Performance

Report

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| Name of service: | Carine Parkside Care Community |
| Service address: | 29 Silica Road CARINE WA 6020 |
| Commission ID: | 7466 |
| Approved provider: | DPG Services Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 13 September 2022 to 16 September 2022 |
| Performance report date: | 10 November 2022 |

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

**This performance report**

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

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others;
* the provider’s response to the Site Audit report received 13 October 2022; and
* the Performance Report dated 24 September 2021 for the Assessment Contact – Site undertaken on 12 August 2021.

# Assessment summary

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

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

# Areas for improvement

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

Standard 1 Consumer dignity and choice:

* Requirement 1(3)(a): Ensure staff practice is respectful of each consumer and supports and maintains consumers’ dignity through provision of care which is in line with each consumer’s unique needs and preferences.

Standard 2 Ongoing assessment and planning with consumers:

* Requirement 2(3)(d): Ensure 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.

Standard 3 Personal care and clinical care:

* Requirement 3(3)(a): Ensure consumers receive safe and effective personal care and clinical care, including continence, personal hygiene care and weight monitoring which is in line with their needs and optimises consumers’ health and well-being.

Standard 4 Services and supports for daily living:

* Requirement 4(3)(f): Ensure meals provided are varied and of suitable quality and quantity, and consumer feedback is considered in meal planning.

Standard 6 Feedback and complaints:

* Requirement 6(3)(c): Ensure complaints are actioned and responded to, with communication and consultation with the complainant.
* Requirement 6(3)(d): Ensure all complaints are recorded on the complaint register to monitor appropriate actions occur, trends are identified and areas for improvements in care and services are identified.

Standard 7 Human resources:

* Requirement 7(3)(a): Ensure sufficient numbers and skill mix of staff are provided to deliver safe and effective care to consumers. Ensure monitoring systems, including complaints and feedback and call bell response times are used to review and plan staff rosters and allocations.
* Requirement 7(3)(e): Ensure staff performance is effectively monitored to identify deficits in staff practice.

Standard 8 Organisational governance:

* Requirement 8(3)(c): Ensure the service effectively implements and applies the organisation’s management systems in relation to workforce governance and complaints management. Ensure ongoing monitoring of governance systems identifies and actions any deficits or areas for improvement.
* Requirement 8(3)(d): Ensure the service effectively and consistently implements and applies the organisation’s risk management framework.
* Requirement 8(3)(e): Ensure the open disclosure framework is applied consistently. Ensure ongoing monitoring of governance systems identifies and actions any deficits or areas for improvement.

# Standard 1

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

Findings

This Quality Standard is Non-compliant as one of the six Requirements in this Quality Standard has been found Non-compliant.

The Assessment Team recommended Requirement 1(3)(a) as Not Met. While several consumers felt they were treated with respect, others provided feedback about experiences which were not respectful or dignified, including the following examples:

* Two consumers advised they often have to wait extended times for assistance with continence needs and with personal hygiene, which makes them feel embarrassed and upset.
* One consumer advised they are often incontinent of urine at night and their bed is wet because they are not attended to regularly by care staff during the night. In addition, the consumer’s preferences in relation to frequency of showers are not supported.
* One representative advised the consumer is not assisted with continence care in a timely and effective manner resulting in body malodour.
* One representative advised the consumer complained to them one night, staff were rough with them and this interaction left the consumer distressed. The representative advised they reported this incident to management immediately when they received this information and they have not heard from the service for nearly two weeks since the day it was reported.

The Approved Provider acknowledges the gaps identified in the Assessment Team’s report, however, does not agree with all the findings in this Requirement. The Approved Provider has commenced an action plan to address the gaps identified and has provided further information. This information and improvement actions include, but are not limited to:

* Acknowledged deficits in provision of personal care that is delivered in a way to promote each consumer’s dignity. In response, the service increased their monitoring of continence management, based on feedback provided in the Assessment Team’s report and established a working group to review this area of care provision and improve current process.
* In relation to the incident of alleged elder abuse, the Approved Provider did not provide specific response under this Requirement and referred to its response in relation to this incident under Requirement 8(3)(d) where it states based on the information provided by the consumer, team interviews, no prior history of concerns or complaints in relation to the conduct of team members involved in the incident and that the police indicated they would not be investigating, the decision was made not to stand the team members down but to relocate them to another wing of the service because the allegation was unsubstantiated. The consumer was assessed and reassured in a timely manner.

I acknowledge the Approved Provider’s response and associated documentation provided. However, based on evidence in the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Site Audit, the service did not ensure each consumer was treated with dignity and respect.

I have considered that overall, consumers felt they were treated with dignity and respect and that staff valued their unique culture, identity and diversity. However, in this Requirement, it is expected that each consumer is treated in this way.

I have considered three consumers and one representative indicated direct care, such as personal hygiene and continence care were important components of dignified care and this was not provided in line with the consumers’ expectations, beliefs and preferences.

I have also considered the incident where a consumer alleged they were treated in a rough manner by staff members. Whilst I acknowledge the Approved Provider’s response describing how they reported this incident in line with regulatory requirements and conducted an internal investigation, I consider the consumer’s experience was traumatic, regardless of whether the Approved Provider’s assertions about the consumer’s medical condition and diagnoses impacting their ability to accurately recollect events were true or not.

Accordingly, I find Requirement 1(3)(a) Non-compliant.

I am satisfied Requirements 1(3)(b), 1(3)(c), 1(3)(d), 1(3)(e) and 1(3)(f) are Compliant.

Consumers confirmed they were satisfied they were supported to make decisions about their care and maintain their connections. Consumers and their representatives confirmed consumers are supported to do the things they wish to do even where risk is involved, and they feel staff manage those risks with them. Consumers’ feedback confirmed they have accurate information and are able to make choices about their care and services.

The service promotes awareness and inclusion for different cultural backgrounds through a range of mechanisms, including through adopting a regular lifestyle program of ‘armchair travel’. The service identifies locations to be visited which align with consumers’ countries of origin.

Staff interviewed spoke of consumers with respect and demonstrated knowledge of the specific cultural and personal support needs of each consumer. Staff described how they support consumers to maintain relationships inside and outside the service. Diversity is supported by the service, including policy documents to support consumers who identify as lesbian, gay, bi-sexual, transsexual and intersex.

Care planning documentation reflects risk assessment processes, including discussion with the consumer regarding risks associated with choices that may be harmful to them. Where appropriate, medical officers, allied health and other stakeholders are included in these discussions.

The service uses a range of mechanisms to ensure consumers are provided with current, accurate and timely information to enable them to exercise choice. Menus were observed displayed in each dining room showing what was being served on the day. The service produces a monthly newsletter to keep consumers and families informed about activities, and upcoming special events and includes regular profiling of staff members to keep consumers informed of any additions or changes at the service.

Access to consumers’ personal information is protected by a range of measures, including the protection of computer access by individual passwords. Hard copy consumer files and information are stored securely in each nurse’s station, with access requiring a swipe card or digital code.

