the information and evidence indicates that each consumer has not been provided with safe and effective personal and/or clinical care that is best practice, is tailored to their needs and optimises their health and well-being.

In coming to my finding, I have placed weight on Consumers F and E’s medication management.

Consumer F has a condition which requires medications to be administered within a specified therapeutic timeframe to ensure the consumer does not experience adverse physiological impacts. I find that Consumer F does not always receive these medications within the specified therapeutic window. While the provider presented a sample of administration timings for these medications, this demonstrates the consumer is not always receiving their medications in accordance with best practice, in accordance with the Consumer F’s needs, or in a manner to optimise the consumer’s health and well-being. Consumer F has reported negative physiological outcomes when medications are not administered in the prescribed therapeutic window.

In relation to Consumer E, while the provider asserts staff were acting in accordance with the medical officer’s directives when administering Consumer E’s medication, I consider that Consumer E’s feedback, coupled with the medical officer progress notes submitted by the provider, indicates clinical staff were aware that the medication was required to be administered in accordance with specified therapeutic guidelines and this should have prompted a review of the administration instructions for this medication. Additionally, documentation demonstrated Consumer E was not receiving their medication at their preferred time or in accordance with therapeutic guidelines which was not in accordance with best practice or optimised the consumer’s health and well-being. I acknowledge that the provider has since supported a meeting between Consumer E and the medical officer to support the medications to be administered in accordance with Consumer E’s preference and therapeutic guidelines.

In relation to feedback from other consumers and representatives about the provision of personal care, I have considered that four consumers/representatives are not satisfied with an aspect of personal care. Two representatives were not satisfied with personal care relating to hygiene and support with applying dentures, however, only one matter had been raised with staff. I consider that while management indicated Consumer F removes their own dentures, this has indicated that denture management has not been fully considered to ensure the dentures are fitted in accordance with the Consumer F’s needs and preferences.

Additionally, the Assessment Team observed two consumers (including Consumer F) to not be positioned appropriately in their chairs, with one occasion where staff were alerted to this fact, but rectification of the consumer’s positioning did not appear to have occurred.

The provider was able to provide further information which indicated Consumer C has been provided with showers at times which has not impacted their activity attendance and improvement actions have been initiated to allow consumers and representatives an opportunity to raise issues with personal care.

I have also considered information and evidence from Requirement (7)(a) in Standard 7 Human Resources which indicates a further two representatives are not satisfied with one aspect of care. I consider this feedback directly relates to dissatisfaction with the provision of care rather than staffing numbers and mix.

I have also considered information and evidence from Requirement (4)(a) in Standard 4 Services and supports for daily living in relation to Consumer F who was observed on all four days of the Site Audit to be leaning in their chair, with their body twisted and both legs leaning and against a metal bar. Additionally, Consumer F reports the wheelchair causes them discomfort. The provider presented information which included that the consumer had been regularly reviewed by the occupational therapist in relation to the suitability of the chair, and actions have been taken amongst difficulties to obtain the correct equipment. However, while I acknowledge and find the service has taken action to meet Consumer F’s preferences and provide a suitable chair and other equipment, I consider Consumer F has not been positioned appropriately in their chair to support their comfort and minimise their pain. I relied upon the Assessment Team’s observations of Consumer F’s position in the chair on each day of the Site Audit and staff apathy to changing Consumer F’s position when alerted to their position. I find Consumer F has not been provided with appropriate care relating to re-positioning to support their comfort and minimise pain.

I have also considered feedback from Consumer G in Requirement (3)(b) of this Standard in relation to their dissatisfaction with the timeliness of pain medication. The provider asserts the consumer’s pain has been managed in accordance with their medication profile, including that in January 2023, the consumer had 18 administrations of ‘as required’ pain relieving medication, with all being evaluated and consideration of alternative pain-relieving strategies. However, this does not respond to Consumer G’s concerns that medication for pain is not provided in a timely manner in the first instance.

For the reasons detailed above, I find that each consumer has not been provided with safe and effective clinical care or personal care. I acknowledge the service has implemented a PCI to remedy the deficits in this Requirement, however, the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved consumer outcomes. Therefore, I find the service to be non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

**Requirement (3)(b)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(b) in this Standard. This non-compliant finding related to the service being unable to demonstrate that each consumer had their high-impact or high-prevalence risks associated with their care effectively managed.

The Assessment Team found in response to the non-compliance that the service has provided education and training to staff in relation to pain management and introduced pain checks. However, the Assessment Team found the service was still unable to demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer, specifically in relation to pain management. The Assessment Team provided the following information and evidence relevant to my finding:

* A representative for a consumer (Consumer H) stated that when they visited their family member, Consumer H reported that three days earlier they had been involved in an incident with a staff member which caused them to feel injury in their limb. Progress notes did not indicate staff had monitored or considered Consumer H’s pain. However, the Serious Incident Response Scheme (SIRS) report did state Consumer H had been requesting and receiving medication for pain since the incident. Consumer H’s representative indicated the consumer had been in excruciating pain from the day they visited to the date of the x-ray, 10 days after the alleged incident which confirmed the consumer had sustained a fracture.
* A representative for Consumer E stated the service did not manage the consumer’s pain following a fall in which Consumer E felt they had broken ribs. While Consumer E acknowledged they were being provided with pain relieving medication, they were still in pain and felt their concerns regarding pain were not taken seriously nor that pain was managed effectively. An initial x-ray following the fall indicated the consumer had not sustained a fracture, however, a subsequent x-ray identified a fracture to the ribs.
* Consumer G indicated that on the seldom occasion they request pain relieving medication for a headache, it can take a long time for the nurse to administer the medication.
* A consumer’s (Consumer I) representative stated the consumer’s pain was not managed well and they had to ‘push’ to get it sorted, including having to wait for the weekly medical officer round to have a pain review. Pain charting which was commenced for Consumer I’s back pain demonstrated there was a 24-hour gap between entries for pain, with the consumer being transferred to hospital at the end of this period with severe pain.
* A consumer’s (Consumer J) representative stated they were concerned Consumer J’s leg/foot pain had not been managed well prior to a hospital transfer where it was identified there had been impaired circulation to that leg. While staff commenced a pain chart for the leg pain, there was only one entry on the day of hospital transfer for pain and significant decreased circulation to the leg, but two doses of ‘as required’ pain-relieving medications were administered. Additionally, this leg pain was identified four days earlier, however, a pain chart was not commenced until the day of hospital transfer.
* Consumer J and Consumer I’s pain charting did not include comprehensive information, including how long the consumers had been in pain prior to pain-relieving medication administration and how long the medications took to be effective. Additionally, the pain chart for Consumer I for an approximate week period, showed that four out of eight ‘as required’ pain medication administrations did not have an evaluation.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer H, progress notes show that the first day pain was identified was on the day the consumer’s representative visited when Consumer H said they had been involved in an incident with a staff member. Documentation, specifically the COVID-19 monitoring tool, does not identify any changed behaviour from the consumer in the preceding three days from the day the alleged incident was reported. On the day of the representative’s visit, the consumer was administered ‘as required’ pain reliving medication and a review by a nurse practitioner was undertaken. Additionally, the residential care line assessed Consumer H later that day, with instructions to give ‘as required’ pain relieving medication, apply a compression bandage, apply an icepack three times daily and to elevate the leg, and if no improvement in the following 48 hours then to proceed to have an x-ray.
* In relation to Consumer I, clinical staff are known to document their evaluation at the end of the shift so often consumers’ pain is assessed at the correct time. However, the implementation of a mobile application will support in remedying delays in documentation, with staff being able to document in real time. Additionally, while the provider acknowledges staff did not complete a pain chart for Consumer I in accordance with the service’s procedure in the day before the hospital transfer, there were progress notes in relation to Consumer I’s pain, including the administration of ‘as required’ pain-relieving medication.
* In relation to Consumer E, the consumer attended a health centre following a fall where no fractures were identified and was prescribed regular and ‘as required’ pain relieving medication. Consumer E was regularly assessed for pain and records indicate the consumer had no or minimal pain, with weekly medical officer reviews until the consumer was feeling better and did not require a review.
* In relation to Consumer G, the consumer’s pain has been managed in accordance with their medication profile. In January 2023, the consumer had 18 administrations of ‘as required’ pain-relieving medication, with all being evaluated and consideration of alternative pain-relieving strategies. Staff referred Consumer G to the medical officer for review due to the frequency of use of the ‘as required’ pain-relieving medications and the consumer has been prescribed regular pain-relieving medication following this review.
* In relation to Consumer J, progress notes demonstrate the consumer’s wife was in attendance and reported to staff that the consumer was comfortable. Progress notes also demonstrate that care staff report pain to clinical staff, the consumer was administered regular pain-relieving medications which were evaluated, and the pain check tool was used on several occasions.
* The provider’s PCI actions in relation to this Requirement include:
  + A pain policy and procedure to be a standing agenda item at clinical meetings, including ongoing guidance on expected documentation requirements.
  + Audit of pain charts and ‘as required’ pain medication administrations and progress notes to be implemented.
  + Clinical staff professional development days to include pain education.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified in this Requirement, I find that the information and evidence indicates that each consumer has not had their high-impact of high-prevalence risks associated with the management of pain associated with incidents and changes in health condition managed effectively.

In coming to my finding, I have placed weight on the monitoring of pain for Consumer H, Consumer J and Consumer I which demonstrated that while new pain presented, pain assessment and monitoring processes were not effectively completed to ensure risks associated with the changes in pain condition were effectively managed.

