Bupa Templestowe

Performance Report

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**Commission ID:** 3974

**Provider name:** Bupa Aged Care Australia Pty Ltd

**Site Audit date:** 8 March 2022 to 11 March 2022

**Date of Performance Report:** 12 May 2022

# Performance report prepared by

S Byers, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 5 April 2022.
* the service was issued a Notice of Decision to Impose Sanctions and Notice of Requirement to Agree to Certain Matters in March 2022 following a finding of non-compliance with seven of the eight Quality Standards in 21 requirements.
* the service was issued a Non-Compliance Notice in October 2021 following a finding of non-compliance with the Quality Standards in 2(3)(e), 3(3)(b), 7(3)(c) and 8(3)(d). The service did not rectify the non-compliance and the non-compliance is ongoing.

# STANDARD 1 NON-COMPLIANTConsumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Most consumers did not consider they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. For example:

* Consumers and representatives said consumers are not made to feel valued as they are not treated with dignity and respect. Representatives provided examples where the management of consumers continence and personal hygiene resulted in their dignity not being respected.
* Consumers described how staff do not always respect their personal privacy, often entering their rooms prior to gaining permission.
* Most consumers and representatives were satisfied consumers receive culturally safe care and services.
* Consumers were satisfied staff know what is important to them and that they are encouraged to do things for themselves.
* Consumers confirmed they have choice in their daily activities and are supported in maintaining connections inside and outside the service.
* Consumers confirmed that they are supported to take risks.

Staff described how they provide individualised care to consumers and support consumers to make decisions about their care and services. Staff described how they support consumers to take risks and assist consumers in making informed decisions.

Consumers’ care planning documents were individualised and reflected the consumers cultural needs and preferences. Consumer care files demonstrated the service supports consumers to take risks.

The Assessment Team observed some staff entering consumers rooms without knocking or gaining permission prior to entering.

The Quality Standard is assessed as Non-compliant as two of the six specific requirements have been assessed as Non-compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Non-compliant

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

The Assessment Team found that each consumer is not treated with dignity and respect, with their identity, culture and diversity valued. For example:

* Some consumers and representatives were dissatisfied that consumers are treated with dignity and respect. Examples included management of continence and personal hygiene resulting in consumers’ dignity not being respected.
* While staff demonstrated knowledge of individual consumers and their specific needs and preferences, meeting minutes demonstrated several consumers were concerned that agency staff do not know their needs and preferences.
* While staff were observed to treat consumers with respect and in a caring manner, some staff did not refer to consumers in their preferred name.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. For example:

* consultation with consumers and representatives.
* development of a comprehensive training plan including respect and dignity.

The Approved Provider advised it is an expectation of the service that all consumers are addressed in their preferred way as recorded in their care plan.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate each consumer is treated with dignity and respect. I find the service is Non-compliant with this Requirement.

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Non-compliant

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

While the service demonstrated personal information is stored securely and kept confidential, the service did not demonstrate that each consumer’s privacy is respected. For example:

* Dissatisfaction from consumers that staff do not respect their privacy when entering their rooms.
* Staff were observed on several occasions entering consumers’ rooms without knocking or gaining permission to enter.

Management explained staff are expected to knock on consumers’ doors prior to entering the room.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit.

The Approved Provider acknowledges that some staff were not following organisation work instruction that instructs all staff must knock and gain permission prior to entering a consumer’s room. The Approved Provider has developed a comprehensive training plan that addresses dignity and respect, including maintaining consumers’ privacy and realigning staff practice.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate each consumers’ privacy is respected. I find the service is Non-compliant with this Requirement.

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Most consumers did not consider they feel like partners in the ongoing assessment and planning of their care and services. For example:

* Consumers and representatives were not satisfied care and services are planned around what is important to consumers and not all staff know what is important to consumers in terms of how their care is delivered.
* While consumers and representatives said they were aware they had a care plan, they have not been offered a copy or the opportunity to discuss the care plan for some time.

High risk practices related to restrictive practices were not identified, assessed or planned for some consumers.

Assessment and planning did not identify current needs, goals and preferences within end of life care plans and advanced care directives for consumers.

The service did not demonstrate effective processes are in place to engage and partner with consumers and/or their representatives and to communicate outcomes of assessment and planning to the consumer and/or their representative.

The service did not demonstrate care and services were always reviewed for effectiveness or when incidents impact of the needs and preferences of the consumer.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

Whilecare documentation generally demonstrated that care planning includes relevant assessment and risk identification, risks related to restrictive practices were not identified, assessed or planned for some consumers. For example:

* There was no documented evidence of informed consent, regular review or risk assessment for a consumer subject to mechanical restraint.
* While a dignity of risk record was in place, no documented evidence of informed consent or regular review was in place to demonstrate a consumer subject to seclusion was appropriately risk assessed and managed by the service.

All staff interviewed confirmed both consumers were subject to restrictive practices. Management confirmed the consumers were subject to restrictive practices and should have had further documentation in place to manage the risk.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken during and since the site audit. For example:

* risk assessments have been completed, informed consent has been obtained and regular reviews scheduled for relevant consumers. The dignity of risk process is completed for one consumer and in progress for the other.
* consumer care plans have been updated with reviewed strategies for relevant consumers.
* development of a comprehensive training plan that includes identification, assessment and planning of restrictive practices.

In relation to the mechanical restraint the Approved Provider advised the restrictive practice had been implemented by the physiotherapist without consultation with the service and the consumer’s representative. The Approved Provider submits a new physiotherapy provider has been engaged and consultation with the consumer’s representative is ongoing.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that risks relating to restrictive practices were considered and appropriately documented to inform the delivery of safe and effective care and services to consumers subject to mechanical restraint and seclusion. I find the service is Non-compliant with this Requirement.