# Standard 2

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

Findings

This Quality Standard is Non-compliant as one of the five Requirements in this Quality Standard has been found Non-compliant.

The Assessment Team recommended Requirement 2(3)(b) as Not Met because they found deficiencies in care planning documentation in four sampled consumer files. The Assessment Team found the following information and evidence relevant to their recommendation:

* There were discrepancies in information recorded in two consumer files. One was related to a consumer’s risk of falls. Another was related to specialised nursing care needs.
* Another two consumer files did not have detailed information about strategies to manage consumer refusals of care. One consumer’s care plan did not state whether the consumer preferred male or female care staff to provide personal care and there was no evidence the consumer’s representative feedback had been sought to develop an effective personal hygiene care plan.

Whilst the Approved Provider acknowledges some deficiencies in documentation identified in the report, the Approved Provider does not agree with all the findings in this Requirement and recommendation of Not Met. The Approved Provider submitted the following information and evidence to refute the Assessment Team’s recommendation and to demonstrate the service’s compliance with this Requirement:

* In relation to the consumer with specialised care needs, whilst the Approved Provider acknowledged the consumer’s care plan was not timely updated to reflect the consumer no longer required specialised nursing care in relation to the device for draining urine, other care planning assessments and documents reflected the consumer’s current needs. The progress notes attached to the response demonstrate appropriate care was provided to the consumer resulting in positive health outcomes.
* In relation to the second consumer’s file, where discrepancies in risk rating were found on two separate documents, the Approved Provider acknowledged and accepted discrepancies. However, noted that a repeated risk assessment showed accurate initial risk rating on a main document.
* In relation to the third consumer who refuses assistance with personal hygiene, an external service provider’s email was attached to the response where it was acknowledged interventions staff were utilising to provide assistance with personal hygiene were appropriate and mostly effective. These interventions, whilst simple and not extensive, have been effective and were reflected in the consumer’s care plan at the time of the Site Audit.
* In relation to the fourth consumer, the Approved Provider acknowledged and accepted the Assessment Team’s findings that the recommendations from the external service provider’s report had not been transferred to the consumer’s extended care plan. However, asserts these recommendations have been communicated to staff who were utilising them.

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

The intent of this Requirement is to ensure organisations do everything they reasonably can to plan care and services that centre on the consumer’s needs and goals and reflect their personal preferences. I have considered that the service demonstrates compliance with this Requirement in line with its intent. I have considered evidence in the Assessment Team’s report across Standards 1, 2, 3 and 4 relevant to this Requirement, including but not limited, to the following:

* consumers reported they were satisfied the services and supports for daily living were meeting their needs, goals and preferences;
* consumers’ preferences in relation to staff gender to assist with personal care delivery were identified and addressed;
* consumers’ social, cultural, religious, spiritual and medical needs were identified and addressed;
* consumers’ end of life care needs, goals and preferences were identified and addressed.

In relation to the consumer who had specialised nursing care needs, I consider the consumer’s needs were identified and addressed as evidenced by progress notes in the Approved Provider’s response. I accept the consumer’s care plan was not updated to reflect the change and I have considered this information under Requirement 2(3)(e) where this information is more relevant.

I consider discrepancies in falls risk ratings in the care planning documentation does not reflect deficiencies in the service’s processes of identifying and addressing consumer goals, needs and preferences but rather accuracy of assessment process of risks which is more relevant to Requirement 2(3)(a) where this information was considered.

I have considered, whilst the Assessment Team identified the third consumer’s representative’s feedback and ideas on how to manage the consumer’s refusals of care was not incorporated in the care plan, this does not indicate the consumer’s needs, goals and preferences in relation to personal hygiene were not identified, assessed or addressed as neither the Assessment Team’s report nor the Approved Provider’s response include evidence in relation to the consumer’s personal hygiene assessment.

In relation to the consumer whose care plan was not updated with recommendations from the external service provider specialising in dementia, I consider this does not indicate failure in planning of the consumer’s care as the service should have trialled proposed interventions in the first place to determine their effectiveness before incorporating them in the care plan. I have considered this information in Requirement 3(3)(a) where it is more relevant.

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

The Assessment Team recommended Requirement 2(3)(d) Not Met as they were not satisfied the service demonstrated outcomes of assessment and planning are effectively communicated to consumers and documented in a care and service plan that is readily available to the consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

* One representative said they had only seen a care plan when the consumer first entered the service and had not seen one ever since.
* One consumer said they have never seen their care plan and there was no plan available in the consumer’s bedroom during the Site Audit.
* Outcomes of assessment and planning in relation to one consumer’s medical condition was not effectively communicated to the consumer’s representative.
* The service has a process to discuss the care plan at case conferences and can provide a copy, however, only two out of seven consumers or representatives advised this had occurred.

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

* In relation to the first consumer’s representative, a care plan was discussed and was shown to the representative during the most recent care conference meeting. The consumer’s representative agreed that it was current and reflective of the consumer’s needs. In addition, the consumer’s summary care plan was located in the consumer’s bedroom.
* The Approved Provider acknowledged there was no copy of the care plan in the second consumer’s bedroom because it had not been replaced when it was last updated. The care plan since has been discussed with the consumer and placed in the consumer’s bedroom.
* Disagrees outcomes of assessment and planning in relation to two concerns highlighted in the report were not effectively communicated to the consumer’s representative. There have been several conversations about these matters with the consumer and the representatives. Progress notes in relation to these discussions were included in the Approved Provider’s response.
* Acknowledges not every consumer and their representative had an opportunity to participate in yearly care conferences which was due the impact of COVID-19 outbreaks. However, consumers and representatives can ask to arrange a case conference at any time and there are numerous and frequent informal conversations about care that occur daily between care managers and consumers or their representatives.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with Requirement 2(3)(d). While current consumer care plans are readily available to staff, the outcomes of assessment and planning are not always available and effectively communicated to the consumer and/or representative.

In coming to my finding, I have considered that consumers and representatives have indicated to the Assessment Team they have not viewed consumers’ care plans. Whilst there might be various reasons why a care plan was not readily available to consumers and representatives, information in the Assessment Team’s report and the Approved Provider’s response shows the service does not take all reasonable steps to offer a consumer and the relevant representative a copy of the care plan and also make them aware they can request a copy if they wished.

Accordingly, I find Requirement 2(3)(d) Non-Compliant.

I am satisfied the remaining Requirements 2(3)(a), 2(3)(c), 2(3)(e) are Compliant.

Consumers and their representatives interviewed confirmed they feel like partners in the ongoing assessment and planning of consumers’ care and services. Consumers and representatives are invited to meet with clinical staff and other members of the multidisciplinary team to discuss consumers’ care plans.

The service has processes to ensure comprehensive assessments are completed for each consumer to develop care plans. The service has assessment tools to identify risks and monitor and record changes and deterioration in consumers’ condition which then inform strategies recorded in the care plan. The service involves other health professionals where required to complete assessments and plans for consumers.