In relation to Consumer H, while the consumer’s representative indicated the consumer was in pain from the day they visited and reported an alleged incident had occurred three days earlier which the consumer felt had caused injury, the provider asserts the COVID-19 monitoring tool did not identify any change in the Consumer H’s behaviour in those three days. Additionally, they assert that progress notes show that the first day pain was identified was on the day the representative visited, which initiated a review by the nurse practitioner and residential care line, where several pain-relieving strategies were implemented. Based on the consumer’s receipt of pain-relieving medication from the day of the alleged incident and coupled with the directives from the residential care line for several pain management strategies, I consider Consumer H was presenting with signs and symptoms of pain, but staff did not effectively monitor this new pain as demonstrated by the minimal documentation relating to pain during this period.

In relation to Consumer I, the provider asserts that Consumer I’s pain was effectively evaluated and at an appropropriate time because the time of evaluation is based on documentation rather than the time of the actual evaluation, and there were progress notes which included evaluations of the consumer’s pain. However, I consider that the pain chart entries in combination with the progress notes does not demonstrate effective monitoring of new pain for the consumer. I have relied on the progress notes presented by the provider and the Assessment Team’s evidence which demonstrates pain was not routinely monitored in the 24 hours preceding a hospital admission, where the consumer was found to have severe pain. I have also considered that the provider has acknowledged staff did not complete a pain chart in accordance with the service’s procedure to ensure effective pain monitoring. Additionally, the pain chart for Consumer I for an approximate week period, showed four out of eight ‘as required’ pain medication administrations did not have an evaluation.

In relation to Consumer J, I have considered that while the provider asserts progress notes demonstrate staff reporting the consumer’s pain to clinical staff and ‘as required’ pain reliving medications were administered, and the pain check tool was used on several occasions, I consider the service did not effectively monitor Consumer J’s pain when a change in the consumer’s foot/leg first presented. I have relied upon evidence from the Assessment Team’s report which indicates a pain chart was not commenced until the day the consumer was transferred to hospital for pain and when the chart was commenced, there were minimal entries. The progress notes do not demonstrate a comprehensive approach to assessment and monitoring of the consumer’s new foot/leg pain to support the identification and management of risks presented with the new pain.

In relation to Consumer E, the provider asserts the consumer was prescribed and administered regular and ‘as required’ pain-relieving medication, including that regular assessments of pain were undertaken. Based on the provider’s response, and evidence in the Assessment Team’s report which indicated pain medication was administered and evaluated, with staff interviewed stating the pain was managed well, I consider Consumer E’s pain was being monitored and responded to. However, evidence was not provided of the outcomes of the pain assessment following pain medication administration, therefore, I am unable to ascertain with certainty if the consumer’s pain was effectively managed in considering the consumer’s feedback. However, I have considered Consumer E’s dissatisfaction and feelings that their concerns were not taken seriously in relation to their pain in Standard 6 Requirement (3)(c).

In relation to Consumer G, while the provider asserts the consumer’s pain has been managed as evidenced by regular administration of ‘as required’ pain-relieving medication, the response does not address the consumer’s concern that they feel it can take a long time for pain-relieving medication to be administered after it has been requested. However, this issue is related to the provision of pain management for Consumer G in accordance with assessed needs and has been considered in Requirement (3)(a) of this Standard.

For the reasons detailed above, I find that each consumer has not had their high-impact or high-prevalence risks associated with the management of pain associated with incidents and changes in health condition managed effectively. I acknowledge the service has implemented a PCI to remedy the deficits in this Requirement, however, the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved consumer outcomes. Therefore, I find the service to be non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

**Requirement (3)(d)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(d) in this Standard. This non-compliant finding related to the service being unable to demonstrate that deterioration of consumers’ condition was effectively recognised or responded to in a timely manner resulting in negative impacts for consumers.

However, while the service states they have completed work to ensure deterioration is recognised and responded to as evidenced by an in increase in unplanned hospital admissions, the Assessment Team found the service was unable to demonstrate staff had recognised and responded to deterioration in a timely manner for two consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumer J’s leg/foot pain and discolouration was not effectively monitored, and deterioration was not recognised in a timely manner, resulting in an emergency hospital transfer. Consumer J’s representative indicated that at the hospital they were required to decide between Consumer J having their leg amputated or to implement palliation measures. Consumer J’s representative stated they were still coming to terms with what had occurred and was having trouble remembering the timeline of events.
  + Progress notes for a five-day period showed that from when foot/leg pain was first identified staff did not effectively assess the source of pain until day four when it was identified there had been a change indicating a circulation/potential ischaemic event occurring. Additionally, once the indication of change in circulation was identified on the evening of the fourth day, there was no evidence of further monitoring of Consumer J’s foot/leg circulation even though the consumer continued to experience pain overnight. The progress notes indicate it was not until the next morning that staff identified Consumer J’s foot and leg to show significant signs of compromised circulation, which initiated a hospital transfer.
* Consumer H’s pain following an alleged incident was not recognised or responded to until the consumer’s representative raised the issue three days after the alleged incident and an x-ray was not completed until 10 days after the incident which identified a fracture. Specifically,
  + The SIRS report included that Consumer H was requesting and receiving pain relieving medication in the three days from the date of the alleged incident until the day the representative reported the incident. However, progress notes entries in this period do not provide any indication the consumer was in pain or discomfort.
  + Consumer H’s representative indicated the consumer was in excruciating pain in the days following the reporting of the alleged incident and was under the impression the service had organised an x-ray but then identified no appointment had been made, causing a further two-day delay in having the x-ray. The representative stated that they remain very dissatisfied with the process for obtaining an x-ray which resulted in a six-hour wait in the emergency department and 21 hours in total at the hospital.
  + The x-ray confirmed Consumer H had a fracture.

The provider submitted a response to the Assessment Team’s report and has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer J:
  + The Assessment Team contacted Consumer J’s representative on the first day of the Site Audit, which was less than 24 hours following their bereavement. It would have been appropriate for the Assessment Team to terminate the interview because it was noted the representative was distressed and was having trouble remembering.
  + The change in circulation/potential ischaemic event in Consumer J’s leg was identified as a suspected pressure injury, therefore, the policy does not indicate for staff to conduct a circulation assessment.
* In relation to Consumer H:
  + Progress notes show that the first day pain was identified was on the day the consumer’s representative visited when Consumer H reported they had been involved in an incident with a staff member. Documentation, specifically the COVID-19 monitoring tool, does not identify any changed behaviour from the consumer in the preceding three days. On the day of the representative’s visit, the consumer was administered ‘as required’ pain-relieving medication and a review by a nurse practitioner was undertaken. Additionally, the residential care line assessed Consumer H later that day, with instructions to give ‘as required’ pain-relieving medication, apply a compression bandage, apply an icepack three times daily and to elevate the leg, and if no improvement in the following 48 hours, then to proceed to have an x-ray.
  + The referral for the x-ray for Consumer H was sent to pathology services the day after the review by the nurse practitioner and Consumer H’s representative requested they attend the x-ray. Staff requested that the representative contact the radiology department so they could make an appointment which was convenient for them. Three days later the service received notification from the representative that radiology services had not received the referral for Consumer H. The service immediately resent the referral and an appointment was made for the following day and they assisted with the hospital transfer.
  + The provider asserts that the service responded promptly and acted appropriately to all requests from medical practitioners and the representative.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the additional information provided for each consumer identified in this Requirement, I find that the information and evidence indicate that Consumer J and Consumer H have not have a change in their clinical condition recognised or responded to in timely manner.

In relation to Consumer J, I consider the service was unable to demonstrate effective assessment or monitoring following initial pain in Consumer J’s foot. While pain relief was being provided, progress notes do not indicate the source of pain was assessed to identify the reason for a change in clinical condition.

Additionally, when a change in Consumer J’s foot appearance occurred four days later, potentially indicating a potential ischaemic event, the service did not demonstrate it monitored this change in condition. While the provider asserts the change in the foot appearance was identified as a suspected pressure injury, the provider did not include any evidence or information in their response relating to reassessment or implementation of interventions associated with the management and care of the new or deteriorating pressure injury. Therefore, I have relied upon the registered nurse’s observation that they noticed a change in colour of the foot and query of impaired circulation in coming to my finding that the service did not respond effectively to the change in the consumer’s foot colour. I have also relied upon the requirement for Consumer J to have an emergency hospital transfer the next day after there had been a significant change in the consumer’s foot/leg indicating a circulation issue. Additionally, the representative indicated at the hospital they needed to decide between amputation and palliation measures, suggesting that a significant clinical change had taken place. The provider asserts the Assessment Team should have ceased the interview with the representative because their bereavement period had started less than 24 hours prior, and the representative was having trouble remembering. However, I consider that the representative ultimately chose to speak with the Assessment Team and indicated they were having trouble remembering the timeline of events rather than actual events. Therefore, I find that the representative’s recollection of their medical decision when at the hospital to decide to either amputate or to provide palliation measures for Consumer J is a reliable consideration.

In relation to Consumer H, I consider the service was unable to demonstrate they effectively assessed or responded to pain for Consumer H, nor ensured the consumer had an x-ray in a timely manner to assist in identifying the cause of pain and subsequent treatment/management.

Consumer H’s pain following an alleged incident was not effectively identified or assessed until the representative raised the occurrence of a potential incident three days earlier which caused Consumer H pain. The provider asserts that the first day pain was identified was the day in which the representative reported the alleged incident and the COVID-19 monitoring tool did not note any change in the consumer’s behaviour. However, I have relied upon the SIRS report which included that Consumer H had requested and was receiving pain-relieving medication in the three days prior to the representative reporting the incident. I consider that this change in pain should have triggered staff to consider the cause of pain and initiated assessment processes, which only occurred three days following the alleged incident after the representative reported the incident.