### Requirement 2(3)(b) Non-compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team found:

Care documentation sampled including advance care directives and end of life care plans demonstrated assessment and care planning does not identify and address consumers’ current needs and are not tailored to the individual consumer. For example:

* Advanced care plans were inconsistent, out of date or incomplete.
* Information in advanced care plans were limited and did not include personal goals or preferences for consumers.
* End of life wishes were not documented for two consumers commenced on an end of life pathway.
* Information about care strategies and interventions were inconsistent across consumers care planning documentation.
* Representatives expressed overall dissatisfaction in the services communication and management of consumers’ end of life care.

Clinical staff and management acknowledged the deficits in relation to end of life care needs and preferences resulting from the transition from paper based to electronic documentation.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken during and since the site audit. For example:

* development of an advance care directive tracker to guide staff in reviewing all advance care directive’s in consultation with consumers/representatives.
* development of a comprehensive training plan to build staff capability in end of life care, individualised care planning and best practice documentation. Effectiveness of the education will be evaluated through individual consumer evaluations, competency reviews and consumer/representative feedback.

The Approved Provider acknowledged the need to improve the documentation of individual consumer care planning to include goals and preferences regarding end of life care and advance care directives. The Approved Provider cited a commitment to ensure care and services are planned in partnership with consumers and representatives.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that 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. I find the service is Non-compliant with this Requirement.

### Requirement 2(3)(c) Non-compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The Assessment Team found that while care planning documents mostly reflected the consumer and others they wish to participate in assessment and planning, most consumers and representatives expressed dissatisfaction in their involvement in the consumers’ care and services.

While the service demonstrated processes are in place to engage with consumers and their representatives, the service did not demonstrate assessment and planning is based on ongoing partnership with the consumer and representatives. Examples included:

* Referrals made to other organisations, individuals and providers of care without informing representatives. For example, referral to a dietitian in response to a consumer’s weight loss.
* Implementation of new care and services for consumers without representatives being informed. For example, changes to a consumer’s medication.
* Irregular and inconsistent communication with consumers and representatives about consumer care and services.

Care planning documents demonstrated input from other organisations such as wound specialists, geriatricians and physiotherapists.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken during and since the site audit. For example:

* resident of the day review of all consumers that includes a family conference.
* development of a comprehensive training plan that includes staff communication and consultation with consumers and representatives, the effectiveness of the training will be evaluated through review and analysis of consumer and representative feedback.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that assessment and planning is based on an ongoing partnership with consumers and representatives. I find the service is Non-compliant with this Requirement.

### Requirement 2(3)(d) Non-compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The Assessment Team found the service did not demonstrate outcomes of assessment and planning are effectively communicated to consumers and/or representatives.

While consumers and representatives were aware they had a care plan, they expressed overall dissatisfaction with the availability and accessibility of care plans. One representative said they had not been involved in a care plan review for over six months, another raised concerns that care plans are restarted with each change in management.

The service’s electronic care system demonstrated care plans with easy to understand language and information relevant to the consumer. Management advised that family conferences are part of care plan reviews, however care plans reviewed by the Assessment Team identified that consultations were not occurring for all consumers and had only recently commenced.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. The Approved Provider advised family conferences had not been completed due to resourcing challenges COVID-19 posed to the service and have since been re-established with the commencement of the new management team

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that outcomes of assessment and planning are effectively communicated to the consumer and/or representatives where care and services are provided. I find the service is Non-compliant with this Requirement.

### Requirement 2(3)(e) Non-compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The service was found non-compliant with this Requirement on 7 October 2021 following a Serious Incident Report Scheme (SIRS) investigation. The Assessment Team found the service had not implemented improvements to address the deficits identified through this investigation.

The service provided the Assessment Team a plan for continuous improvement (PCI) to address the identified gaps in care provision. Several of the actions were commenced but had not been completed including a comprehensive six month education framework and engagement of a nurse practitioner.

Management acknowledged the actions were incomplete and cited instability of permanent staff and COVID-19 outbreaks as contributing factors to the delay. The education program was to recommence in March 2022.

The Assessment Team found that care documentation did not demonstrate that care and services were reviewed for effectiveness following implementation. The Assessment Team’s evidence included:

* No consumers that had pain charting in place following falls or changes in pain management had documented evaluation of the charting following completion.
* No consumers subject to fluid restrictions being monitored via fluid balance charting had documented assessment of fluid balance status every 24 hours.
* No consumers subject to food and fluid charting to manage weight loss had documented evaluation of the charts.
* Two consumers receiving ‘as required’ (PRN) medication did not have effectiveness documented following administration.
* The service did not review behaviour management or implement behaviour charts for two consumers following an incident. The service did not report the incident through its incident management system as required. Staff acknowledged the incident should have been reported.

Staff acknowledged that without review and evaluation of clinical charting, completion of charts do not inform care for consumers.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. For example:

* two new Clinical Care Managers and an Acting General Manager have commenced at the service and have prioritised progressing the plan for continuous improvement. The plan for continuous improvement has been reviewed to capture the ongoing non-compliance and embed necessary improvements.
* development of a comprehensive training plan that include the review and evaluation process, the effectiveness of the training will be evaluated through monitoring the impact on consumer care and services.

The Approved Provider acknowledged the improvements to address the current non-compliance were not completed within the required timeframe

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents occur. I find the service is Non-compliant with this Requirement.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Overall sampled consumers did not always consider they receive personal care and clinical care that is safe and right for them. For example:

* Representatives expressed dissatisfaction with the management of consumers behaviours, weight loss and falls.
* Representatives were not satisfied with the service’s communication of needs, goals and preferences for consumers.

The service did not demonstrate the management of each consumer’s pain, skin integrity or restrictive practices was best practice, tailored to their needs or optimised their health and well-being. Two consumers did not have restrictive practices identified or appropriately managed, one consumer did not have effective pain management implemented prior to complex wound management and two consumers’ skin integrity risks were not appropriately managed.

The service did not demonstrate it effectively manages the high impact or high prevalence risks associated with falls, weight, fluid balance requirements or behaviour management.

The service did not demonstrate that comfort was maximised and dignity preserved for consumer on an end of life pathway.

