Craigcare Maylands

Performance Report

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**Commission ID:** 7867

**Provider name:** Glenn-Craig Villages Pty Ltd

**Site Audit date:** 17 January 2022 to 19 January 2022

**Date of Performance Report:** 07 April 2022

# Performance report prepared by

Andrea Hopkinson, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; 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 2 March 2022.
* the service’s compliance history.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Overall sampled consumers considered they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they choose. For example:

* Consumers sampled said staff were respectful towards them, their individual identity, culture and diversity was valued, and they were encouraged and supported to maintain their independence.
* Consumers said they were supported to maintain connections with people important to them including their family, other consumers within the service and the wider community.
* Consumers said the information provided to them was current, accurate and timely, and enabled them to make informed choices about their care.
* Consumers and representatives stated they felt consumers’ privacy was maintained and respected by staff.

Staff demonstrated they knew the sampled consumers well. Staff said they usually communicated with consumers in person, about their choices and preferences and used hand gestures and sign where consumers may have language barriers.

Staff were able to describe how they ensured consumers’ preferences were respected, and how their culture, values and background influenced the delivery of care and services. The Assessment Team observed care staff to provide care and services generally in the way that supported each consumer’s privacy and dignity.

Care planning documents sampled showed individualised information was documented about each consumer. This included consumers’ personal histories, preferences for care, friends and family of special significance to them, activities of interest, whether the consumer wished to take risks, and aspects of their lives which were of particular importance in relation to their identity, culture and diversity.

Documentation generally showed evidence of ongoing discussions with consumers and representatives about clinical care, personal care and preferences and where incidents had occurred. There were also processes to support the assessment, discussion and monitoring of risk for consumers.

The organisation had policies and procedures in place in relation to dignity of risk as well as diversity and inclusion in order to guide staff practice. Information was provided to consumers about their rights, the range of services provided as well as policies and procedures about safety and risk taking.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Overall sampled consumers considered they felt like partners in the ongoing assessment and planning of their care and services. Feedback included:

* Consumers and representatives were satisfied with how consumers’ care was planned by an appropriately skilled workforce.
* Consumers and representatives said they were involved in the care planning process including in relation to management of risks relating to pain, diabetes and smoking and felt the organisation listened to the consumer.
* Consumers and representatives advised registered nurses regularly discussed consumers’ care and/or changing care needs via formal or informal methods and were aware they could access consumers’ care plans on request.

#### The service was able to demonstrate assessment and planning, included a consideration of risks to the consumers’ health and well-being and informed the delivery of safe and effective care and services. Validated risk assessment tools were used to assess and manage areas of risks such as pressure injuries, falls and malnutrition.

Assessment and planning documents for the sampled consumers, reflected the consumer and others (the consumer wished to be involved in planning of care) were involved on admission and on an ongoing basis.

Consumers’ goals were documented, together with their identified care and lifestyle preferences. Care planning documentation included discussion of advance care planning and end of life planning, if the consumer wished to participate in such discussions. While the Assessment Team noted advance care planning discussions were held and end of life wishes recorded for over 50 percent of consumers, management advised all consumers were given the opportunity to complete an advance care directive during their initial assessment and at any time during their stay, and staff respected if the consumer refused.

Consumer records sampled by the Assessment Team demonstrated registered nurses generally conducted a three-monthly review of each consumer’s care and service needs. There was a comprehensive assessment of the consumer’s care needs and preferences completed within the previous twelve months and reassessment of care needs was triggered when a consumer’s condition changed.

Clinical**,** lifestyle and allied health staffdescribed the consumer assessment and care planning process and how they used the information gathered to determine the consumer’s daily care and lifestyle needs and preferences. Care and nursing staff accessed care planning documents electronically and clinical staff advised vital information about the consumer’s clinical care was communicated during handover.

The organisation had policies, procedures and guidelines in place to guide staff in the assessment, planning and advance care planning.