Once Consumer H was assessed three days after the alleged incident, it was found that the consumer had a change in condition which required specified actions, including the taking of an x-ray if no improvement was observed. The provider asserts it was incumbent on the representative to make the x-ray appointment in accordance with the service’s procedure. However, I have relied upon the representative’s interview which indicates the referral to pathology was not initially successful and that the consumer was reportedly in excruciating pain in the days prior to the x-ray, which is consistent with the eventual identification of fracture. While it may be the service’s procedure for representatives to make radiology appointments, I consider the service has a responsibility to follow-up and ensure the consumer receives pathology services in a timely manner to support effective management of the presenting clinical issue. In this case, evidence and information presented by both the Assessment Team and the provider indicates the consumer was in continued pain for several days before an x-ray was completed, and I consider staff should have been following up with the representative about the date of the x-ray as part of monitoring and managing the consumer’s pain, which could have ensured the x-ray was completed in a timelier manner.

For the reasons detailed above, I find the service has not effectively monitored or responded to changes in Consumer J’s and Consumer H’s clinical conditions. Therefore, I find the service to be non-compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

**Requirement (3)(e)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(e) in this Standard. This non-compliant finding related to the service being unable to demonstrate information about consumers’ condition, needs and preferences were effectively documented and communicated.

The Assessment Team found in response to the non-compliance that the service had reviewed and changed the handover process. However, the Assessment Team found that while regular staff could describe the condition of consumers and their care needs, agency staff, were unaware of the risks and care requirements of consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* Three agency staff were unable to identify any consumers at risk of falls or pressure injuries. Agency staff said they had not been given access to the electronic record.
* The Assessment Team observed handover and risks, such as falls, or pressure injuries were not included in the handover.
* The care staff handover sheet does not include risks to consumers.
* Five consumers and representatives stated they must regularly tell staff about consumers’ care needs.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* Agency staff are provided with an orientation prior to commencement of their shift, which includes access to care plans and electronic records system. Agency staff sign a form to confirm they have participated in the orientation process and copies of these forms are stored in the agency file.
* The three agency staff referenced by the Assessment Team followed the above orientation process.
* The provider’s PCI actions in relation to this Requirement include:
  + The handover sheet for care staff to be updated with consumer photographs, individual risks, and specific care requirements.
  + Care plans to be printed and located in each consumer’s wardrobe. Clinical and allied health staff to have duty lists updated to include reminders to replace the care plan if changes are made to assessments/care plans.
  + Introduction of ‘get to know me’ prompt cards for consumers, associated education for staff and consent from consumers.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the response submitted by the provider and the improvement actions, I find that consumers’ condition, needs and preferences are not always effectively documented or communicated.

In coming to my finding, I have relied upon feedback from five consumers and representatives that they feel they must regularly tell staff about consumers’ care needs.

I have also considered that while the provider asserts agency staff had orientation prior to their shifts, handover sheets for care staff did not provide comprehensive information about consumers to support regular and agency staff to quickly understand consumers’ needs and preferences.

While I acknowledge that the service has updated the handover sheet to include consumer photographs, individual risks and care requirements, I consider the improvement initiative was only recently implemented and requires time and monitoring to establish efficacy, inclusive of improved consumer satisfaction with communication processes in relation to their care needs.

For the reasons detailed above, I find the service to be non-compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

**Requirement (3)(f)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(f) in this Standard. This non-compliant finding related to the service being unable to demonstrate that timely and appropriate referrals were initiated in response to changes in consumers’ conditions.

The Assessment Team found in response to the non-compliance that the service had reviewed and changed its processes to ensure timely referrals. However, the Assessment Team found consumers/representatives were not satisfied with the process and timeliness to access other providers of care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* The service’s PCI evidenced that medical officers and registered nurses were satisfied with referral processes, but it did not indicate if consumers were satisfied.
* Three consumers/representatives provided examples of delays in seeing other service providers which has impacted on their well-being:
  + Consumer E’s representative requested several times for the consumer to see a medical officer following a fall and ongoing pain. However, documentation does not support that the consumer was reviewed by a medical officer. Additionally, Consumer E states they have been wanting to see a medical officer or registered nurse for a few weeks to discuss medications but this has not occurred.
  + Consumer H’s representative said they were not aware the service had not arranged a referral for an x-ray which resulted in a delayed diagnosis.
  + Consumer G had been waiting for a dental review for several months and says it is hard to see a medical officer.
  + A consumer’s representative said they have waited for three weeks for the medical officer to sign a referral to the dentist.
* Management stated they had issues in the past with a medical officer not having a locum, but this had resolved now.

The provider submitted a response to the Assessment Team’s report and has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to a consumer’s representative waiting for a medical officer sign a referral to the dentist, the medical officer and representative are in private agreement. The request for referral was given to the medical officer when it was presented, however, the medical officer chose not to act on this.
* In relation to Consumer E, the consumer attended a health centre following a fall where no fractures were identified and was prescribed regular and ‘as required’ pain relieving medication. Consumer E was regularly assessed for pain and records indicate the consumer had no or minimal pain. The consumer also had weekly medical officer reviews until the consumer was feeling better.
* In relation to Consumer E wanting to see the medical officer or registered nurse about their medications, the consumer has now been supported to have a meeting with the medical officer to have their medications administered in accordance with their preferences.
* In relation to Consumer H, the referral for the x-ray for Consumer H was sent to pathology services the day after the review by the nurse practitioner and Consumer H’s representative requested they attend the x-ray. Staff requested that the representative contact the radiology department so they could make an appointment which was convenient for them. Three days later the service received notification from the representative that radiology services had not received the referral for Consumer H. The service immediately resent the referral and an appointment was made for the following day and assisted with the hospital transfer.
* In relation to Consumer G, an assessment in December 2022 identified broken teeth. However, a dental appointment in February 2023 did not identify any chipped teeth or trauma to the oral cavity.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the response submitted by the provider and information provided for individual consumers, I find that timely and appropriate referrals to other providers of care and services did not always occur.

In coming to my finding, I have relied upon feedback from consumers/representatives that referrals and requests to see medical officers and other health care providers are not always actioned.

In relation to a representative’s request for the medical officer to sign a dental referral, I consider that while the provider asserts the medical officer and representative are in private agreement, the service should support consumers with referral processes through regular follow-up and ensure that requests for referrals have been actioned. In this case, it this appears to have only been followed up based on the Assessment Team’s feedback, rather than through the service’s routine follow-up processes.

In relation to Consumer E, I consider that Consumer E has now been supported to meet with a medical officer to ensure their medications are now administered in accordance with their preferences, however, this was only initiated by the Assessment Team’s feedback. In relation to the representative’s request for the consumer to see a medical officer in relation to pain following a fall, while the provider asserts the consumer was assessed and reviewed weekly, this does not support that the timely referral was made in relation to the representative’s request.

In relation to Consumer H, I find that that while the provider asserts it was up to the representative to make an appointment for the x-ray, the service should have followed-up the representative to ensure the appointment had been made.

In relation to Consumer G, the consumer has requested for several months to see a dentist and the provider’s response suggests that a change in the consumer’s dental state was identified in December 2022 but the consumer was not reviewed by the dentist until February 2023.

For the reasons detailed above, I consider that consumers/representatives are not always satisfied with the timeliness of referrals and that the service does not always ensure supports and actions are taken to follow-up progress of initiated referrals. Therefore, I find the service to be non-compliant with Requirement (3)(f) in Standard 3 Personal care and clinical care.

**Requirements (3)(c) and (3)(g)**

In relation to the Requirements (3)(c) and (3)(g) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Five consumers’ documentation demonstrated the service had adhered to consumers’ wishes and staff were able to describe how it is important to prioritise comfort at the end of life. Two representatives stated they were satisfied the service provided end of life care which ensured the consumers were pain-free and comfortable.

Six consumers and representatives stated they are satisfied with the service’s management of infections and the recent COVID-19 outbreak. The service has processes to prevent the spread of infection and minimise the risk of infection. Additionally, they demonstrated they monitor antibiotic usage and ensure appropriate use to minimise antibiotic resistance.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(c) and (3)(g) in Standard 3 Personal care and clinical care to be compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Non-compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirements (3)(a) and (3)(c) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirements (3)(a), (3)(c) and (3)(f) as not met and all other Requirements in this Standard as met. In relation to Requirements (3)(a), (3)(c) and (3)(f) in this Standard, the Assessment Team found the service was unable to demonstrate:

* that each consumer was receiving safe and effective services and supports for daily living which are tailored their needs, goals and preferences to optimise independence and quality of life, specifically in relation to one consumer;
* they support consumers to participate in activities which are of interest to them; and
* meals provided are varied and of suitable quality and quantity.

I have come to different view from the Assessment Team in relation to Requirement (3)(a). I have provided reasons for my findings in relation to Requirements (3)(a), (3)(c) and (3)(f) below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(a)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard. This non-compliant finding related to the service being unable to demonstrate they had ensured each consumer was provided with safe and effective services and supports for daily living to meet their needs, goals, and preferences and optimise independence, health and well-being.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* An occupational therapist has been employed for four days per week, and review of consumers’ lifestyle preferences has been completed.
* An updated activity planner has been devised for each ‘house’.
* A trial of an additional therapy assistant shift from 3.00pm to 7.00pm on Monday to Thursday commenced in December 2022 and was planned to be reviewed in February 2023.