All assessments and care plans are recorded and communicated to those providing care to the consumer. Regular reviews and reassessment of consumers’ needs occur, including following incidents or changes in consumers’ physical or cognitive health.

# Standard 3

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

Findings

This Quality Standard is Non-compliant as one of the seven Requirements in this Quality Standard has been found Non-compliant.

Requirement 3(3)(a) was found Non-compliant following an Assessment Contact undertaken on 12 August 2021, where it was found the service did not demonstrate each consumer received personal or clinical care which was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to pain management. At the Site Audit conducted from 13 to 16 September 2022, the Assessment Team found the service has successfully implemented improvements around pain management. However, the Assessment Team identified a number of consumers did not receive assistance with toileting and personal hygiene in line with their needs, and clinical care was not effective, specifically in relation to close monitoring of consumer weight in line with the doctors’ orders and management of altered bowels patterns for one consumer. Summarised evidence includes, but is not limited to, the following:

* Seven consumers and representatives provided feedback indicating consumers did not receive assistance with personal care at the preferred frequency or in a timely manner resulting in body malodour, loss of dignity and soiled linen and clothing.
* Two consumers were not weighed daily in line with their care plan requirements. One of the two consumers reported the service did not do anything about their swollen legs until they were so big it was making it difficult to move.
* Staff do not always complete bowel charts. One consumer was administered medications to manage misdiagnosed constipation as a result of deficiencies in bowel charting.

The Approved Provider submitted a response the Assessment Team’s report and while the Approved Provider acknowledges the gaps identified in the report, does not agree with all the findings in this Requirement. The Approved Provider has commenced an action plan to address the gaps identified and have provided further information. This information and improvement actions include, but are not limited to:

* The Approved Provider acknowledges and accepts two consumers’ weight was not monitored in line with the health practitioner recommendations to confirm loss/gain in a timely manner. The Approved Provider is committed to undertaking education with staff about the importance of completing weight monitoring in line with health practitioner recommendations. Relevant key personnel will be monitoring staff practices and consumer records to ensure consistency.
* In addition to the above, prior to the Site Audit, the service commenced an improvement where the clinical leadership team meets weekly to discuss consumers’ weight changes or those at risk of unplanned weight changes to ensure timely and appropriate interventions are implemented to address these changes with referrals to allied health initiated as required.
* Acknowledge the identified consumer felt that nothing was done about their swollen legs. However, progress notes attached to the Approved Provider’s response demonstrate several reviews of the consumer’s swollen legs by health professional over the last six months and evidence of timely escalation.
* Acknowledge and accept seven consumers’ and representatives’ feedback about inadequate supports to maintain personal hygiene and continence care needs. Acknowledge that episodes of incontinence can be distressing for consumers and this will be addressed as a priority and an apology will be provided for any distress that has occurred.
* Expressed commitment to initiate a number of actions and provided examples of actions that have already been implemented, including but not limited to, commencing continence reassessment, reviewing consumers’ care plans and ensuring consumers’ preferences are communicated and accessible for all relevant team members.
* In relation to gaps in bowel charting for one consumer and unnecessary administration of medications to manage constipation, this information is incorrect. The Approved Provider’s response included bowel chart entries and ‘as required’ medication administration showing the consumer had not required and was not administered unnecessary medication as a result of missing bowel chart entries.

I acknowledge the Approved Provider’s response. However, based on the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Site Audit, each consumer was not provided safe and effective personal and/or clinical care which was best practice, tailored to their needs and which optimised their health and well-being, specifically in relation to provision of personal care, including assistance with personal hygiene, toileting, continence care and clinical care in relation to close monitoring of weight loss and gain. I have also considered information and evidence presented in the Assessment Team’s report in relation to Requirement 2(3)(d) where the service did not demonstrate they trialled strategies offered by an external service provider to assist with providing personal hygiene support to a consumer living with dementia who refuses assistance with personal care.

Based on the evidence summarised above, I find Requirement 3(3)(a) Non-compliant.

The Assessment Team recommended Requirement 3(3)(b) Not Met because the Assessment Team found ineffective management of risks of falls for two consumers and risks associated with the use of restrictive practices for two consumers. The Assessment Team’s findings were based on the following summarised information and evidence:

* Whilst one consumer did not have chemical restraint used very often, one progress note entry incorrectly recorded that the consumer required ‘as required’ chemical restraint to manage refusals of care. In the past, the consumer had incontinence associated dermatitis likely associated with refusals of care. There was no mention of the review of the consumer, specifically in relation to one unwitnessed fall.
* The second consumer’s vital and neurological observations were not taken following one fall which resulted in a laceration to the head. The service did not complete required documentation and nor obtain an informed consent for the restrictive practices. The consumer was often observed unsupervised on four days of the Site Audit despite the care plan stating not to leave unsupervised.

The Approved Provider acknowledges some gaps identified in the report. However, does not agree with all the findings in this Requirement and the recommendation of Not Met.

* The first consumer was referred to and reviewed by a health professional following the abovementioned fall. Due to the consumer’s vomiting episode preceding the fall, this was given a priority as could have potentially led to serious adverse health outcomes. The Approved Provider accepts the practitioner did not document information specific to the fall. However, clarify health practitioners are responsible for documenting the assessments they have made and communicating the findings of these assessments effectively in line with their own registration and practice license requirements. The service’s clinical team is present throughout all reviews to ensure appropriate handover of any directives or changes occurs post review. The consumer did not sustain any injuries following the abovementioned fall.
* The incontinence associated dermatitis for the first consumer was resolved in June 2022. There has been no recurrence of this condition since that time, indicating the consumer is being cared for appropriately to optimise their skin condition. Chemical restraint has not been utilised since 17 June 2022. The fact that this has not been relied upon and used for a period of three months demonstrates the service is committed to minimising the use of chemical restraint and that it is only ever used as a last resort.
* In relation to the second consumer, allied health documentation for the consumer shows the consumer was assessed by the allied health professional for positioning and safe use of the restrictive practice. The attached documentation confirms that this is not a mechanical restraint. The allied health professional has documented clearly that the tilting of the device is for appropriate support and comfort.
* Acknowledge one unwitnessed fall incident was incorrectly identified as a “near miss” and neurological observations were not carried out as per the policy. However, the incident was discussed with the team member who completed the report and training was provided to them to improve their documentation standards. The consumer has not experienced any negative or adverse outcomes as a result.
* It is not correct that the consumer was left unsupervised in their chair because they were placed in an area from where the consumer could be monitored to ensure their safety and this is in line with the consumer’s assessed needs.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

In coming to my finding, I have considered that most evidence presented in this Requirement does not indicate systemic issues with the management of high impact/high prevalence risks associated with the care of each consumer.

I have considered high impact risks associated with chemical restraint used for the first consumer were managed effectively because the chemical restraint was used very rarely and only as the last resort.