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

## Assessment of Standard 2 Requirements

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

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

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

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

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

*The organisation demonstrates that assessment and planning:*

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

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

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

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

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

# STANDARD 3 COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Overall sampled consumers considered they received personal care and clinical care that was safe and right for them. For example:

* Consumers and representatives confirmed staff meet consumers’ personal care needs daily including receiving assistance with showering, personal hygiene and dressing.
* Consumers felt their needs and preferences were effectively communicated between staff and they did not have to repeat information.
* Consumers were generally satisfied they had access to medical officers and other relevant health professionals when they need it.

Care documentation for the sampled consumers included progress notes, handover information, hospital transfer forms and referrals to the relevant health professionals and service providers. Documentation reflected adequate information to support effective and safe sharing of consumers’ care and generally showed the consumer or their substitute decision maker was involved in the decision-making process, to ensure clinical care was tailored to their needs.

Care staff advised they reported any changes to a consumer’s physical or emotional health status to the registered nurse and staff demonstrated knowledge of the individual care needs and preferences of the consumers sampled. All staff said they were satisfied with the quantity and quality of information provided to them to enable safe and effective provision of care.

Staff advised various policies and procedures around clinical care guided them on safe care delivery and on what was considered best practice. Allied and clinical staff described how clinical care optimised the consumers’ health and well-being.

The organisation demonstrated the needs, goals and preferences of consumers nearing the end of life were recognised and addressed, their comfort maximised, and their dignity preserved. The service had a process to consult and complete end of life wishes for consumers and staff demonstrated an understanding of how to support consumers at the end of life. Policies and guidelines were available to staff to guide them in providing best practice palliative care.

In relation to infection control, staff demonstrated their knowledge in standard and transmission-based precautions to prevent and control infection. Staff were aware of the locations of outbreak management kits, reported they had received training in relation to COVID-19 and were observed to practice good hand hygiene.

The service had implemented practices to promote appropriate antibiotic prescribing and use, to support optimal care and reduce the risk of increasing resistance to antibiotics. This included working effectively with general practitioners to ensure antibiotics were only prescribed and dispensed when they were needed.

However, the Assessment Team recommended not met in relation to two requirements relating to high impact and high prevalence risks and the management of deterioration (Standard 3 Requirement (3)(b) and Requirement (3)(d)). The Approved Provider provided a response in relation to these matters. Based on the information before me, I have come to a different view and find both these requirements as Compliant. The reasons for my decision are outlined below.

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

### Assessment of Standard 3 Requirements

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

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

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

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

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

The Assessment Team recommended this requirement as not met. This recommendation was based on the ineffective management of schedule eight medications (in the form of oral solutions) for two consumers, whereby there was a potential risk of significant harm.

The Assessment Team provided the following information:

* The service had identified discrepancies in the drug of dependence register in mid-December 2021 for two consumers on a similar schedule eight medications (oral solution). The variances were noted to be up to 40mls, with one consumer’s medication being higher and one consumer’s medication being lower.
* Following the identification of the second consumer’s discrepancy, an incident form had been completed. The service’s initial investigation recorded the likely cause was due to the wrong medication bottles being used and there was an increased risk as labels on the bottle were faded.
* Whilst Consumer A and Consumer B were prescribed the same oral medications, the Assessment Team noted the dosage/strength of this was different and the service was not able to demonstrate it had initially recognised the potential higher dose to support further follow up for Consumer B (given the initial reason for the discrepancy).
* At the time of the visit (approximately one month after the identification of these variations), another explanation had been provided as to the cause, with management reporting the variances were due to incorrect drawing up/medication running over the syringe.