However, while the Assessment Team found the service had implemented the above improvements, the service was unable to demonstrate they meet this Requirement for one consumer whose postural support needs have not been addressed. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumer F said the wheelchair provided for them to sit in was uncomfortable, the armrests were too high and that the chair caused them to have pain.
* The Assessment Team observed Consumer F on all four days of the Site Audit to be leaning in the chair, with their body twisted with both legs leaning and against a metal bar.
* Documentation showed that while the occupational therapist had reviewed the wheelchair on two occasions, Consumer F continues to experience discomfort and pain.
  + On 19 January 2023, the occupational therapist reviewed the consumer’s wheelchair following the consumer falling out of the wheelchair and found it to be suitable. The occupational therapist also included instructions for staff in relation to positioning of Consumer F in the wheelchair.
  + On 24 January 2023, the occupational therapist recorded they had provided a wheelchair with a slightly wider width and longer depth, with a gel cushion. However, a pressure reliving cushion was on backorder.

The provider submitted a response, inclusive of additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* Specifically in relation to Consumer F:
  + Prefers sitting in a wheelchair that they are able self-propel which has created a challenge to assist them to sit comfortably due to multiple health conditions.
  + Has been reviewed by the occupational therapist on six occasions since entering the service in December 2022.
  + The service has been working to meet the consumer’s complex seating arrangements to meet their needs and preferences, but a suitable chair was not available on entry and attempts to secure an appropriate chair have been hindered by retail suppliers closing over the Christmas/New Year period.
  + A more suitable chair was provided but it required a cushion which was ordered on 30 January 2023, a rental cushion was sourced until the new cushion arrived on 16 February 2023.
  + Consumer H has been referred and reviewed by the site physiotherapist 13 times since admission.

Based on the Assessment Team’s report and the provider’s response, I find the service to be compliant with this Requirement.

In coming to my finding, I have considered that the service has been taking action to ensure Consumer F gets services and supports which meets their needs, goals and preferences to optimise their independence, health, well-being and quality of life.

The provider’s response outlines that Consumer F is being supported to sit in a chair of their preference but due to the consumer’s several health conditions, it has been challenging to find a suitable chair. The occupational therapist has been regularly involved in assessment and review of the consumer’s chair and have demonstrated review of the appropriateness of the chair and have made changes and updates to the chair and equipment. I also acknowledged the service were inhibited by the stock supplies in relation to the provision of pressure reliving cushion.

Consumer F said the wheelchair provided was uncomfortable and caused them pain, but I have considered the consumer’s discomfort and pain in the context of Requirement (3)(a) in Standard 3 Personal care and clinical care, considering regular occupational therapy reviews found the chair to be suitable and updated as required. Based on the Assessment Team’s observations of Consumer F on each day of the Site Audit, Consumer F was observed to not be positioned appropriately, which I consider has contributed to Consumer F’s discomfort and pain, rather than the provision of suitable equipment. Please see Requirement (3)(a) in Standard 3 Personal care and clinical care for further information.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(a) in Standard 4 Services and supports for daily living.

**Requirement (3)(c)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(c) in this Standard. This non-compliant finding related to the service being unable to demonstrate consumers were being assisted to participate in activities of interest to them.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* An occupational therapist has been employed for four days per week, and review of consumers’ lifestyle preferences has been completed.
* An updated activity planner has been devised for each ‘house’.
* A trial of an additional therapy assistant shift from 3.00pm to 7.00pm on Monday to Thursday commenced in December 2022 and was planned to be reviewed in February 2023.

However, while the Assessment Team found the service had implemented the above improvements, they found the service was unable to demonstrate they provide support for consumers to participate in activities that are of interest to them. The Assessment Team provided the following information and evidence relevant to my finding:

* Six consumers and representatives said consumers do not attend, or are not supported to attend activities, and that activities provided are not meaningful or of interest to them. Feedback included:
  + Consumer C would like to attend a weekly activity but has not attended for several weeks due to not being ready on time. Consumer C’s leisure care plan includes this activity as their preference and the activity planner shows this activity as the only activity of interest. A review of activity charts shows the consumer has only attended one activity in January 2023, which was not their preferred activity.
  + A consumer (Consumer L) said they rarely attend activities as there are not many of interest to them. A review of charts shows the consumer has attended four activities in January 2023, with one activity appearing passive. Additionally, the consumer told the Assessment Team about one of their very keen interests, but this was not recorded as an interest.
  + Consumer D said they are not offered or supported to do things they want to do and activities offered are not of interest. The Assessment Team observed Consumer D to be positioned on their own, with activity happening behind them even though the consumer’s interests are recorded as group activities. Most of Consumer D’s identified activities of interest are not reflected in their activity planner and attendance charts demonstrates the consumer attended 10 activities in January 2023. Consumer D’s representative indicated staff ‘never’ offer Consumer D support to do things of interest to them and nothing has changed even though the issue has been raised with management.
  + Consumer F said they do not attend activities because they are not of interest to them, but staff support them to go outside each day, which they like. A review of charts for the preceding month shows the consumer had not attended any activities.
  + Consumer A said they do not attend activities because they are not of interest to them. However, the consumer’s leisure plan does not reflect their interests as described by the consumer’s representative. A review of charts for the preceding month show they attended four activities.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a Plan for Continuous Improvement (PCI) in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer L, in January 2023, the consumer attended four activities and declined four activities due to being comfortable in their room. Consumer L prefers to watch TV in their room and enjoys watching AFL and history programs. Consumer L attended the AFL grand final party and footy tipping, even though it has not been identified an interest. Consumer L’s records have been updated.
* In relation to Consumer C, therapy activity records indicate there were only three occasions in the preceding six months in which Consumer C was not able to attend activities due to personal care not being attended to. These occasions were all in October 2022 and there have been no further occasions. Additionally, the service has moved this preferred activity to the afternoons, but Consumer C has still declined to attend. Consumer C also declines to attend activities due to personal commitments.
* In relation to Consumer D, the consumer has attended several activities that are listed as their preference and included eight examples of activities attended. The provider asserts that Consumer D choses to spend the afternoon in bed in accordance with their wishes which limits activities they can attend. Consumer D regularly watches sports when they are in season, including participating in associated tipping competitions and a party. Therapy staff also meet with Consumer D to encourage music therapy.
* In relation to Consumer F, the consumer has attended eight sports and exercise groups in January 2023 and February 2023 and has participated in entertainment groups. The consumer has declined to participate on some occasions due to fatigue or having some visitors.
* In relation to Consumer A, the provider did not specifically respond in relation to this Requirement. However, indicated that Consumer A lives with dementia and is unable to give a recount of days, dates and times.
* The provider’s PCI actions relation to this Requirement include:
  + Survey of preferred activities to be undertaken and activities program to be reviewed to include consumers’ preferences.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified, I find that the information and evidence indicates services and supports for daily living do not always support consumers to do things of interest of them.

In coming to my finding, I have considered and relied upon consumers’ feedback that they are not offered to participate in activities which are of interest to them. Additionally, activity attendance records demonstrate each consumer identified has attended a limited number of activities in January 2023, considering there are 31 days in this month, and these activities are also not necessarily in accordance with their identified preferences.

In relation to Consumer L, while the provider has demonstrated they are aware of the consumer’s very keen interest and indicated the consumer had participated in related activities, Consumer L indicates they rarely attend activities because they are not of interest to them. While the provider asserts Consumer L had declined to attend activities due to being comfortable in their room, it does not provide evidence that Consumer L is offered activities of interest to them.

In relation to Consumer C, the provider submitted information to indicate Consumer C’s concerns have not been occurring recently in relation to not being able to attend an activity of interest due to not having personal care attended to in a timely manner. Additionally, the service has moved this preferred activity to the afternoons, but Consumer C has still declined to attend. However, in considering Consumer C’s feedback in my finding, I have considered that this is the only activity of interest identified for Consumer C and that evidence has not been provided that indicates how Consumer C is supported to engage in activities of interest to them.

In relation to Consumer D, while the provider indicated the consumer has attended several activities, I consider that most of Consumer D’s activities of interest have not been reflected in their activities planner, which supports their view they are not offered activities of interest to them.

In relation to Consumer F, while they are supported to go outside daily, and records show they have attended eight sports and exercise groups in January 2023 and February 2023, and has participated in entertainment groups, in considering Consumer F’s feedback in my finding, I have relied upon their report that they do not attend activities because they are not of interest to them.

For the reasons detailed above, I find that consumers have not always been supported with services and supports for daily living to engage in activities of interest to them. Feedback from several consumers which indicates they are not offered activities of interest to them, with some consumers not having their plans inclusive of their interests, coupled with the limited number of activities attended for identified consumers, indicates the activities provided are not tailored to their preferences. While I acknowledge the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy. Additionally, time is required for the service to understand each consumer’s interests and develop an individualised activities plan. Therefore, I find the service to be non-compliant with Requirement (3)(c) in Standard 4 Services and supports for daily living.