Whilst there was one occasion where there was no documented evidence of the medical officer or nurse practitioner’s review of the consumer, specifically in relation to a fall, this does not indicate the consumer’s high risk of falls were not managed effectively. In addition, there is no information in the Assessment Team’s report showing whether there were other falls, and how many, that could have been prevented. Lastly, whilst the Assessment Team’s report highlighted the consumer’s frequent refusals of showering, there is no information or evidence in relation to whether these refusals placed the consumer at any risk. I have considered the Approved Provider’s response showing the consumer did not have any wounds or issues with skin integrity associated with the refusals of showering.

In relation to the second consumer, I have considered the allied health practitioner records stating ‘ensure consumer is fully tilted in chair (using red handle) to help with comfort, positioning and pressure relief’. I consider the Assessment Team’s finding in relation to staff mechanically restraining the consumer by tilting the chair is incorrect. I have also considered there is no evidence to suggest the consumer was in discomfort or distress while observed sitting in the device on four days of the Site Audit which indicates the device was used appropriately as per the allied health professional’s advice and facilitated management of the consumer’s risks associated with pressure injuries.

I accept one unwitnessed fall was wrongly classified as a “near miss” and there were no appropriate monitoring of the consumer’s neurological observations following the fall. However, this is an isolated incident and does not indicate the consumer’s falls were not managed effectively because there is no detail presented in the report in relation to other falls and whether they could have been prevented or whether they were not managed in line with the policies.

In coming to my finding, I have also considered information in the Assessment Team’s report in Requirement 2(3)(a) where it is stated a review of eight consumer files showed all consumers had risk assessments completed on admission, including falls, pressure injury risk and malnutrition risk with strategies to prevent the incidents from occurring or to minimise the harm from incidents documented. There were two examples provided where strategies to manage the risks were implemented.

I have also considered information about a quality improvement initiative commenced prior to the Site Audit presented in the Approved Provider’s response where the service implemented a range of actions to reduce high impact risk of falls at the service level resulting in reduction in falls of 38% in two months of the program being in place.

Based on the evidence summarised above, I find Requirement 3(3)(b) Compliant.

I am satisfied the remaining Requirements within this Standard, 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) are Compliant.

Most consumers and representatives confirmed medical officers and other health specialists are available and involved in managing consumers’ clinical needs or following an incident or change.

Consumer files showed the service effectively identifies and monitors changes, including pain, wounds and weight loss and appropriate strategies are implemented to inform staff on how to manage the consumers’ needs. Consumers are referred to specialists when ongoing incidents or deterioration occurs. Consumers’ files viewed showed consumers at end of life have appropriate personal and clinical care implemented to support consumer dignity and comfort.

Staff explained incident reporting processes and confirmed they are informed of changes to consumers’ needs through handovers, progress notes and other communication tools. Staff demonstrated and confirmed infection control practices in line with current infection control guidelines.

# Standard 4

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

Findings

This Quality Standard is Non-compliant as one of the seven Requirements in this Quality Standard has been found Non-compliant.

The Assessment Team recommended Requirement 4(3)(f) as Not Met. The Assessment Team found four of six consumers interviewed regarding the menu provided feedback indicating the service does not provide meals which are varied and/or of suitable quality and quantity. The Assessment Team’s findings were based on the following information and evidence:

* One consumer advised they provided feedback to relevant staff about wanting to have more salads on the menu, however, this feedback has not been implemented or acknowledged.
* One consumer advised they have experienced ongoing dissatisfaction with the quality of food tailored to their preferences since they entered the service two years ago.
* One consumer advised they supplement their diet by purchasing their own food, including bread. They reported they have complained about food not meeting their personal preferences multiple times, however, nothing has changed.
* Other consumers’ complaints about quality of the food were around food being served cold.

The Approved Provider acknowledged consumers’ feedback in relation to the variety and quality of the food and expressed commitment to work with the consumers to ensure their individual preferences are met. The Approved Provider recognises, however, that food is a personal experience, and the service is unable to replicate the exact style, taste and feeling that an individual’s own cooking brings to consumers’ lives.

The Approved Provider states they have recently appointed a new Head Chef and since their commencement, they have had a significant increase in the number of positive comments and feedback regarding the food. This feedback was provided to the Assessment Team to review during the Site Audit.

I acknowledge the Approved Provider’s response and their commitment to improve consumers’ satisfaction with food. Under this Requirement, it is expected organisations ensure consumers not only have enough to eat and drink to maintain life and good health, but also the food and drinks provided are based on consumer assessed needs, including consumers’ preferences and cultural consideration. I consider, at the time of the Site Audit, four consumers’ preferences were not met.

Accordingly, I find Requirement 4(3)(f) Non-compliant.

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

Consumers sampled said they were generally satisfied with the services and supports provided for daily living and this was meeting their needs, goals and preferences. Consumers receive safe and effective services that maintain their independence, well-being and quality of life. Staff demonstrated knowledge of each consumer’s needs and preferences for activities. Lifestyle planning documentation identified consumers’ choices and provided information about the services and supports consumers needed to undertake the things they want to do.

Consumers felt connected and engaged in meaningful activities that are satisfying to them. Staff provided examples of supporting consumers for their emotional and psychological well-being. Care planning documentation recorded consumers’ individual emotional support strategies and how these are implemented.

Consumers sampled felt supported to participate in activities within the service and in the outside community as they choose. The service enables consumers to maintain social and personal connections that are important to them. Care planning documentation identified the people important to individual consumers and the activities of interest to the consumer.

The service has effective processes and systems for identifying and recording each consumer’s condition, needs and preferences, including when they change.

Consumers felt safe when using the service’s equipment and confirmed it was easily accessible and suitable for their needs. Equipment used for activities of daily living was observed to be safe, suitable, clean and well maintained.

# Standard 5

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

Findings

This Quality Standard is Compliant as three of the three Requirements in this Quality Standard have been found Compliant.

The Assessment Team recommended Requirement 5(3)(b) Not Met because four consumers had electronic keycode locks installed on their doors, as per the consumers’ request. However, there have been no risk assessments undertaken for the locks to ensure the safety of the consumers at all times. The Assessment Team provided the following information and evidence relevant to their recommendation of Not Met:

* Four consumers reported they did not always feel safe and have requested the service to install electronic keycode locks to prevent wandering consumers from entering their bedrooms and to help prevent the loss of their personal belongings.
* There have been no documented risk assessments for the use of the locks in the four consumers’ files.

The Approved Provider acknowledges the gaps identified in the report. However, does not agree with all the findings in this Requirement. The Approved Provider has commenced an action plan to address the gaps identified by the Assessment Team. This information and improvement actions include, but are not limited to:

* The locks that have been installed on consumer rooms have a failsafe mechanism that allows staff to have unrestricted access to the consumer rooms in the event of emergency. The locks can be overridden by a key which is carried by all clinical staff and had design features ensuring staff can access the code easily.
* Rooms can be easily accessed in an emergency because of a risk minimisation strategy embedded in the lock design which is known to staff and management. If power to the lock is interrupted, the key on the clinical staff lanyard can be used to open the door. Consumers can freely exit their rooms as the door only locks on entry.
* Acknowledge there were no formal risk assessments, which have been completed since the Site Audit. However, asserts there is no increased risk in these locks being installed. The fire coordinator has been contacted and digital locks have been put on fire plan.