While mixed feedback was received from consumer representatives, the service demonstrated deterioration or change in consumers health status was responded to in a timely manner. Care planning information reflected the service responded to changes in consumers’ health status. Staff described deterioration, reporting and assessment processes for consumers.

While the service demonstrated it has processes to document and communicate information about consumers’ condition, needs and preferences including verbal and written handover, consumer representatives were not satisfied with how the service communicates consumer information.

While mixed feedback was received regarding appropriateness of referrals, the service demonstrated referrals are appropriate and made in a timely manner. Staff described how they make referrals to external services. Care planning documents evidenced referrals were made where necessary.

The service demonstrated it has policies and procedures, as well as equipment and supplies to manage both COVID-19 and any other infectious outbreaks. The service has an antimicrobial stewardship (AMS) plan in place to guide staff practice. Standard and transmission-based precautions have been implemented to support the service to prevent and control infection.

The Quality Standard is assessed as Non-compliant as four of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found the service did not demonstrate that each consumer receives personal and clinical care that is effective, safe and optimises their health and well-being. The Assessment Team identified deficits in care across several clinical areas including restrictive practices, pain management, skin integrity and wound management. For example:

* One consumer did not have their pain managed effectively prior to complex wound management. Wound management plans were in place for the consumer’s five pressure injuries. The consumer, who is bed bound and non-verbal had been reviewed by a geriatrician who had observed the consumer to be in visible discomfort during wound care and identified ‘as required’ pain medication was not being utilised consistently to manage the consumer’s pain. The geriatrician provided several recommendations to manage the consumer’s pain including use of ‘as required’ analgesics and topical analgesics prior to wound care. Document review identified the consumer had not been provided ‘as required’ analgesics to relieve pain on several occasions prior to wound care. While document review demonstrated a consultation had occurred with the consumer’s representative regarding the use of topical analgesia the outcome of this discussion was not documented. Clinical staff advised that a decision had been made to not implement the use of topical analgesia to manage the consumer’s pain during wound care, however this was not documented. Clinical staff acknowledged the deficit in the consumer’s pain management.
* Two consumers did not have restrictive practices identified or appropriately managed by the service. For example:
* The Assessment Team did not view any documentation to evidence the service had considered the use of a lo-lo bed by a consumer to be mechanical restraint. Clinical staff acknowledged the use of the lo-lo bed for the consumer should have been assessed as mechanical restraint.
* Risk management strategies relating to the management of a consumer subject to seclusion were inconsistently documented in the consumer’s care documentation. Close supervision charting records did not consistently document close supervision of the consumer by staff when the consumer’s bedroom door was locked. The consumer’s representative advised they had requested the consumer’s bedroom door to be locked due to concerns with the service’s ability to safely supervise the consumer. The request was made following an incident with another consumer. Management acknowledged the practice of locking the consumer’s door without consistent supervision was high risk and did constitute a restrictive practice that required further risk assessment and consideration by the service.
* The service did not demonstrate it utilises ‘as required’ psychotropic medication appropriately for consumers or that it is always administered as a last resort. Documentation review of a consumer prescribed psychotropic medication identified non-pharmacological strategies were not recorded prior to the use of the medication and effectiveness was not documented. Behaviour charting was not completed to monitor another consumer following a change in psychotropic medications.
* One consumer at high risk of skin tears due to blood thinning medication did not have strategies documented in their care documentation to minimise the risk. The consumer’s representative described strategies in place to minimise the risk of skin tears including limb protectors. Care staff were not aware of any strategies to minimise the consumer’s risk of skin injury. The Assessment Team observed the consumer to have multiple dressings and bruising on their forearms. The consumer was not wearing limb protectors and was observed mobilising through the service consistently bumping into door frames and furniture.
* Another consumer at high risk of pressure injuries had documented strategies in place that booties were to be worn at all times and the consumer was not to be positioned on their back due to a high risk of developing a pressure injury. The Assessment Team observed the consumer to be positioned on their back and not wearing booties during the site audit. Documentation demonstrated the consumer had been positioned on their back multiple times between February and March 2022 and that this intervention had not been transferred from the handover document to the consumer’s care planning documentation. Further interventions in place and identified as not being adhered to by the Assessment Team were position changes every four hours.

I have also considered the deficits in documentation and risk assessment relating to restrictive practices and the Approved Providers response under Standard 2, Requirement 2(3)(a). I note the Approved Providers response and actions commenced in relation to restrictive practices documentation under Standard 2 Requirement 2(3)(a) and have considered this when evaluating the Assessment Team’s evidence with regard to the service’s identification, management and monitoring of restrictive practices.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken prior and since the site audit. For example:

* review of pain management strategies, medication charts, skin integrity assessment and strategies for relevant consumers.
* development of a comprehensive training plan that includes pain management, restrictive practices, assessment and planning documentation.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate each consumer receives personal and clinical care that is effective, safe and optimises their health and well-being, particular in relation to restrictive practices, pain management, skin integrity and wound management. I find the service is Non-compliant with this Requirement.

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

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

The service was found non-compliant with this Requirement on 7 October 2021 following a Serious Incident Report Scheme (SIRS) investigation. The Assessment Team found the service had not implemented improvements to address the deficits identified through this investigation.