**Requirement (3)(f)**

The Assessment Team found the service was unable to demonstrate that meals provided are varied and of suitable quality and quantity. The Assessment Team provided the following information and evidence relevant to my finding:

* Six consumers and representatives are dissatisfied with the quality, choice and variety of meals provided. Specific examples include:
  + Consumer B said they do not like the food, and they have no choice due to the service misplacing their menu. Staff confirmed the consumer’s menu was misplaced but the issue cannot be rectified until a particular catering staff member returns.
  + Consumer D’s representative indicated they were only recently informed about alternative menu options which the consumer is now receiving. Additionally, the representative finds the quality of the food is ‘pretty poor’.
  + Consumer F and Consumer L indicated the chicken is not of good quality and Consumer F finds the meals to be ‘so-so’.
  + A consumer stated the food ‘is not the best’, with another consumer stating the ‘food is mediocre, and dishes are repeated too often’.
* Staff explained for a new consumer or when the menu changes, there is a seven-to-10-day turnaround in relation to consumers’ food choices to commence, so until then the consumer is provided a frozen meal or a meal the catering team deems appropriate.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement, which are inclusive of improvement actions from the PCI:

* There is always a choice of a hot meal, including frozen alternatives, salads and sandwiches and consumers are offered a choice from what is available.
* In relation to Consumer B, staff have now spent time with them and completed a new menu and their eating and drinking assessment has also been updated to reflect their likes and dislikes.
* In relation to Consumer D, the consumer had functional swallowing difficulties and it was only at the most recent speech pathology assessment that an alternative menu option for this consumer became available.
* The provider did not specifically respond to Consumer L and F in relation to this Requirement.
* The provider’s PCI actions in relation to this Requirement include:
  + A Food Matters Group has been implemented and consumers have been invited to participate in this group.
  + An initial survey is currently being completed and results will form the basis of a new menu, if suitable. Consumers will be invited to sample the new menu prior to finalisation.
  + Other improvement initiatives will relate to the dining service, plating, temperature of the food and ambiance.
  + Consumers’ feedback will be raised with the catering service.
  + The catering team are to shadow hotel services staff to determine if there are any process/knowledge gaps and plan corrective actions as necessary.
  + Staff education in relation to the meal experience will include plating, service, food choices and ambiance.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, I find that the information and evidence indicates that meals provided are not always of suitable quality.

In coming to my finding, I have considered and relied upon consumers’ feedback about the quality of the food, and where concerns have been raised by some of these consumers in relation the food, there have not been actions taken to address them.

For the reasons detailed above, I find that meals provided are not always of suitable quality. While I acknowledge the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy. Additionally, time is required for the service to understand consumer satisfaction with menu changes. Therefore, I find the service to be non-compliant with Requirement (3)(f) in Standard 4 Services and supports for daily living.

**Requirements (3)(b), (3)(d) (3)(e) and (3)(g)**

In relation to the Requirements (3)(b), (3)(d), (3)(e) and (3)(g) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Consumers were able to provide examples of how the service supports their emotional, spiritual and psychological well-being. Consumer care files reviewed demonstrated staff have recorded what provides consumers with feelings of well-being. Management also indicated after a consumer moves into the service, at the three-month mark each consumer and representative are contacted to provide an opportunity to discuss any services or supports which may be required.

In relation to supports and services for daily living, consumers’ care files reviewed showed this information was included and consumers and representatives confirmed staff generally know about consumer and refer to the internal and external providers as required. Management was able to provide examples of how consumers have been referred to individuals to support their independence.

Consumers said they are satisfied with the equipment provided, including that chairs, mobility aids and assistive devices are safe, suitable, clean and well maintained. Documentation evidenced that consumers had been assessed prior to using or purchase of mobility aids.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 4 Services and supports for daily living to be compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

At the Site Audit, the Assessment Team recommended all Requirements in Standard 5 Organisation’s service environment as met. The Assessment Team found the service environment to be welcoming, clean and allows consumers to move freely both indoors and outdoors. They also found that equipment, furniture and fittings are safe, clean and well maintained.

The Assessment Team provided the following information and evidence relevant to my finding:

Consumers and representatives said the service environment is welcoming and consumers feel comfortable living at the service. Consumers indicated they can personalise their own rooms and the Assessment Team observed consumers’ rooms to have personal items, such as furniture, photographs, paintings and artwork. The Assessment Team observed consumers and visitors in the communal areas of the service to be chatting and engaging with others.

Consumers confirmed the service environment is kept clean, is well maintained and is comfortable. The Assessment Team observed consumers to move freely around the service and have access to indoor and outdoor communal areas. Staff described cleaning and maintenance schedules and how cleaning or maintenance issues are referred for rectification.

Consumers who use equipment and mobility aids said they feel safe when using equipment. The Assessment Team observed mobility aids and equipment to support transfers to be clean. The Assessment Team observed a sample of equipment to be current in accordance with the service’s schedule of service and tagging requirements.

Based on the Assessment Team’s report, including the evidence and information above, I find all Requirements in Standard 5 Organisation’s service environment to be compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirements (3)(c) and (3)(d) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirement (3)(c) as not met and all other Requirements in this Standard as met. In relation to Requirement (3)(c), the Assessment Team found the service was unable to demonstrate appropriate action is taken in response to complaints made by consumers/representatives and a process of open disclosure is not always used when things go wrong. I have provided reasons for my findings in relation to Requirement (3)(c) below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(c)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(c) in this Standard. This non-compliant finding related to the service being unable to demonstrate that appropriate action was taken in response to complaints or an open disclosure process was consistently applied.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* New processes have been implemented to ensure all feedback is managed by the management and leadership team.
* The management team are conducting ‘walk the floor’ to enable opportunities for them to speak directly with consumers about any concerns they have.
* Resident and representative meetings have re-commenced with analysis and actions being a standing agenda item.
* Staff have participated in training in relation to complaints management.
* A new system for capturing and tracking complaints has been implemented.

The Assessment Team found that while the service has implemented improvements, feedback from consumers demonstrates that appropriate action and response to complaints is not always undertaken and a process of open disclosure is not always used when things go wrong. The Assessment Team provided the following information and evidence relevant to my finding:

* Seven consumers/representatives are not satisfied they have been provided with the actions, investigations and outcomes of complaints they have raised with management.
  + Four consumers indicated they had raised their preference with management for several months about staff working in one specific area, rather than in all areas of the service because consumers do not always know the staff and staff do not always know consumers’ care needs and preferences. Management had not provided sufficient feedback to consumers to satisfy their concerns had been recognised and that appropriate actions had been taken to resolve their concerns.
  + Specific examples were provided by consumers/representatives in relation to concerns raised with management in which they had not received feedback about actions and outcomes. Specific examples included Consumer B and their representative in relation to management of an incident and food preferences, Consumer G in relation to an incident regarding pain relief, and Consumer H’s representative in relation to concerns about the handling of referral processes for an x-ray which had not being identified as a formal complaint.
* Consumer E and their representative are not satisfied their concerns with an aspect of clinical care have been addressed even though the matter has been raised with staff on several occasions.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer B, the incident was discussed with the clinical manager and was documented in progress notes. A meeting with Consumer B has been held to provide the consumer an opportunity to discuss concerns regarding the incident, to check if they feel safe and provide an opportunity for them to share what they will make them feel safe. In relation to the consumer’s concerns regarding food, staff have now spent time with the consumer and completed a new menu.
* In relation to Consumer G, the provider’s response did not specifically address the consumer’s concerns regarding the incident.
* In relation to Consumer H, the response did not specifically address the representative’s views about their concerns being identified as formal complaint. However, it did provide further information about the representative’s concerns regarding handling of a referral process. The provider asserts a referral was made for the x-ray and staff acted appropriately in relation to the referral of the x-ray and the management team have discussed the matter with the representative.
* The provider’s PCI actions relation to this Requirement include:
  + Feedback to be added as a standing agenda item at all staff meetings, and residents and relatives meeting.
  + Feedback training package to be developed and delivered to all staff.
  + Care plans to be printed and located in each consumer’s wardrobe. Clinical and allied health staff to have duty lists updated to include reminders to replace the care plan if changes are made to assessments/care plans.
  + Introduction of ‘get to know me’ prompt cards for consumers, associated education for staff and consent from consumers.
  + Management to ensure all feedback is logged and a weekly review of feedback to ensure feedback loop has been completed.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the response submitted by the provider and PCI initiatives and actions, I find that the service was unable to demonstrate appropriate action is taken in response to complaints.

In coming to my finding, I have relied upon feedback from consumers/representatives that concerns raised are not adequately addressed and/or responded to with communication regarding actions and outcomes. I have considered that several consumers are not satisfied with management’s response to complaints and specifically for the three identified consumers, there is no evidence to support that a complaint has been raised in response to these issues to ensure appropriate communication regarding actions and outcomes can be implemented.

For the reasons detailed above, I find that the service has not demonstrated that appropriate action is taken in response to complaints. I acknowledge the service has implemented a PCI to remedy the deficits in this Requirement, however, the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved consumer outcomes. Therefore, I find the service to be non-compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

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

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(d) in this Standard. The Assessment Team found the service has made the following improvements in relation to this non-compliant Requirement:

* A process was implemented to ensure all feedback is managed by the service manager and the site leadership team.
* Feedback is discussed at staff meetings and include the new monthly performance reporting.
* Resident and representative meetings have been restarted, and analysis and action taken in response to feedback is a standing agenda item which is discussed at these meetings.

In relation to the Requirements (3)(a), (3)(b) and (3)(d) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

Consumers and representatives interviewed said they understand the process to provide feedback to the service and make complaints when deemed necessary. They also indicated the new management team is more visible and approachable, with the resident and representative meetings providing an opportunity to raise issues and give feedback. The Assessment Team observed feedback forms and a secure deposit box in the reception area.

Brochures and flyers in relation to external complaints and advocacy was displayed within the service. Two representatives were aware of external complaints avenues.

Management demonstrated that improvements are made when formal complaints are made to the service and a review of documentation shows that when the service acknowledges a complaint has been received and actions are identified to improve the quality of care and services.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(a), (3)(b) and (3)(d) in Standard 6 Feedback and complaints to be compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirements (3)(a), (3)(b) and (3)(d) as not met and all other Requirements in this Standard as met. In relation to Requirements (3)(a), (3)(b) and (3)(d) in this Standard, the Assessment Team found the service was unable to demonstrate:

* the number and mix of staff enable the delivery of safe and quality care and services;
* staff are kind and caring; and
* staff have the training and support required to effectively complete incident investigations and to identify and manage risks.