Based on the Assessment Team’s report and the Approved Provider’s response, I find the service Compliant with this Requirement.

I consider at the time of the Site Audit the service environment was safe, clean, well maintained and comfortable and enabled consumers to move freely, both indoors and outdoors. I have considered evidence in the Assessment Team’s report where all consumers expressed satisfaction with the cleanliness of the service and the service was observed by the Assessment Team to be clean, safe and well maintained. In addition, consumers were observed moving freely through the service and accessing several courtyards and balconies around the service.

In coming to my finding, I have considered that lack of formal risk assessments for key coded locks reflects the core deficiencies associated with Requirement 8(3)(d) in relation to a risk management system in place to guide staff in recognising, recording and evaluating risks for consumers.

In addition, I have considered the electronic keycode locks were installed as per the consumers’ request and there was no intention to restrict these consumers’ movement. I have considered the consumers are able to open the door independently and can freely exit their rooms as the door locks only on entry. In addition, the Approved Provider’s response shows the locks have a failsafe mechanism that allows staff to have unrestricted access to the consumer rooms in the event of emergency.

Accordingly, I find Requirement 5(3)(b) Compliant.

I am satisfied the remaining Requirements 5(3)(a) and 5(3)(c) are Compliant .

Most consumers interviewed said they like living at the service and find the décor comfortable and relaxing. Consumers confirmed they have been supported to personalise their rooms and they are satisfied the service environment and equipment are clean and well maintained.

The reception area is the focal point for consumers and visitors to the service and is located opposite the main entry doors to the service. A café is located adjacent to this area and was observed to be well patronised by consumers and visitors to the service.

Observations confirmed consumers are able to move freely throughout the service, including outdoors. Reception staff were observed to welcome and orientate visitors to the service. The service appeared clean and well maintained with appropriate furnishings throughout the service to enhance the environment.

The service has scheduled and reactive cleaning and maintenance programs in place, including accessing external contractors to service equipment and monitor safety systems. Staff confirmed the processes of cleaning and maintenance in line with the schedules. The service has monitoring systems to ensure the cleaning and maintenance systems are effective.

# Standard 6

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

Findings

This Quality Standard is Non-compliant as two of the four Requirements in this Quality Standard have been found Non-compliant.

The Assessment Team recommended Requirement 6(3)(a) as Not Met. The Assessment Team found whilst consumers and representatives interviewed said they know how to give feedback or make a complaint, and staff and management were able to describe how they encourage and support consumers and/or their representatives to provide feedback, consumers, their family, friends, carers and others were not encouraged and supported to provide feedback and make complaints which was based on the following summarised evidence:

* One representative advised they sought assistance from staff to complete written feedback forms. However, were denied assistance.
* Four staff members interviewed did not know of the process to enter feedback or complaints online that would feed into the electronic complaints system.
* One staff member advised one consumer said a day before the Site Audit commenced that the fish was too tough. However, this was not escalated and the staff member did not have knowledge of how to enter this feedback online.
* One consumer provided feedback about their room temperature and that their breakfast was cold. Whilst the temperature in the room was immediately actioned and staff expressed empathy regarding breakfast, the feedback was not immediately escalated as per the organisation’s complaints handling process.

The Approved Provider’s response included the following information and evidence including but not limited to:

* In relation to the first consumer’s representative, an incident described in the report was witnessed by other team members. It is not true that the representative was denied assistance to complete a feedback form. The representative requested some assistance to share feedback and the team member replied that they would go and retrieve a feedback form and provide any support necessary to complete the form.
* In relation to four staff members not knowing how to complete feedback or complaints online, staff are all well aware of their option to share feedback with the management team who have good knowledge of the complaints management system.
* Whilst there is a preference for all complaints to be recorded in the complaints management system, staff often need to balance this with the imperative to return as much time to care as possible.

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

I find consumers and representatives are encouraged and supported to provide feedback and make complaints. I have considered information in the Assessment Team’s report showing consumers and representatives interviewed said they know how to give feedback or make a complaint, and staff and management were able to describe how they encourage and support consumers and/or their representatives to provide feedback. The Assessment Team observed a range of avenues in place for consumer and representatives to do so.

Whilst I accept one consumer’s representative advised they felt they were not supported to complete a feedback form, the Approved Provider’s recollection of the incident differs significantly from the representative’s feedback. Additionally, I have considered that none of 27 consumers and representatives interviewed by the Assessment Team over four days of the Site Audit described similar experience.

I consider lack of staff knowledge and experience of using the online feedback mechanism is more relevant to Requirement 7(3)(c) where it was considered. The intent of this Requirement is about ensuring everyone is made aware of their rights to provide feedback and make a complaint and every effort is made to ensure everyone willing to provide feedback and/or make a complaint feel comfortable and safe and aren’t treated in a negative way because of their feedback or complaint. Whilst one consumer’s representative expressed they did not feel supported, I find it does not show systemic issue in this Requirement.

Based on the evidence summarised above, I find Requirement 6(3)(a) Compliant.

The Assessment Team recommended Requirement 6(3)(c) as Not Met because it found the service was unable to demonstrate the system for managing and resolving complaints is effective and includes the use of open disclosure when things go wrong. The Assessment Team provided the following information and evidence relevant to my finding:

* Eleven consumers and representatives who have provided feedback or raised concerns were not satisfied the service actively addressed and actioned them or that an open disclosure approach was used to inform them of outcomes.

The Approved Provider submitted a response to the Assessment Team’s report and accepts most findings in the Assessment Team’s report. The Approved Provider has commenced an action plan to address the deficiencies identified by the Assessment Team.

In its response, the Approved Provider advised they have already met or are in the process of organising a meeting with the abovementioned consumers and representatives to discuss their concerns and agree on solutions. The Approved Provider expressed its commitment to resolve the consumers’ and their representatives’ concerns, to continue working closely with them in an open and transparent manner to support resolution and provide reassurance that their complaints are heard and responded to.

I acknowledge the Approved Provider’s response and proposed actions. However, based on the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Site Audit, the service did not demonstrate appropriate actions were always taken in response to complaints and open disclosure was consistently used.

Accordingly, I find Requirement 6(3)(c) Non-compliant.

The Assessment Team recommended Requirement 6(3)(d) as Not Met because the service did not demonstrate feedback and complaints were used to improve the quality of care and services.