The Assessment Team found the service did not demonstrate effective management of high impact or high prevalence risks associated with falls, weight loss, fluid balance and behaviour management. The Assessment Team found deficits in the way these aspects of consumers’ care is delivered. For example:

* One consumer, assessed as high falls risk who has experienced several unwitnessed falls, two of which resulted in injury, had interventions documented in their care plan including staff assistance for all transfers and mobility and ongoing close supervision monitoring. The Assessment Team observed the consumer mobilising throughout the service on multiple occasions during the site audit without staff assistance or supervision. On one occasion the Assessment Team and a visitor observed the consumer to be very unsteady and physically guided them to a chair to prevent a fall, subsequently advising care staff the consumer required assistance. The consumer’s representative expressed concern regarding falls management and lack of supervision by staff. Two other consumer representatives described assisting the consumer on other occasions as no staff were available to assist. Following the near miss fall the Assessment Team identified the near miss incident had not been documented within progress notes or the service’s incident management system and observed the consumer to continue moving through the service unsupervised. Clinical staff identified the consumer was a high falls risk but were unaware staff were not assisting or supervising them in line with their documented interventions.
* Another consumer, who experienced a fall and was transferred to hospital with injury had pain charting commenced on return from hospital, however this was inconsistently completed. Inconsistencies were also identified in documentation that did not align with the administration of ‘as required’ pain relief medication. While risk management strategies were documented in the consumer’s care plan to minimise risk of falls, the Assessment Team observed the strategies were not implemented or actioned in line with care documentation during the site audit. For example, hip protectors were not worn, sensor mats were not in place and close supervision charting was inconsistent.
* For two consumers experiencing weight loss, weekly weights were not completed as per dietitian directives. Deficits were found in food and fluid charting for one of the consumers. Consumer representatives were dissatisfied with the service’s management of the consumers’ weight loss.
* The Assessment Team identified a consumer who had been transferred to hospital and treated for fluid overload. Review of care documentation identified inconsistencies including varying fluid restriction amounts. Weight charts identified daily weighs were not being completed in line with medical directives. Clinical management acknowledged the consumer’s care was not being managed according to their assessed needs which increased the consumer’s risk of repeated episodes of fluid overload.
* While a consumer was reviewed by a geriatrician following an incident with another consumer and behaviour charts were in place and completed, the referral to the geriatrician did not specifically address the incident and seek recommendations to mitigate the risk of the incident reoccurring in the future. The service did not demonstrate behaviour charting was evaluated or demonstrated the consumer had any further review or assessment of their behaviour to minimise the risk to other consumers. For example, in the seven days following the incident multiple behaviour chart entries documented the consumer’s ongoing resistance and refusal of care interventions and all strategies were recorded as ineffective.
* The Assessment Team identified another behaviour related incident had not been reported appropriately and an incident report had not been completed. Clinical management acknowledged this should have been reported to SIRS.

Several consumer representatives expressed dissatisfaction with behaviour management at the service. Two representatives were concerned about the safety of their consumers and cited the lack of staff in the service’s dementia specific wing as contributing factors. The Assessment Team observed minimal staff presence in the dementia specific wing during the site audit. The Assessment Team observed three consumers who had been involved in behaviour related incidents with other consumers wandering without staff supervision.

I have considered the Approved Providers response and actions commenced in relation to staffing deficits under Standard 7 Requirement 7(3)(a).

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken prior and since the site audit. For example:

* falls risk assessments and updated care plans with strategies have been completed for relevant consumers
* assessment of weight management strategies and updates to care plans and handover documents are underway for relevant consumers
* behaviour charts and care plans have been updated to align with strategies for relevant consumers
* development of a comprehensive training plan that includes falls prevention and management, unplanned weight loss and behaviour management.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. I am not satisfied the Approved Provider demonstrated that risk of falls, weight loss, fluid restrictions and responsive behaviours have been managed effectively. I find the service is Non-compliant with this Requirement.

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

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

The Assessment Team identified a consumer on end of life palliative pathway following a deterioration in health. The Assessment Team observed the consumer and identified the care provided did not align with the consumer’s end of life documentation. The Assessment Team observed the consumer’s comfort was not maximised, the consumer appeared to be visibly agitated, restless and mouth care had not been completed. Management and clinical staff were unable to explain the inconsistencies in care and documentation.

The consumer’s representatives expressed dissatisfaction in the service’s management of the consumer’s palliative care needs. For example, care strategies including commencing the consumer on pain medication without informing the representatives, and overall lack of support by the service for the family regarding the consumer’s end of life care.

I acknowledge that in response to the Assessment Team’s observations, the consumer was assessed by a Palliative Care Team during the site audit.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken prior and since the site audit including organising additional support for the consumer’s family and scheduling a family consultation to review the end of life care provided to the consumer.

I have also considered the deficits in end of life care documentation identified by the Assessment Team in Standard 2 Requirement 2(3)(b). I note the Approved Provider’s response and actions commenced in relation to end of life care under Standard 2 Requirement 2(3)(b) and have considered this when evaluating the Assessment Team’s evidence with regard to the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that the needs, goals and preferences of consumers on end of life pathways are effectively recognised and addressed to ensure their comfort is maximised and dignity preserved. I find the service is Non-compliant with this Requirement.

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

The Assessment Team found:

* Consumer representatives were not satisfied with how the service communicates consumer information. For example, one representative advised they contact the general practitioner directly rather than relying on the service, two representatives described how the service no longer communicates with them about changes to their consumer’s care.
* Inconsistencies in care documentation for some consumers relating to the management of fluid restrictions, positioning directives for pressure injuries and weight.

Management acknowledged the ongoing issues identified with communication needs at the service.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken prior and since the site audit. For example:

* re-commencement of family conferences.
* consumer care plans have been reviewed and updated for relevant consumers.
* development of a comprehensive training plan that includes communication. The effectiveness of the training will be evaluated through consumer and representative feedback.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate that consumer information is communicated effectively within the organisation and with others where responsibility for care is shared. I find the service is Non-compliant with this Requirement.

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 NON-COMPLIANTServices and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Most consumers did not consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. For example:

* Consumers and representatives were not satisfied with the program of lifestyle activities.
* Consumers and representatives are not satisfied there is adequate support for emotional, spiritual and psychological well-being.
* Consumers stated that they are supported to remain in contact with their family and friends through visits or through telephone and video calls.
* While the majority of consumers and representatives expressed satisfaction with meals, some consumers and representatives raised concerns about the quality and sufficiency of meals.

While consumers and representatives were not satisfied communication about consumer needs and preferences occurred within the organisation and with others as appropriate, care plans captured information about consumers’ conditions, lifestyle needs and preferences with updates reporting participation in offered activities.