I have come to a different view to the Assessment Team in relation to Requirement (3)(a) in this Standard. I have provided reasons for my findings in relation to Requirements (3)(a), (3)(b) and (3)(d) below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(a)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(a) in this Standard. This non-compliant finding related to the service being unable to demonstrate there were adequate numbers and mix of staff to deliver safe and quality care and services.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* A new roster was implemented in December 2022, inclusive of extended carer shift times, introduction of a new care staff ‘float’ role, additional therapy assistance in the memory support unit, a new carer team leader role and clinical nurse role implemented. Additionally, the clinical nursing structure changed to increase clinical oversight.
* Weekly call bell analysis is undertaken with direct follow-up by management for call response times greater than 10 minutes.
* Staff names and designations are put on an electronic screen in the main reception, so consumers and representatives know which staff are looking after consumers.

However, while the Assessment Team found the service had implemented the above improvements and is in regular discussion with staff, consumers and representatives about the changes that are being made, they found staff and consumers continue to report staffing issues which are impacting on the quality of care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Two consumers and one representative do not feel confident there are adequate numbers of staff to provide quality care and services.
* One consumer said there are not enough staff in the morning to assist them to get ready in time to attend their chosen activities.
* Three representatives provided examples of aspects of care which are not always attended to, including the application or provision of support/assistive equipment/items.
* Some staff indicated it can be challenging to provide supervision when assisting consumers, specifically on morning shifts.
* The Assessment Team observed there were no staff immediately visible in the ‘houses’ because they were in consumers’ room assisting with care. The Assessment Team observed on one occasion in the memory support unit, a consumer to be banging on the doors and another removing their continence aid to commence toileting while staff were not visible in the area.
* Allocations sheets for a three-week period showed most unfilled shifts were filled but allocation sheets did not demonstrate the impact of short notice replacement in relation to missing the commencement of the morning shift.

The provider submitted a response to the Assessment Team’s report and has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* The provider has reviewed the roster and ensured each of the ‘houses’ are adequately staffed to meet consumers’ needs. While staff may not be visible due to attending to other consumers and being on breaks, staff from other ‘houses’ are available to help if required and there are systems to support this process.
* The implementation of the mobile application will support the visibility of staff, but staff are required to support consumers’ privacy and dignity when providing care and are required to close doors.
* There are additional support staff not listed on allocation sheets who can be relied upon to provide care and support.
* The service has been actively engaging in staff retention activities which has seen a significant improvement with turnover percentage well below the current industry standard.

Based on the Assessment Team’s report and the provider’s response, I find the service to be compliant with this Requirement.

In coming to my finding, I have considered that the feedback provided by consumers and representatives does not demonstrate a significant failure to provide care and services based on inadequate staffing levels of inappropriate staffing mix. Consumers and representatives’ views indicate there are some deficits in relation to the provision of care, which I have considered in Requirement (3)(a) in Standard 3 Personal care and clinical care. Additionally, other consumer and representative comments relates to the confidence in staffing levels, but they do not indicate that current staffing levels are impacting on the current provision of care and services.

Additionally, I have considered that staff have not indicated they do not have enough time to provide care and services but do acknowledge they can find it challenging at times. The Assessment Team made one observation indicating staffing were not present when consumers required assistance, but this does not seem to have reoccurred on several occasions throughout the Site Audit, nor does the observation detail how long staff were absent for on that occasion.

I consider 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. However, I do note there are deficiencies relating to the provision of care, but the evidence presented does not indicate the root cause of these issues is staffing levels or skills mix.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(a) in Standard 7 Human resources.

**Requirement (3)(b)**

The Assessment Team found the service was unable to demonstrate that all workforce interactions were kind, caring and respectful of each consumer’s identity, culture and diversity. The Assessment Team provided the following information and evidence relevant to my finding:

* Four consumers and one representative said new staff often do not have rapport with consumers or present with a kind or reliable manner.
* SIRS reports between September 2022 and January 2023 include six incidents where consumers have alleged that staff have used unreasonable use of force or neglect. In relation to these incidents management said three staff members had been put on performance management plans, with two staff members having their employment terminated.
* Management stated the service’s new leadership team is in the process of implementing a change of culture and this will take time to embed.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* Cultural awareness training is currently being undertaken by staff.
* Afternoon and night staff are supported by management who attend site after hours and staff meetings have been arranged for this specific staff group.
* The provider’s PCI actions relation to this Requirement include:
  + The senior management team are to continue to work with the afternoon and night shift staff to identify any causes of inappropriate behaviour and manage accordingly.
  + Feedback to be added as a standing agenda item at all staff meetings, and residents and relatives meeting.
  + Introduction of ‘get to know me’ prompt cards for consumers, associated education for staff and consent from consumers.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified in this Requirement, I find that the information and evidence indicates that workforce interactions with consumers are not always kind, caring or respectful.

In coming to my finding, I have considered consumer and representative feedback in this Requirement and Requirement (3)(a) in Standard 1 Consumer dignity and choice which demonstrates several consumers feel that staff do not always interact with them in a kind and respectful manner. Additionally, the Assessment Team observed disrespectful interactions from staff towards consumers during the Site Audit.

I have also considered the significant number of allegations of unreasonable use of force or neglect from staff towards consumers, which indicates consumers are not always feeling interactions with staff are kind, caring or respectful.

For the reasons detailed above, I find that workforce interactions are not always kind, caring and respectful of each consumer’s identity, culture, or diversity. The observations of the Assessment Team, coupled with feedback from consumers, and SIRS reports indicates staff have not always interacted with consumers in a kind, caring and respectful manner. While I acknowledge, the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved consumer outcomes and staff culture. Therefore, I find the service to be non-compliant with Requirement (3)(b) in Standard 7 Human resources.

**Requirement (3)(d)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(d) in this Standard. This non-compliant finding related to the service being unable to demonstrate the workforce was trained, equipped, and supported to deliver the outcomes required by these Standards.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* There is a human resources partner now based on site to support the service with recruitment.
* Training for staff has been held in relation to core practice domains, such as behavioural management, diabetes, dysphagia, medication administration, manual handling, and managing high-impact or high-prevalent risks.
* A training schedule has been developed and implemented and an electronic centralised tracker also implemented.
* Changes to onboarding and buddy shift processes.

However, while the Assessment Team found the service had implemented the above improvements, they found the organisation has not ensured sufficient and timely support in relation to risk management training for new staff members in roles with designated responsibility for managing risk and incidents. The Assessment Team provided the following information and evidence relevant to my finding:

* Incident management documentation and interviews with staff demonstrated a lack of knowledge and understanding of the incident investigation process. Specifically:
  + Two new members of the management team who are responsible for incident investigations have not yet completed serious incident training.
  + The Assessment Team reviewed several incident forms for serious allegations which lacked detail and were not investigated in accordance with the organisation’s policy to identify what happened, why it happened and actions to prevent reoccurrence. Examples include Consumer H and Consumer K.
* Management stated there were already plans for staff to be booked into incident management training and this was expedited for senior staff following feedback from the Assessment Team.
* While management have implemented a new staffing structure to improve clinical oversight, this improvement has not been in place for a sufficient period to be embedded or its effectiveness evaluated.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* External advisors who were appointed to in response to the Notice to Agree in May 2022 were involved with the service until 23 December 2022 which had hindered the site leadership team’s ability to embed ongoing changes. These changes will be more evident once more time has passed in accordance with the industry standard that the length of time to embed any change is up to 12 months.
* In relation to Consumer H, the allegation was thoroughly investigated, including meeting all reporting requirements. Relevant staff were interviewed and reported nothing eventful had occurred, therefore, no incident was identified as having occurred.
* In relation to Consumer K, staff were removed from the roster until an investigation was completed. Staff were interviewed separately, and it was concluded staff were not at fault. However, education was provided to all staff regarding the escalation procedure.
* The provider’s PCI actions in relation to this Requirement include:
  + The implementation of a clinical support structure to support clinical management, including a clinical advisor to be based on site.
  + Training for staff in relation to SIRS has been booked.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, and the additional information provided for each consumer identified in this Requirement, I find that the information and evidence indicates that key personnel have not been supported with relevant training to support them to undertake their role effectively.

In coming to my finding, I have considered that while a variety of training has been held for staff in relation to core practice domains, relevant training for key management staff in relation to incident management has not been provided, which has resulted in significant deficits in the service’s incident management system (see Requirement (3)(d) in Standard 8 Organisation governance for further information).

While the provider asserts the examples provided in relation to consumer incident investigations demonstrates that appropriate action was taken, they were unable to demonstrate how staff had considered all aspects of the incident investigation, particularly the actions to prevent reoccurrence.

I have also considered the significant number of allegations of unreasonable use of force or neglect from staff towards consumers, which was not identified by these staff as a trend to trigger a planned analysis and response of the trend.

For the reasons detailed above, I find that while the workforce is effectively recruited, they are not trained, equipped or supported to deliver the outcomes required by these Standards, specifically in relation to incident management systems and processes. While I acknowledge the provider has submitted a PCI to remedy the deficits in this Requirement, including training for staff, I consider that the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved consumer outcomes and staff practices. Therefore, I find the service to be non-compliant with Requirement (3)(d) in Standard 7 Human resources.

I have provided reasons for my findings in relation to Requirements (3)(c) and (3)(e) which were recommended by the Assessment team as met below and were previously found to be non-compliant.

**Requirement (3)(c)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(c) in this Standard. This non-compliant finding related to the service being unable to demonstrate that the workforce was competent or had the qualifications and knowledge to effectively perform their roles.