* Eleven consumers and representatives felt the service has not improved the quality of care and services as their concerns were ongoing. Examples of feedback provided included issues with delivery of personal care, clinical care and quality of food.
* The service’s plan of continuous improvement notes the issue of food, including size, taste, temperature and presentation. However, despite identifying these issues, the service did not take effective actions and the consumers’ dissatisfaction with food is ongoing.
* The service has not demonstrated they are reviewing feedback and complaints to improve quality of care and services and this correlates with the multiple concerns about food temperature raised with the Assessment Team during the Site Audit.

The Approved Provider did not dispute recommendation of Not Met and has commenced an action plan to address the deficiencies identified by the Assessment Team, actions include but are not limited to:

* The service commenced a review of the process of the transport of food from the main kitchen to the serveries in each wing of the service, as well as a review of the workflow process and environment to identify where food may be losing heat. It was identified that the dining room tables were positioned beneath the air-conditioning vents on the ceiling, furniture has since been rearranged and this has been resolved.
* A hospitality team meeting has been arranged with chefs and catering team in attendance. The above areas for improvement will be discussed with them and strategies to improve will be developed and implemented.
* Expressed its commitment to resolve the consumers’ and their representatives’ ongoing concerns.

I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate feedback and complaints were reviewed and used to improve the quality of care and services. I have considered feedback from multiple consumers and representatives about ongoing complaints in relation to various aspects of care and services indicating the service has not learnt from complaints and has not made effective improvements.

Accordingly, I find Requirement 6(3)(d) Non-compliant.

I am satisfied the remaining Requirement 6(3)(b) is Compliant.

All consumers and representatives interviewed confirmed they are aware of other services that can assist them, with some consumers and representatives describing how they have been supported by an external service to help resolve concerns they have raised.

Most staff interviewed were aware of advocacy, language and external complaints services and confirmed they would assist consumers and/or their representatives with information and assistance if these were required.

Information regarding external services to assist with feedback and complaints, advocates and language services was observed posted throughout the service in multiple languages.

# Standard 7

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

Findings

This Quality Standard is Non-compliant as two of the five Requirements in this Quality Standard have been found Non-compliant.

Requirement 7(3)(a) was found Non-compliant following an Assessment Contact conducted on 12 August 2021. At the Site Audit conducted from 13 to 16 September 2022, the Assessment Team found the service has made improvements in their staffing levels, however, it was still insufficient to ensure consumers are provided quality care and services. Summarised relevant evidence included:

* Four consumers and three representatives were not satisfied there are sufficient numbers of staff to provide appropriate personal care, continence care, assistance with transfers and mobility resulting in consumers having body malodour, experiencing feeling of embarrassment due to wetting bed linen and wearing soiled continence aids and loss of dignity.
* Consumers and representatives provided examples of not enough staff to respond to consumers’ call bells and provided examples of waiting for extended periods of time to get assistance.
* Call bell response data for one of the consumers who raised concerns showed frequent delays with staff response to the call bell up to 50 minutes.
* Most staff across different disciplines confirmed staff are rushed and do not have sufficient time to provide care and supervision and vacant shifts are not always filled.
* Allocation sheets for the period of 14 days in one wing of the service show that wing was short staffed on 11 of the 14 days.
* Observations by the Assessment Team show there were insufficient staff available to assist and support consumers, including consumers at risk of falls and one consumer looked dishevelled.

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

* The service’s clinical team allocation comprises of Registered and Enrolled Nurses and one medication competent carer. Carine Parkside Care Community is currently 15% below occupancy levels that the Master Roster is set to allow for. Overall, team hours have exceeded the Master Roster even though occupancy is reduced. As is the case when the leadership team support care provision on the floor, team do not always recognise this or when shifts are filled by agency partners.
* The Approved Provider acknowledged and accepted three consumers’ feedback in relation to not getting timely and effective assistance with personal hygiene and continence care.
* Acknowledge the need for improvement in call bell response.

I consider, despite some changes being implemented, the organisation did not demonstrate that, at the time of the Site Audit, the number and mix of staff enabled safe and quality care and services, or that monitoring and review processes were effective. I have considered feedback from multiple consumers and representatives which indicates they are not satisfied with staffing levels resulting in delays with getting assistance with care and services or not getting assistance altogether. I have also considered staff feedback confirming they are not always able to provide care in line consumer’s needs and preferences. Lastly, I have considered call bells response time showing some consumers experience delays with up to 50 minutes for their call bells being responded to.

Accordingly, I find Requirement 7(3)(a) Non-compliant.

The Assessment Team recommended Requirement 7(3)(c) as Not Met because it found the service did not demonstrate the workforce was competent and staff had the knowledge to perform their roles effectively. The Assessment Team’s summarised information and evidence to support their findings include the following:

* Information recorded in three consumers’ care plans is incorrect or conflicting.
* The shower chart had nil recordings for four consecutive days.
* One consumer’s chart was not updated resulting in the consumer recorded in the ‘not having bowels open for five days’ report for further action.
* One consumer’s fall was not classified correctly resulting in the consumer not having monitoring in line with the policies and procedures.
* One consumer’s tilt chair was not identified as a restrictive practice.
* Staff have raised the issue of one consumer frequently being soiled along with her bedding, yet nothing has changed.
* Staff do not change consumers’ continence aids in a timely manner.
* One consumer was observed not to be supervised when sitting in the tilt chair which is not in line with the consumer’s care plan.

The Approved Provider does not agree with the Assessment Team’s recommendation. The Approved Provider acknowledges the deficiencies in relation to care planning documentation, however, asserts this does not indicate the workforce is not competent and does not have the qualifications and knowledge to effectively perform their roles.

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

I have considered information in relation to inconsistencies in two consumers’ care plans in Standard 2. In both cases, the consumers were not impacted as a result of the documentation error. Evidence presented in the Approved Provider’s response showed the first consumer received appropriate specialised nursing care which demonstrates nursing staff are competent and have right skills and knowledge to provide safe and effective clinical care. There is no evidence the second consumer was not provided appropriate assistance with mobility as a result of conflicting information in the care plan and personal hygiene assessment where two different falls risk ratings were recorded.

I have considered the Assessment Team’s finding in relation to bowel chart for one consumer not being completed under Requirement 3(3)(a). This information was received by the Assessment Team from a staff member, however, was not corroborated with documentation review. Therefore, this piece of information alone cannot be relied on for assessment of staff competency, skills and knowledge to provide safe and effective bowel management.

In relation to one consumer’s tilt chair that the Assessment Team found was not identified as a restrictive practice, I have considered this information in Requirement 3(3)(b) where the Approved Provider demonstrated when staff tilted the chair it was not used as a restrictive practice whilst some staff believed it was.

I consider evidence in the Assessment Team’s report across Standards 1, 3 and 7 showing staff not changing consumers’ continence aids and not providing assistance with personal hygiene in a timely manner is related to insufficient staffing and not indicative of staff incompetence or lack of skills and knowledge on how to provide continence care and showering.