The activity program offers only limited options for consumers and does not meet the needs of many consumers. Advertised programs to provide one-on-one support for consumers are not provided. Consumers were observed isolating in their rooms with little staff interaction. Religious services are not available face-to-face resulting in many consumers being unable to participate in religious ceremonies as per their preferences.

Care plans document relationships that are important to consumers and describe their previous lifestyle interests and hobbies. Staff described supports for consumers to maintain relationships even during the COVID-19 lockdown.

Dietary needs and preferences are catered for and nutritional supplements are provided as required. Catering staff explained how consumers are provided opportunities to have input into menu selections and they are encouraged to provide feedback to the kitchen on meal satisfaction.

Equipment provided is safe, suitable and well maintained.

The Quality Standard is assessed as Non-compliant as two of the seven specific requirements have been assessed as Non-compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The Assessment Team found consumers are not provided with effective supports for daily living that meet their needs, goals and preferences. For example:

* Consumers and representatives were dissatisfied with the lifestyle activities offered and stated that these do not meet consumer’s needs.
* Representatives were concerned the limited number of lifestyle staff in the dementia specific wing impacted the support provided to consumers.
* At the time of the site audit the service did not have a lifestyle coordinator to oversee the program being offered to consumers and ensure the program is meeting consumer’s needs.
* Lifestyle staff stated that they had not received any training around provision of lifestyle programs in the last 2 -3 years.
* The activity program does not include visiting entertainers or face-to-face supports from religious personnel to support consumers’ well-being.
* Only small groups of consumers were observed to participate in offered activities.

The Assessment Team observed a number of consumers remained in their rooms throughout the day without any supports provided to these consumers. Staff confirmed that despite many consumers requiring one-on-one time there is little time to provide this with the current staffing model.

The Assessment Team observed consumers placed in front of televisions in the various lounges of the service. A number of these consumers were asleep in fallout chairs not watching the screen.

While music videos were played in the dementia specific wing in the afternoons for consumers to sing to, the Assessment Team observed many of the consumers were disengaged with this activity, with some continuing to wander aimlessly.

Management advised that they are currently recruiting for a new lifestyle coordinator who will be able to oversee the activities and lifestyle program. Management advised that they plan to recommence having volunteers return soon and are working on organising bus trips.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. For example:

* consultation will be undertaken and feedback opportunities provided to consumers and representatives in relation to lifestyle activities.
* the lifestyle program is being revised including updating activity calendars to reflect consumers’ preferences.
* a new lifestyle coordinator has been recruited.
* recruitment to increase the lifestyle team is ongoing
* arrangements have been made to re-commence bus trips, face to face religious services, visiting volunteers and visiting entertainers. Bus trips and music concerts commenced in March 2022.
* development of a comprehensive training plan that includes education for lifestyle staff on lifestyle assessment, consultation and consumer engagement in activities to be evaluated through level of consumer engagement and feedback.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate each consumer receives 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. I find the service is Non-compliant with this Requirement.

### Requirement 4(3)(b) Non-compliant

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

The Assessment Team found services and supports for daily living do not support consumer’s and representatives emotional, spiritual and psychological well-being.

Representatives provided feedback regarding the lack of emotional and spiritual support provided to consumers and representatives.

Care plans informed staff about emotional and spiritual supports required for consumers, documenting the need for many to have one-on-one support as they were isolated in their rooms. Staff advised that due to the current lifestyle staffing model there was insufficient time to provide one-on-one support to consumers’ isolating in their rooms. The Assessment Team observed that many consumers remained in their rooms throughout the site audit, including not attending the dining room for meals. Lifestyle activities do not provide support for consumers who are isolated in their rooms.

A displayed poster advised of the community visitors scheme that lifestyle staff organise for visitors to come and spend one-on-one time with consumers if they are feeling isolated. The service advised this has not been operational since 2020 due to COVID-19 restrictions.

Due to restrictions enforced during the COVID-19 lockdown there is no face-to-face support from religious personnel available to consumers unless they are being palliated.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. For example:

* review of consumer strategies and increased one on one support for consumers isolated in their rooms
* arrangements have been made to recommence face to face religious services
* ongoing recruitment of lifestyle staff.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. I find the service is Non-compliant with this Requirement.

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

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall sampled consumers considered that they feel they belong in the service, and feel safe and comfortable in the service environment. For example:

* Consumers and representatives said that the service is welcoming and the environment helps them feel at home.
* Consumers and representatives are satisfied the service is comfortable and well-maintained and generally noted improvements in cleaning of the service.
* Consumers and representatives are satisfied fittings furniture and equipment is kept clean and well maintained.

The service is welcoming and promotes consumer independence and belonging. The living environment was observed to be clean, comfortable and well maintained. Furniture, fittings and equipment are clean and in good order.

While there is freedom of movement in most areas of the service, doors leading to outside areas in the dementia specific wing were locked, with supervised access by staff. Management promptly addressed this during the site audit.

Staff described processes for reporting faults with equipment and confirm these are safe and well-maintained. Maintenance staff demonstrated reactive and preventative maintenance protocols.

Documentation demonstrated a program of preventative maintenance and timely response to address reported deficits.

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Overall sampled representatives did not consider that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. For example:

* While consumers and representatives were aware of the various ways they can provide feedback or make a complaint, a number of consumers/representatives said that they were not satisfied with the management of their complaints and no changes have occurred. Representative stated they had been required to escalate their concerns to external authorities.

Staff demonstrated an awareness of complaints mechanisms available including provision for making an anonymous compliant. Information on accessing an interpreter was displayed for consumers and representatives with languages other than English.

Management and staff described improvements that have been made as a result of feedback at the service, including new way finding pictorial signage in the memory support unit and new dementia specific equipment.