The Assessment Team found the service’s PCI included improvement actions for this requirement, including:

* There is a human resources partner now based on site to support the service with recruitment, including ensuring staff who are employed have the appropriate levels of knowledge and skills.
* Clinical risk meetings are held weekly to discuss issues and provide an opportunity to identify issues with staff knowledge, skills and competency.
* The organisation supports the new clinical management structure.

The Assessment Team found the service demonstrated its workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following information and evidence relevant to my finding:

* Management described how new employees are required to complete off-site training prior to completing ‘buddy’ shifts, complete a three-month probationary period and complete a performance assessment before finishing the probation period.
* Consumers and representatives reported regular staff are very confident and feel they know how to manage consumers’ needs.
* One representative indicated there has been observable improvement in clinical care and communication in the preceding months.
* The Assessment Team found there had been competent wound care and referrals to specialists when required.
* The service provided a report showing all relevant staff have current professional registrations and police clearances.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(c) in Standard 7 Human resources to be compliant.

**Requirement (3)(e)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(e) in this Standard. This non-compliant finding related to the service being unable to demonstrate regular monitoring of the performance of each member of the workforce in accordance with the organisation’s processes.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* A performance management schedule has been implemented and is monitored by the new service manager.
* There is a human resources partner now based on site to support the service, including to assist with performance management.

The Assessment Team found the service demonstrated it assessed and monitors the performance of each member of the workforce. The Assessment Team provided the following information and evidence relevant to my finding:

* Management demonstrated staff performance appraisals had been completed and the associated schedule is being monitored.
* Management demonstrated the performance management processes used for staff who are not performing to the required standard and provided three specific examples.
* Management stated and documentation supported that management do not have agency staff return for further work when they receive feedback about agency staff performance.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in Standard 7 Human Resources.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in this Standard.

At this Site Audit, the Assessment Team have recommended Requirements (3)(b), (3)(c) and (3)(d) as not met and all other Requirements in this Standard as met. In relation to Requirements (3)(b), (3)(c) and (3)(d) in this Standard, the Assessment Team found the service was unable to demonstrate:

* the organisation promotes a culture of safe, inclusive and quality care and services and to be accountable for the delivery of high quality and safe care to consumers;
* effective governance systems in relation to information management, continuous improvement, workforce governance, and feedback and complaints; and
* effective risk management systems to respond effectively to abuse and neglect of consumers and to manage and prevent incidents occurring.

I have come to a different to the Assessment Team in relation to Requirement (3)(c). I have provided reasons for my findings in relation to Requirements (3)(b), (3)(c) and (3)(d) below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement (3)(b)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(b) in this Standard. This non-compliant finding related to the service being unable to demonstrate the governing body promoted a culture of safe, inclusive and quality care and services.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* A new governance committee structure has been implemented, including identifying senior staff from the organisation who will be able to provide staff support, and a new schedule of key meetings to ensure clinical issues are identified, discussed and improvement actions identified.
* A new quality management system has been implemented to enable monthly performance reports for each service within the organisation.
* Enhanced onboarding and ongoing education program to increase staff knowledge and retention.

However, while the Assessment Team found the service had implemented the above improvements, they found the organisation had not provided sufficient, timely or effective support in relation to risk management and incident management or ongoing safety and satisfaction of consumers. The Assessment Team provided the following information and evidence relevant to my finding:

* The service did not identify or investigate incident trends in relation to allegations of unreasonable use of force or neglect.
* Since the Site Audit in April 2022, a new leadership team is still in the process of becoming established and an improved incident management system has not yet been implemented.
* Consumers report ongoing dissatisfaction with personal and clinical care and how their feedback is acknowledged and managed.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* The provider’s PCI actions relation to this Requirement include:
  + The corporate support will continue to be embedded at site with continued education, policy and procedure refreshers, training and culture change management.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement and the actions taken to provide corporate support at a site level, I find that the information and evidence indicates the governing body has not promoted a culture of safe, inclusive and quality care and services and is accountable for their delivery. Specifically relating to the ongoing deficits in the provision of clinical care, staff culture not always demonstrating respect for each consumer and the significant number of allegations of abuse or neglect by staff towards consumers.

I acknowledge there is a new governance committee structure which identified senior staff from the organisation who will be able to provide support to staff and new schedule of key meetings, however, this has not ensured that all deficits previously identified at the Site Audit in April 2022 have been rectified. Specifically, the organisation has not demonstrated effective monitoring and reporting on performance in relation to the service’s performance against these Standards by using established governance processes to monitor the delivery of care and services. I have also considered consumers’/representatives’ feedback which indicates they are not confident in staffing levels or have been satisfied with all aspects of care and services.

For the reasons detailed above, I find the governing body has not promoted a culture of safe, inclusive and quality care and services and is accountable for their delivery and always respected as individuals. While I acknowledge the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the result of improved corporate support requires monitoring and time to establish efficacy and improved consumer outcomes and compliance with the Quality Standards. Therefore, I find the service to be non-compliant with Requirement (3)(b) in Standard 8 Organisational governance.

**Requirement (3)(c)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(c) in this Standard. This non-compliant finding related to the service being unable to demonstrate effective organisation wide governance systems relating to continuous improvement, workforce governance, and feedback and complaints.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* Increased electronic devices so staff can access the electronic care record.
* An ‘agency nurse’ folder was developed to improve agency staff orientation.

However, while the Assessment Team found the service had implemented the above improvements, they found the organisation did not demonstrate effective governance systems relating to information management, continuous improvement, workforce governance, and feedback and complaints. The Assessment Team were satisfied there were effective governance systems in relation to financial governance and regulatory compliance. The Assessment Team provided the following information and evidence relevant to my finding:

* Information management:
  + Six consumers and representatives said new and agency staff do not know the consumers’ names, needs or risks associated with care. Agency staff reported they do not have access to the electronic care record and hard copy care plans were not accessible.
  + Handover with agency staff was previously identified a requiring improvement, however, this was in respect of nursing staff, not care staff.
  + Three consumer representatives provided examples of consumers not being provided with assistive equipment/devices/items.
* Continuous improvement:
  + The service has a PCI which is focused on the non-compliant Requirements, so while action has been undertaken, the service is still in the process of evaluating and embedding changes.
  + The Assessment Team found ongoing deficits in areas previously which have already been identified as non-compliant.
  + Management statement improvement initiatives are prompted by a review of incidents, feedback and monthly analysis of performance. However, staff had not recognised an opportunity to improve from a trend in incidents.
* Workforce governance:
  + The service has not had the opportunity to assess or evaluate the new staffing roster and consumers continue to be dissatisfied with staffing numbers and allocation.
  + Training and support in relation to incident management has not been provided to key personnel.
* Feedback and complaints:
  + While consumers and representatives acknowledge improvements are being made, nine consumers/representatives are not satisfied with actions taken in response to feedback and complaints.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* Information management:
  + Agency staff are provided with an orientation prior to commencement of their shifts, which includes access to care plans and electronic records system. Agency staff signed a form to confirm they have participated in the orientation process and copies of these forms are stored in the agency file.
  + In relation to one consumer representative’s concerns some supportive equipment was not provided, this issue has been managed and the representative is now satisfied.
* The provider’s response did not include a response to deficits identified in continuous improvement, workforce governance or feedback and complaints.
* The provider’s PCI actions relation to this Requirement include:
  + Handover sheets for care staff to be updated with consumer photographs, individual risks and specific care requirements.

Based on the Assessment Team’s report and the provider’s response I find the service to be compliant with this Requirement.

In coming to my finding, I find that overall, the service has effective organisation wide governance systems in relation to information management, financial governance, regulatory compliance, continuous improvement, workforce governance and feedback and complaints. I consider that other deficits in other Requirements in these Standards have the core deficiencies but that overall, there are not systemic deficits relating to governance systems. Specifically:

While the Assessment Team have found information management systems to be ineffective, this is specifically relating to agency staff being unaware of consumers’ names, needs or risks and some aspects of care delivery not being performed. I consider that this issues relates to Requirement (3)(e) in Standard 3 Personal care and clinical care which I have found to be non-compliant. I have considered other evidence and information in the Assessment Team’s report which indicates consumers are provided with information to make decisions, are involved in assessment and planning processes and are positive about the reinstatement of resident and relative meetings. Additionally, staff are provided with information to assist them to perform their roles.

While the Assessment Team have found continuous improvement systems to be ineffective, they did find the service had a PCI focused on previous findings of non-compliance, but while action has been taken, the service is still in the process of evaluation and embedding some changes. While the Assessment Team assert that ongoing deficits and consumer/representative dissatisfaction demonstrates improvement actions have not led to sustainable change, I consider the service does have a continuous improvement system, but ongoing deficits are related to other Requirements in these Standards and there has been improvement in some areas of care and services previously identified as non-compliant and there have been some new areas which require attention. The Assessment Team have acknowledged the service are in the process of evaluating and embedding changes, indicating that continuous improvement processes are being undertaken. Additionally, they found that improvements are made when formal complaints are made to the service and a review of documentation shows that when the service acknowledges a complaint has been received, actions are identified to improve the quality of care and services. Consumers and representatives have also acknowledged that improvements are being made.

While the Assessment Team found workforce governance systems are not effective due to the service not assessing or evaluating the new staffing roster, consumers continued to be dissatisfied with staffing and training was not provided to key personnel in relation to incident management, I have found that staffing levels and mix are adequate based on consumer feedback and concerns relate to confidence and trust in the current staffing arrangements. I consider this directly relates to Requirement (3)(b) in this Standard, rather than workforce governance systems. Additionally, the Assessment Team provided evidence and information which indicates that staff participate in wide range of training, which is now being tracked and monitored. I found that there was significant oversight in supporting key personnel in relation to incident management training, but this does not indicate there are systemic issues relating to workforce governance and these deficits will be addressed in Requirement (3)(d) in Standard 7 Human resources and Requirement (3)(d) in Standard 8 Organisational governance.