I consider one incident when a consumer’s fall was not classified correctly resulting in the consumer not having monitoring in line with the policies and procedures was an isolated incident and a recommendation of Not Met based on this example of staff incompetency is not proportionate.

Lastly, I have considered observations of the consumer sitting in a tilted chair unsupervised was not related to staff incompetency or lack of certain skills and knowledge to perform their duties safely and effectively.

Based on the evidence summarised above, I find Requirement 7(3)(c) Compliant.

The Assessment Team recommenced Requirement 7(3)(d) as Not Met because they found the service was unable to demonstrate the workforce is trained, equipped and supported to deliver the outcomes required by the Quality Standards. The Assessment Team included the following information and evidence relevant to their recommendation:

* Three representatives provided feedback indicating they are not confident staff, including agency are sufficiently trained and supported to provide quality care.
* One representative reported missing clothing items and advised agency staff do not know the consumer’s needs preferences so the representative placed signage in the consumer’s room.
* One representative advised they are not confident staff are skilled to provide care to consumers with cognitive impairment.
* One representative advised they were not confident staff had required knowledge to provide care to the consumer who was diagnosed with a specific disorder.
* Two agency staff advised they were only provided with brief orientation to the area of the service they were to work and not of the other areas of the service, and a handover sheet with only brief information on it.

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

* In relation to comments by one representative about staff not having a required knowledge to provide care to the consumers living with cognitive impairment, the Approved Provider expressed commitment to engage with the representative in providing education to staff on the representative’s approach.
* In relation to one representative’s feedback about their lack of confidence staff had required knowledge to provide care to the consumer with a specific disorder, there are currently six consumers living with this condition and this is the first time the service has received feedback in relation to the staff’s capability and approach to care for consumers living with this condition.
* However, the Approved Provider expressed commitment to provide additional education to staff on this matter and to meet with the consumer’s representative to reassure them that this has occurred.
* Agency teams are provided with a walk through and orientation to the area in which they are working, amenities and key services. The handover sheet is designed to give them information about risks to be considered, they also participate in handover and huddles. Permanent team is available to provide guidance and support. Their orientation includes an introduction to our team in their area and they are assigned a “buddy” for their shift.
* Where agency cover is required, the service requests the same personnel so that there is continuity and familiarity for them and for the consumers.
* In relation to not all staff have attended training to deliver outcomes required by the Quality Standards, the Approved Provider accepts not all staff completed training as per the training calendar.

Based on the Assessment Team’s report and the Approved Provider’s response I find Requirement 7(3)(d) Compliant.

I consider the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards. Evidence presented in the Assessment Team’s report and the Approved Provider’s response shows staff are recruited to specified roles requiring relevant qualifications and/or experience and are provided with position descriptions.

I consider the Approved Provider’s response where they describe how the service’s rostering system ensures that Registered and Enrolled Nurses have current registration, they are vetted prior to employment to ensure there are no restrictions on practice. The majority of newly recruited clinical and care team are experienced with over two years’ of experience. Care staff’s qualification is minimum Certificate III qualified Assistants in Nursing and a care staff who administers medications is Certificate IV qualified who had undergone a robust training program completed over several weeks.

Whilst I accept that not all staff completed all the training, there is no information provided in neither the Assessment Team’s report nor the Approved Provider’s response in relation to the proportion of staff not completing the training, whether they had not completed training was imperative to the particular staff member to safely perform their duties required by their role and whether there were staff who, despite not completing mandatory training, were rostered to work. For this reason, whilst I have considered this information in coming to my finding in relation to this Requirement, I could not place weight on it.

I accept some representatives expressed their doubts in some staff’s competencies and skills. However, I found lack of examples to demonstrate the representative’s views in the Assessment Team’s report.

I have also considered information in the Assessment Team’s report that demonstrated the organisation monitors and reviews performance against this requirement. In response to identifying staff training deficiencies, the service developed an action plan to address the identified gaps in staff knowledge.

Accordingly, I find Requirement 7(3)(d) Compliant.

The Assessment Team Recommended Requirement 7(3)(e) Not Met because they found whilst the service had systems and processes in place to monitor assessment, monitoring and review of the performance of each member of the workforce, it has been ineffective placing consumers at risk. The Assessment Team provided the following information and evidence relevant to my finding:

* The vast majority of staff have not had a performance appraisal post their probationary period or in the past 12 months with some over two years.
* The service did not take all reasonable steps relevant to this Requirement to ensure effective review of two staff members’ performance occurred following the incident of alleged elder abuse from the two staff members. There were no records of performance management as per the organisation’s policy provided to the Assessment Team during the Site Audit, and the two staff members were moved to work in another area after being stood down for one shift prior to the investigation being finalised.

The Approved Provider’s response includes, but is not limited to, the following:

* Acknowledge and accept deficiencies in staff performance appraisals. An action plan has been developed to complete outstanding performance appraisals for all staff.
* In relation to the incident of alleged elder abuse, the Approved Provider did not address this incident under this Requirement and provided information about it under Requirement 8(3)(d) where the Approved Provider states based on the information provided by the consumer, the team members interviews, no prior history of concerns or complaints in relation to the conduct of the two team members and that the police indicated they would not be investigating, the decision was made not to stand the team members down but to relocate them to another wing of the service because the allegation was unsubstantiated.

Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement 7(3)(e) Non-compliant.

I have considered staff have not had performance appraisal on a regular basis. I acknowledge the Approved Provider’s commitment to conduct overdue performance review of staff. However, at the time of the Site Audit, the service’s own systems were not effective in identifying deficiencies in its performance against this Requirement. I considered information in relation to the incident of alleged abuse in Requirement 8(3)(d) which I found Non-compliant.

The Assessment Team recommended Requirement 7(3)(b) Met.

The Assessment Team found that the interactions with consumers and their representatives are kind, caring and respectful of their culture, identity and diversity. Consumers and representatives provided various examples of how staff interactions with consumers are caring and respectful by staff being kind and patient at all times acknowledging some consumers have different diagnoses and needs impacting their ability to engage in conversations and show patience towards staff.

Accordingly, I find Requirement 7(3)(b) Compliant.

# Standard 8

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

Findings

This Quality Standard is Non-compliant as three of the five Requirements in this Quality Standard have been found Non-compliant.

The Assessment Team recommended Requirements 8(3)(a) and 8(3)(b) as Met.

The service has various methods to engage consumers in the development, delivery and evaluation of care and services to provide feedback, such as feedback and complaint methods, resident and representative meetings, food focus groups, weekly emails from General Manager, newsletter, surveys and care plan reviews.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and these values are endorsed at every meeting. The organisation’s purpose and values are discussed with consumers and representatives on admission, in the resident’s handbook and displayed in the service. The Board of Directors meet monthly to review reports of emerging and actual risks and instigate action where required. The leadership team meet monthly to discuss hazards and incidents, critical quality indicators, risks, investigations and complaints and provide this data to the governing body.

Based on the information summarised above, I find Requirements 8(3)(a) and 8(3)(b) Compliant.