The Assessment Team observed information displayed within the service on internal and external complaints. Feedback forms were available to consumers and representatives with locked mailboxes placed for receipt of forms located throughout the service.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

The Assessment Team foundthe service does not have a robust complaints system that ensures that complaints are managed, investigated and resolved to the satisfaction of the complainant.

The Assessment Teams evidence included:

* Negative feedback from some consumers/ representatives that appropriate action is not taken to complaints. Some representatives stated that they had at times escalated their complaints to an external body as they remained dissatisfied with the internal complaints’ management process.
* While there is a complaint policy that documents the need to ensure complainants are satisfied with outcomes, the service could not demonstrate the complaint policy was being applied as documented.
* Documentation demonstrated that complaints are not actioned in a timely manner. For example, an ongoing complaint from several consumers had not been actioned for at least three months. The lack of action was confirmed by staff.
* The service’s customer feedback analysis reports do not capture feedback and complaints from all sources. For example, focus groups, surveys and Resident and Relatives meetings. Therefore, complaint data and analysis is not accurate and does not record and monitor all feedback is actioned and issues escalated to management’s attention.

Management advised they were aware of the issues raised by representatives and were planning actions to address the concerns and complaints.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. For example:

* recommencement of family conferences.
* management are meeting with representatives with outstanding concerns to progress the resolution process.
* development of a staff training plan that includes complaints management and open disclosure.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate effective complaint systems were in place to ensure complaints are appropriately actioned by the service. I find the service is Non-compliant with this Requirement.

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

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall consumers did not consider that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. For example:

* Consumers and representatives are not satisfied that the number and mix of staff enables the delivery of safe and quality care and services.
* Consumers and representatives are not satisfied or feel confident staff are competent to effectively perform their roles.

Staff expressed concern about high levels of staff turnover and the impact on shifts. Roster documentation shows high use of casual and agency staff and that not all unplanned leave is replaced. New management acknowledged challenges with the current workforce and are implementing a plan of action to address the deficits.

Staff were not always observed demonstrating required competence relative to their role, however observation of interaction between staff and consumers was generally observed to be kind and caring.

While staff described information and support provided at the time of their induction, records provided by management demonstrated high proportions of staff have not completed mandatory training.

Management and staff described formal processes to review the performance of staff and the new clinical management described actions to monitor the day to day performance of staff.

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

## Assessment of Standard 7 Requirements

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

### The Assessment Team found the service, at the time of the site audit, was not adequately staffed to deliver and manage safe and quality care and services.

The Assessment Team’s evidence included negative feedback from consumers, representatives and staff about insufficient staffing levels at the service. Consumers and representatives described examples where lack of staff had directly impacted the quality of care and services provided to consumers. For example, consumers having to wait for staff assistance, meal times in the dementia specific wing, continence care and lifestyle activities. Two representatives spoke about supervising a consumer who frequently falls as there were no staff around to assist.

Staff expressed concern about the high levels of staff turnover and the impact on shifts. Clinical staff expressed concern with the heavy reliance on registered nursing shifts being filled by agency staff. At the time of the audit there was no lifestyle coordinator and two lifestyle staff across three wings. Refer to Requirements 4(3)(a) and 4(3)(b) for impacts to consumers services and supports resulting from lack of lifestyle staff.

I have also considered Assessment Team observations of minimal staff presence in the service’s dementia specific wing under Standard 3 Requirement 3(3)(b) and the increased risk this has on behaviour related incidents.

Roster documentation demonstrated high use of casual and agency staff and that not all unplanned leave is replaced.

Management advised the service had recently undergone a change in the management in the service with the appointment of a new Acting General Manager and two new Clinical Care Managers. Management advised the service experienced challenges during the periods of COVID-19 single site restrictions and that this had a significant impact on staffing in the service, particularly registered nursing shifts. Management acknowledged the issues with staff workflow and demonstrated they had commenced actions to improve workflow and communication.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken prior to and since the site audit. For example:

* seeking feedback from consumers and representatives.
* implementation of a program to re-engage staff impacted by COVID-19 single site restrictions.
* revising the service’s recruitment strategy to focus on retaining current staff and recruiting new staff. Several staff were employed in February 2022.
* Clinical Care Managers adjusted workhours to work weekends to enable direct management engagement with consumers and representatives seven days a week.
* education on staffing levels, staff training and competencies and effective workforce management and deployment will be delivered to management and rostering staff.

The Approved Provider acknowledges that while several of the actions are still in progress, review of workforce data demonstrates the use of agency staff has decreased.

I have also considered the Approved Providers response to Standard 4 Requirement 4(3)(a) and 4(3)(b) where it advised a new lifestyle coordinator has been recruited and recruitment to increase the lifestyle team is ongoing.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate the workforce is planned to enable the delivery and management of safe and quality care and services to consumers. I find the service is Non-compliant with this Requirement.

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

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

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

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

The service was found non-compliant with this Requirement on 7 October 2021 following a Serious Incident Report Scheme (SIRS) investigation. The Assessment Team found the service had not implemented improvements to address the deficits identified through this investigation.

Consumers and representatives provided feedback that they were not satisfied or confident staff are competent to effectively perform their roles. Examples included, agency staff not knowing consumers or care procedures and inadequate management of behaviours and weight loss.

Throughout the site audit the Assessment Team observed deficits in staff practice and knowledge in a significant number of Requirements across seven of the eight Quality Standards. Refer to Standards 1, 2, 3, 4, 6 and 8 for deficits identified by the Assessment Team.

Management advised the improvement action plan to address the deficits which comprised a staff skills development program was ceased after commencement due to staff discontinuity. For example, loss of staff and high number of casual and agency staff.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit.

The Approved Provider acknowledges improvements in the plan for continuous improvement were not embedded within the required timeframe. A comprehensive training plan has been developed to deliver education to staff across all non-compliant requirements. Training will consist of online learning, competency assessments and face to face training.

The Approved Provider is progressing the reduction in the services reliance in agency staff. Where agency staff are to be utilised, the provider is taking steps to ensure consistency in agency staff members.