While the Assessment Team found governance processes relating to feedback and complaints were ineffective, this related to consumers and representatives not being satisfied with actions being taken in response to feedback and complaints. I consider this deficit directly relates to Requirement (3)(c) in Standard 6 Feedback and complaints rather than governance systems associated with feedback and complaints. I have considered that overall, consumers and representatives are aware of complaint processes, advocacy and other complaints processes and feel that improvements are being made. Additionally, management demonstrated that improvements are made when formal complaints are made to the service and a review of documentation shows that when the service acknowledges a complaint has been received, actions are identified to improve the quality of care and services.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(c) in Standard 8 Organisational governance.

**Requirement (3)(d)**

Following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(d) in this Standard. This non-compliant finding related to the service being unable to demonstrate effective risk management systems and practices, specifically in relation to managing and preventing incidents, including the use of an incident management system.

The Assessment Team found the service’s PCI included improvement actions for this requirement including:

* A new governance structure was implemented, including clinical risk meetings where high-impact and high-prevalence risks are discussed.
* Improved performance analysis and monthly reporting, including analysis and trending of incidents related to high-impact and high-prevalent risks.

However, while the Assessment Team found the service had implemented the above improvements, they found the service does not have effective risk management systems to respond effectively to abuse and neglect of consumers and to manage and prevent incidents occurring. The Assessment Team provided the following information and evidence relevant to my finding:

* Incident investigations are not being conducted in accordance with the organisation’s incident management policy. The policy directs staff to identify what happened, why it happened and identify actions to prevent reoccurrence.
* While the service identified the need to improve incident reporting and management following an allegation of assault which was not effectively managed or investigated in June 2022, there were a further six allegations of physical or psychological abuse between September 2022 to January 2023. The incident forms for these incidents did not clearly document the details of the investigation, identify cause or actions to prevent reoccurrence.
  + In relation to the six incidents, management were able to state three incidents had resulted in staff performance management processes for three staff members with two staff members having their employment terminated. While action had been taken in relation to individual staff members, actions to reduce the risk of reoccurrence had not been identified.
  + In relation to the three other incidents in this period, there were no individual staff members identified during the investigation process and management indicated if no staff could be identified, the investigation process could not progress any further.
* The service did not identify a potential trend in allegations of physical or psychological abuse by staff towards consumers overnight during the period of September 2022 to January 2023.
* Staff are not always recognising incidents to ensure it is managed through incident management system, including:
  + Progress notes for a consumer related to an incident of rough handling by a representative towards a consumer. However, no incident form had been completed and no follow-up had occurred.
  + The unauthorised use of mechanical restraint for Consumer A was not recognised as an incident but rather as an error.
* A consumer (Consumer K) had an incident report which identified the consumer had sustained significant bruising. While staff reported the bruising to nursing staff when they first identified it, the cause of the bruising stated on the incident form was not consistent with the medical officer’s concern regarding the mechanism of injury. Management described strategies put in place following this incident, however, they could not demonstrate comprehensive investigation or consideration of mechanisms of injury based on the medical officer’s views in relation to the cause of bruising.
* The representative for Consumer H is very dissatisfied with the action and investigation undertaken following an alleged incident of rough handling.
* Clinical management are responsible for conducting incident investigations, however, incident management training has not yet been provided for responsible staff.
* The December 2022 performance report showed 90 unfinished incidents to finalise.
* In response to feedback from the Assessment Team, the provider implemented a process for incidents occurring overnight and all high priority incidents to be reported to the operations manager for oversight and support of investigations.

The provider submitted a response to the Assessment Team’s report and has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. However, the provider has submitted additional information and requested reconsideration of recommended findings but has not specifically respond to this Requirement but did provide a response to identified consumers. The provider submitted the following information and evidence relevant to my finding in this Requirement:

* In relation to Consumer H, management included further information about the investigation process in response to the allegation of rough handling, including that staff on the shift were interviewed where it was reported by staff that nothing eventful had occurred and no incident was identified as having occurred. Additionally, the outcome of the investigation was explained to the representative.
* In relation to Consumer K, the provider submitted further information about the incident, including considerations of mechanisms of injury and further detail about the consumer’s condition around that period.
* There is corporate initiative to improve the performance analysis and monthly reporting, including trending and analysis related to high-impact or high-prevalence risks. Additionally, all management are booked for root-cause analysis training in March 2023.
* The provider’s PCI actions relation to this Requirement include:
  + SIRS training has been booked.
  + Implement clinical support structure to support clinical staff and management at the service.
  + Implement improved incident management system.

Based on the Assessment Team’s report and the provider’s response, I find the service to be non-compliant with this Requirement.

While I acknowledge the provider’s PCI actions in relation to this Requirement, I find that the information and evidence indicates the service does not use effective risk management systems and practices relating to identifying and responding to abuse and neglect of consumers and managing and preventing incidents, including the use of an incident management system.

In coming to my finding, I have considered that incident investigations are not being conducted in accordance with the organisation’s incident management policy, which has resulted in incident forms for six incidents of allegations of physical or psychological harm which did not clearly document the details of the investigation, identify cause or actions to prevent reoccurrence. I acknowledge that three incidents had resulted in staff performance management processes for three staff members, but in relation to the incidents where a staff member could not be identified, staff have indicated this concludes the investigation process rather than considerations of other possible causes or actions to prevent reoccurrence.

In relation to Consumer K’s incident where significant bruising was identified and confirmed by the medical officer that it was unlikely it was sustained by a roll out of bed, management were able to describe strategies put in place following the incident but could not demonstrate comprehensive investigation or consideration of mechanism of injury. While the provider’s response includes further information about the incident, including considerations of mechanisms of injury and further detail about the consumer’s condition around that period, it is not evident this was considered at the time of the initial investigation.

In relation to Consumer H’s representative being dissatisfied with the action and investigation following an alleged incident of rough handling, the response included that staff on the shift were interviewed where it was reported by staff that nothing eventful had occurred and no incident was identified as having occurred. Additionally, the outcome of the investigation was explained to the representative. However, the service was unable to demonstrate further consideration of mechanism of injury for Consumer H.

There were also two incidents which were not identified by staff as requiring to be reported through the service’s incident management system. Therefore, these incidents have not been subject to the service incident investigation and management processes.

I have also considered that the service did not identify a potential trend in allegations of physical or psychological abuse by staff towards consumers overnight during the period of September 2022 to January 2023. If this trend had been identified, it would be reasonable to expect the organisation to analyse the trends/incidents and respond accordingly, to prevent further incidents or reoccurrence of incidents.

Additionally, the December 2022 performance report showed 90 unfinished incidents which required finalisation, a significant number of incidents to be finalised in the context of using this information to identify trends and ensure each incident has been investigated, with outcomes and actions considered in a timely manner.

For the reasons detailed above, I find that the service does not use effective risk management systems and practices relating to identifying and responding to abuse and neglect of consumers and managing and preventing incidents, including the use of an incident management system. Key personnel responsible for incident management and investigation have not been supported with incident management training and investigations, actions and outcomes of incidents identified by the Assessment Team indicates these personnel have not acted in accordance with the service’s policy in relation incident management, therefore, inhibiting the identification of trends, improvement to the quality of care and services, and to prevent similar incidents from occurring. While I acknowledge, the provider has submitted a PCI to remedy the deficits in this Requirement, I consider that the improvement activities are mostly yet to be implemented and require monitoring and time to establish efficacy and improved investigation processes, identification of trends and relevant actions, and ultimately consumer outcomes. Therefore, I find the service to be non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

**Requirements (3)(a) and (3)(e)**

Prior to the Site Audit conducted on 31 January 2023 to 3 February 2023, following a Site Audit conducted on 19 April 2022 to 21 April 2022, the service was found to be non-compliant with Requirement (3)(e) in this Standard. This non-compliant finding related to the service being unable to demonstrate an effective clinical governance system, specifically in relation to minimising the use of restraint and open disclosure.

At this Site Audit, the Assessment Team have recommended Requirement (3)(e) as met. The Assessment Team found the service had implemented improvement actions in relation to Requirement (3)(e), including:

* Review of the use of psychotropic medications and restrictive practices register.
* Review of behaviour support plans.
* Staff training in relation to open disclosure.
* New clinical meeting schedule.

The Assessment Team found these improvements to be effective and have recommended Requirement (3)(e) met.

In relation to the Requirements (3)(a) and (3)(e) in this Standard, the Assessment Team provided the following information and evidence relevant to my finding:

The service demonstrated it engages consumers in the development, delivery and evaluation of care and services and consumers are supported in that engagement. Consumers and representatives are invited to attend resident and relative meetings where they are provided an opportunity to feedback on care and service delivery, with meeting minutes demonstrating meetings are held regularly and cover a range of topics, including improvement actions. Consumer representatives are included on the organisation wide committee to provide consumer voice.

The organisation has policies and procedures to support staff to manage infections and promote antimicrobial stewardship, minimise the use of restrictive practices and consumer representatives gave examples of where the service has contacted them following an incident to inform them about what has occurred. I note that in relation to Consumer K in Requirement (3)(d) in this Standard, open disclosure was not completely effective in relation to the service informing the representative about the mechanism of injury, but the core of this issue relates to the incident investigation process which I have addressed in that Requirement.

Based on the Assessment Team’s report, including the evidence and information above, I find Requirements (3)(a) and (3)(e) in Standard 8 Organisational governance to be compliant.

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