The Assessment Team recommended Requirements 8(3)(c), 8(3)(d) and 8(3)(e) Not Met.

Requirement 8(3)(c)

The Assessment Team found the service did not demonstrate effective organisation-wide governance systems in relation to workforce governance and feedback and complaints. Summarised relevant evidence included:

* The service does not effectively monitor the workforce, including ensuring sufficient numbers and mix of the workforce are provided and ensuring regular performance of each staff member.
* The service did not have effective feedback systems in relation to ensuring all feedback and complaints are recorded, actioned and responded to. Representatives provided examples of verbal and written feedback and complaints they have raised with management which they are not satisfied are resolved. The service’s feedback and complaints register did not have all complaints recorded.

The Approved Provider does not agree with all of the Assessment Team’s findings. However, in the Approved Provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a detailed resource plan and continuous improvement plan which are being implemented to address the deficits. Improvements include comprehensive staff training in relation to all deficits in staff knowledge identified, including in relation to managing complaints and responsibilities of reporting assaults. The service has implemented additional staff, including senior staff to monitor and review staff practice.

I acknowledge the Approved Provider’s response. However, I find whilst the service has workforce governance systems that are supported and driven by the wider organisation, including policies, procedures and systems to monitor the workforce and manage complaints, the service was not effectively implementing the organisation’s governance systems and monitoring of the service’s performance and implementation of the systems was not effective at identifying the deficits. Management and staff did not demonstrate an understanding and application of the organisation’s governance systems, including managing complaints and monitoring the workforce in line with the organisation’s policies or as required by the Quality Standards.

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

Requirement 8(3)(d)

The Assessment Team found, whilst the service has a risk management system in place, it is not effective in recognising and responding to all risks, actual and potential, including when changes to the environment are made. The service’s risk management system is not effective in identifying and responding to abuse and neglect of consumers. Summarised relevant evidence includes:

* The service has not conducted risk assessments to ensure consumers’ safety when electronic keycode locks were installed on some consumers’ doors.
* One incident of alleged elder abuse from staff members has not been investigated thoroughly. The representative of the consumer expressed their concerns they have not heard anything from the service regarding the investigation into the incident since the day it was reported, approximately two weeks ago.
* Information in relation to the investigation of the incident provided to the Assessment Team during the Site Audit was not comprehensive and included two staff members interviews and a page containing steps taken in bullet points, including that the two staff were taken off the roster on the day when the incident was reported, however, following the interview the decision was made in consultation with management not to stand down the two staff members; police were contacted, the consumer’s representative updated with current review of incident and care conference to be scheduled.
* The second incident identified by the Assessment Team through the consumer’s interview was not recognised by the service as requiring reporting to the Commission.

The Approved Provider generally disagrees with the Assessment Team’s findings and recommendation of Not Met.

* In relation to risk assessments for electronic keycode locks, the Approved Provider did not respond to this information under this Requirement and referred to information in response to the Assessment Team’s finding in relation to Requirement 5(3)(b) where it acknowledged no risk assessments were undertaken at the time of the Site Audit.
* In relation to the incident of alleged abuse, the Approved Provider disputes the Assessment Team’s finding about the investigation not being thorough. Full documentation included management record of telephone interviews with three team members and meeting with the consumer’s representative; a summary of events; copy of the incident notification form; copy of the roster at the time the incident occurred; sleep diary for the consumer; police information and Serious Incident Response Scheme (SIRS) notification.
* In addition, the Approved Provider highlighted the consumer’s recollection of events was potentially being impacted by underlying symptoms of one of the consumer’s diagnoses. The consumer’s plan was updated to reflect not disturbing them overnight unless they call for assistance.
* In relation to the second incident, the consumer’s story provided to the Assessment Team was different to the one the consumer told the service six months ago and that is why the incident was not reported. Once the service was provided new information about the incident by the Assessment Team, it was reported in line with legislative requirements.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with this Requirement.

I consider the Approved Provider demonstrated it took appropriate steps once it became aware of the incident of alleged elder abuse reported by the consumer’s representative. Evidence in the Assessment Team’s report and the Approved Provider’s response shows the organisation referred the case appropriately within and outside of the organisation in line with legislation. I consider, whilst the Assessment Team was not convinced the Approved Provider’s investigation of the incident was thorough and effective and was mostly handwritten notes, I have considered the Approved Provider adequately demonstrated key elements of effective incident management systems.

However, I have considered the organisation did not demonstrate it continuously monitors risks to consumers and takes appropriate and timely actions if a risk has increased. I have considered the service’s risk management system did not identify installation of key coded locks on consumers’ doors involves risk elements that are required to be assessed and addressed.

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

Requirement 8(3)(e)

The Assessment Team found, whilst there is clinical governance framework to guide staff on the policies and procedures for antimicrobial stewardship, minimising the use of restraint and open disclosure, the service could not demonstrate all staff is aware of what constitutes a restraint, the requirements of restraint and follow the principles of open disclosure. Summarised evidence relevant to the Assessment Team’s recommendation includes:

* The service did not have documented records of open disclosure with the consumer and their representative following the incident of alleged abuse.
* Multiple consumers and representatives who provided feedback or raised concerns were not satisfied the service used on open disclosure to inform them of outcomes.
* One consumer’s tilted chair was not recognised as a mechanical restraint.

While the Approved Provider acknowledges some gaps identified in the Assessment Team’s report, they do not agree with all the findings in this Requirement. The Approved Provider has commenced an action plan to address the gaps identified by the Assessment Team and have provided further information including but not limited to:

* In relation to open disclosure with the consumer’s representative, the Approved Provider states recollection of events and feedback from staff and the consumer’s family differed throughout each discussion that took place during the investigation of this incident. Management was cognisant of this and wanted to ensure information provided to the representatives on the progression of the investigation was accurate but also considerate of their belief that the event was ‘as described’ by the consumer and reassure them that the report was taken seriously, and that due diligence occurred. A case conference with the consumer’s representative occurred after the Site Audit to discuss the findings of the investigation. Open disclosure as to the outcomes and findings of the investigation occurred during this case conference.

Based on the Assessment Team’s report and the Approved Provider’s response I find the service Non-compliant with this Requirement. I acknowledge the Approved Provider’s actions and improvements to rectify the deficiencies identified by the Assessment Team. However, at the time of the Site Audit, I find the service did not demonstrate there is an effective framework in relation to open disclosure.

I have considered the tilt wheelchair was not used as a restraint as the Approved Provider included documentation supporting their claim it was prescribed and used as intended for comfort.

In relation to open disclosure, I have considered the organisation’s systems and processes were not effective in ensuring the principles of open disclosure were consistently applied when responding to consumers’ and representatives’ complaints relating to a consumer’s experience of the care and services they receive. As outlined in Requirement 6(3)(c), where consumers or representatives complained about care and services, the service did not use a collaborative approach with complainants to find timely resolutions to complaints through open communication and transparent processes.

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

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