I have considered the information provided by the Assessment Team and the approved provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. I find the service is Non-compliant with this Requirement.

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

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

While staff described available training and education, the Assessment Team found several deficits in staff knowledge and practice in multiple Requirements across seven of the eight Standards. For example:

* Consumers and representatives did not provide feedback on specific training needs required for staff, however expressed dissatisfaction with staff knowledge and practice in clinical and personal care.
* Lifestyle staff advised they had not received any training around provision of lifestyle programs in the last 2 -3 years.
* Training records provided by management demonstrated a high proportion of staff had not completed mandatory training modules.

Management advised they had commenced education for staff based on observation of practice aligned with organisational work instructions.

TheApproved Provider has been found non-compliant with several Standards with deficits identified in staff competency to deliver outcomes under the Quality Standards. For example, care documentation and review systems, management of falls, weight, medication, responsive behaviours, restrictive practices and pain, lifestyle activities and dignity and respect.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit. A comprehensive training plan has been developed to support staff completion of mandatory training and to upskill in areas of concern.

In relation to lifestyle staff comments about the lack of training, the Approved Provider submitted review of attendance records to demonstrate staff had attended several training sessions in 2021. Further, the Regional Lifestyle Manager is working closely with lifestyle staff. The service’s comprehensive training plan includes education required to be completed by lifestyle staff on lifestyle assessment, consultation and consumer engagement and activities.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate the workforce is appropriately trained and equipped to deliver the outcomes required by the Quality Standards. I find the service is Non-compliant with this Requirement.

### Requirement 7(3)(e) Compliant

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

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Overall consumers/representatives did not consider that the organisation is well run and that they can partner in improving the delivery of care and services. For example:

* Feedback from consumers and representatives highlighted high levels of dissatisfaction they have not been engaged in the development, delivery and evaluation of care.

The organisation has effective governance systems in relation to information systems, financial and regulatory compliance, however governance systems in relation to workforce, feedback and continuous improvement are not effective. The organisation did not demonstrate that effective systems are in place to monitor the workforce and identify and respond in a timely manner to workforce deficits, to identify, monitor and respond to individual and trends of feedback and complaints and to ensure continuous improvement is implemented and embedded.

While the organisation provided a documented risk management framework supported by policies and procedures to manage risk, staff knowledge and practices to support the effective application of the associated policies and work instruction are not effective.

While the organisation provided a clinical governance framework that includes antimicrobial stewardship, minimising the use of restraint and an open disclosure policy, staff did not demonstrate an understanding of, and consequently an application, of all aspects of restrictive practices, including risk associated with the use of seclusion.

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

## Assessment of Standard 8 Requirements

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

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

The Assessment Team found that consumers and representative were not satisfied they are engaged in the development, delivery and evaluation of care and services. Representatives described not feeling heard and lack of communication with the service.

Management said they started implementing processes to improve engagement with consumers and representatives. A monthly consumer and representative meeting commenced in February 2022.

While management identified care planning and review processes as mechanisms to engage consumers/representatives, deficits identified in Standard 2, Requirement 2(3)(e) and Standard 3 demonstrate these processes are not effective. I note the Approved Provider’s response and actions commenced in relation to communication and consultation under Standard 2 Requirement 2(3)(e) and Standard 3 and have considered this when evaluating the Assessment Team’s evidence with regard to the services engagement with consumers and representatives in the development, delivery and evaluation of care.

The Approved Provider provided a response that included clarifying information to the Assessment Team’s report as well as actions taken since the site audit.

I have considered the information provided by the Assessment Team and the approved provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate the service had in place systems to ensure consumers are engaged and supported to be engaged in the development, delivery and evaluation of care and services. I find the service is Non-compliant with this Requirement.

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

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

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

While the Assessment Team found the organisation has effective governance systems in relation to information management and regulatory compliance, the service did not demonstrate effective continuous improvement, workforce, feedback and complaints governance systems.

The service was found non-compliant with four Quality Standards on 7 October 2021 following a SIRS investigation. While the service commenced actions to address the deficits through a plan for continuous improvement, the actions were ceased due to instability in staffing and COVID-19 outbreaks. The actions were not completed within the relevant timeframe. TheApproved Provider has been found non-compliant with seven of the eight Standards with a significant increase in deficits identified in several Requirements that have an adverse impact on consumers. The service’s system to monitor care and services did not identify and respond to these deficits in a timely manner.

Evidence in the Assessment Team’s report, most specifically Standards 3, 4, 6 and 7 demonstrates the service does not have effective workforce, feedback and complaint systems. Deficits in workforce systems include, workforce planning, insufficient staff and staff capability that adversely impact on the care and services of consumers. Consumers and representatives are not satisfied their feedback or complaints are actioned appropriately. A common theme in consumer and representative feedback across all Standards is that they did not feel heard and the lack of the communication and response by the service.

I acknowledge that new management of the service is reviewing and progressing the service’s plan for continuous improvement in light of the new non-compliance and has implemented some actions as demonstrated by the Approved Provider’s response to Standards 1, 2, 3, 4, 6, 7 and 8.

I have considered the Approved Provider’s response and actions commenced in relation to workforce and feedback and complaints under Standard 7 Requirements 7(3)(a), 7(3)(c) and 7(3)(d); and Standard 6 Requirement 6(3)(c) including the comprehensive training plan that will include workforce governance, complaints management and open disclosure.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate effective continuous improvement, workforce governance, feedback and complaint systems were in place. I find the service is Non-compliant with this Requirement.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The service was found non-compliant with this Requirement on 7 October 2021 following a Serious Incident Report Scheme (SIRS) investigation. The Assessment Team found the service had not implemented improvements to address the deficits identified through this investigation.

While the service commenced actions to address the deficits through a plan for continuous improvement, the actions were ceased due to instability in staffing and COVID-19 outbreaks.

While the organisation provided a documented risk management framework supported by policies and procedures to manage risk and abuse and neglect of consumers, staff knowledge and practices to support the effective application of the associated policies and work instruction is not effective. This is supported by evidence within the Assessment Team report, most specifically Standards 2 and 3 that demonstrates the service is not effectively identifying and responding to high impact high prevalence risks associated with falls, weight and behaviour management and restrictive practices.

Staff training records demonstrated that 31 staff have not completed mandatory incident and risk management training modules. The Assessment Team identified a SIRS reportable incident that was not reported or any incident raised (refer to Standard 3 Requirement 3(3)(b) for further detail). The new Clinical Care Managers acknowledged the management of incidents and staff practices require improvement.

While I acknowledge that new management of the service were progressing the service’s plan for continuous improvement including the implementation of an electronic care documentation system, the actions were not completed within the required time frame.

I have considered the Approved Provider’s response and actions commenced in relation to risk management under Standard 2 and 3 including the comprehensive training plan that will include effective risk management.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate effective risk management systems to effectively manage high impact high prevalence risks to consumers and prevent incidents. I find the service is Non-compliant with this Requirement.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The organisation’s clinical governance framework and policies that include antimicrobial stewardship, open disclosure and restrictive practices are available to the service.

While the service demonstrated policies and work instructions are in place to manage restrictive practices, staff did not demonstrate an effective understanding and application of the policies, including the identification of risks associated with the restrictive practice. For example, mechanical restraint and seclusion.

The service’s psychotropic medication monitoring tool was not reflective of all consumers subject to chemical restraint at the service. The service did not always utilise as required psychotropic medications appropriately for two sampled consumers. Refer to Standard 3 Requirement 3(3)(a) and Standard 2 Requirement 2(3)(a) for further information.

The Approved Provider acknowledged in its response that the application of its clinical framework did not result in the service understanding, identifying, assessing and planning restrictive practices. The Approved Provider advised that identification, assessment and planning of restrictive practices will form part of the comprehensive training plan being developed and implemented.

I have considered the information provided by the Assessment Team and the Approved Provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the Approved Provider did not demonstrate its clinical governance framework is effectively applied in practice. I find the service is Non-compliant with this Requirement.

# 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 Requirements 1(3)(a) and 1(3)(f)**

* Ensure all consumers receive care and services in line with their personal and needs and preferences.
* Ensure all consumers are treated with dignity and respect, particularly when managing consumers’ continence care and personal hygiene.
* Ensure each consumer’s privacy is respected by staff knocking and gaining permission prior to when entering the consumer’s room.

**Standard 2 Requirements 2(3)(a) - 2(3)(e)**

* Implement processes to ensure that risks related to consumers subject to restrictive practices are identified, assessed, planned and appropriately documented as required.
* Implement processes to ensure assessment and care planning reflects the current needs, goals and preferences of consumers.
* Implement processes to ensure advance care planning and end of life planning for consumers is current and complete and end of life wishes are documented for all consumers on a palliative pathway.
* Implement processes to ensure ongoing partnership and consistent and regular communication and consultation with consumers, representatives and others they wish to involve in assessment, planning and review of care and services.
* Implement effective processes to ensure care planning documents are reviewed when circumstances change or when incidents occur, particularly regarding pain, fluid restrictions, weight loss, medication and behaviour management.
* Establish and implement monitoring processes to ensure deficits in documentation are identified and addressed to ensure all information remains current and relevant and the requirements of Standard 2 are complied with on an ongoing basis.

**Standard 3 Requirements 3(3)(a), 3(3)(b) 3(3)(c) and 3(3)(e)**

* Ensure planned care that is tailored to each consumer’s needs is consistently delivered and best practice clinical principles applied for all consumers, specifically the management of restrictive practices, pain, skin integrity and wounds.
* Ensure effective identification and management of high impact and high prevalence risks associated with falls, weight, fluid balance and behaviour management.
* Implement processes to ensure consumers on an end of life pathway are comfortable and their dignity is preserved.
* Implement processes to ensure effective and consistent communication and consultation with consumers and their representatives.
* Ensure staff have the skills and knowledge to manage high impact and high prevalent risks relevant to consumers living at the service.
* Ensure staff have the knowledge and skills to support processes relating to management of restrictive practices, pain, skin integrity and wounds, weight, fluid balance, falls and behaviours.

**Standard 4 Requirements 4(3)(a) and 4(3)(b)**

* Ensure all consumers get safe and effective services and supports for daily living including consumers in the dementia specific wing.
* Ensure the service’s lifestyle program is developed to meet all consumers’ needs and preferences, including one on one support.
* Ensure lifestyle staff have the knowledge and skills to support processes relating to the lifestyle program and supporting consumers’ emotional, spiritual well-being.

**Standard 6 Requirements 6(3)(c)**

* Ensure all complaints are actioned appropriately.
* Ensure feedback and complaints data is analysed from all relevant sources.

**Standard 7 Requirements 7(3)(a), 7(3)(c), 7(3)(d)**

* Ensure 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.
* Ensure staff are recruited, trained, equipped and supported to deliver safe and quality outcomes under the Quality Standards.
* Ensure all staff complete mandatory training modules.
* Ensure the comprehensive training program developed to address the identified non-compliance is implemented and embedded to build staff capability, competence and practice.

**Standard 8 Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e).**

* Implement processes to ensure consumers are engaged in the development, delivery and evaluation of their care and services.
* Ensure effective workforce, feedback and complaints governance systems are in place at the service and that staff have the understanding and capability to apply the systems in practice.
* Implement an effective continuous improvement system to ensure deficits in consumers’ care and services are identified, managed and monitored in a timely manner.
* Ensure risk management systems are implemented in practice to manage high impact and high prevalence risks associated with the care of consumers, specifically falls, weight and behaviour management and restrictive practices.
* Ensure staff have the knowledge and skills to support processes in incident reporting and risk management.
* Ensure staff have the knowledge and skills to apply the organisation’s clinical governance framework particularly in relation to restrictive practices, psychotropic medication and chemical restraint.