The Approved Provider refuted the Assessment Team’s findings and its response contained further information such as minutes of the Medication Advisory Committee meeting, medication management resources and extracts of its drug of dependence register. Its response outlined:

* Consumer B’s medication was measured to be over two days prior to the shortfall in the Consumer A’s medication and the conclusion of a higher dose provided to Consumer B was not based on fact. There had been a number of scenarios which could account for the discrepancy and all options had been reviewed.
* During the audit, the management had discussed with the Assessment Team their investigation and could not find conclusive evidence of staff mixing up bottles. The position of bottles being switched was the manager’s initial assumption following discussion with the pharmacist. However, it reinforced the absence of evidence did not make this a fact.
* The drug of dependence register was correct in recording the balance of medication following the withdrawal of all liquid prior to administration.
  + The pharmacy was contacted and reported it was not unusual as often equipment has a margin of error in the volume.
  + Staff were to measure the volume removed as opposed to the side of the bottle.
  + The drug of dependence register recorded both variances and this was reported to management in accordance with procedures.
* Schedule eight medications were being checked by two staff each time it was administered, and staff completed all eight medication checks prior to administration. There were multiple occasions in which this medication had been administered on the date of the incident and the Approved Provider advised this would have required multiple staff to have recorded and checked this incorrectly.
* Consumer B did not suffer any untoward side effects as they were not double dosed, and the service had not encountered any liquid variances in the past year.

Furthermore, the Approved Provider outlined in its response to these events, it had undertaken remedial action which included:

* Returning both consumers’ medication bottles to pharmacy as the labels were starting to deteriorate. However, asserted labels were still clearly legible as reported by staff.
* New bottles with plastic covering the label was implemented to maintain the print and bottles ordered with lip/seal to enable accurate drawing up of medications minimise loss.
* An email was sent to staff regarding liquid medications and checking, in addition registered staff had recently completed medication competency testing.
* The service’s pharmacy (responsibility for undertaking education and audits) had provided additional education to registered staff and future audits would focus on liquid medications.
* A senior manager had reviewed the incident prior to the site audit and discussed the potential issue across all Craigcare services.

I acknowledge the Approved Provider’s response and the actions taken in relation to this. In relation to the discrepancies in liquid schedule eight medications do not have sufficient evidence to come to a view about whether either consumer had received an incorrect dose(s) of this medication. However, I am of the view this information is more relevant to the robustness of the service’s investigation and reporting of the discrepancies, and I have considered this is the broader context of Standard 8 Requirement (3)(d).

In coming to a view about compliance for this requirement, I have come to a different view to that of the Assessment Team. This is based on the following reasons and information obtained during and subsequent to the visit.

* I note the service had self-identified these variances in medications and as part of the initial incident investigation had commenced remedial actions prior to the site audit to ensure the safety of consumers and prevent of this type of incident from reoccurring. Actions included the removal and replacement of both medication bottles and placement of plastic tape over medication labels to reduce fading.
* Although limited evidence was noted by the Assessment Team surrounding the incident investigation and actions taken, I note the incident form had recorded staff were counselled on safety in medication administration. Furthermore, during the audit, a registered nurse confirmed there was a discussion of the incident; they were informed staff were required to accurately draw up oral solutions (of schedule eight medications) and the service had arranged special bottle caps to avoid loss.
* Further actions outlined in the Approved Provider’s response identified that since the visit, the incident had been escalated to the Medication Advisory Committee for review in February 2022. Meeting minutes included discussion regarding management of liquid schedule eight medications; reflected additional education had been provided and all registered staff had completed schedule eight management quiz.
* The Assessment Team had interviewed both consumers regarding quality of care and services and reviewed Consumer B’s progress notes. The Assessment Team found although one consumer had reported some delays in the administration of schedule eight medications, overall both consumers were satisfied with their care and no negative outcomes including obvious harm had been identified in progress notes for Consumer B.

Furthermore, I have also considered the totality of evidence such as other evidence provided by the Assessment Team which demonstrated overall it had effectively managed high impact and high prevalence risks, based on:

* There had been other examples of consumers where medications and/or pain had been effectively managed and overall consumer and representative satisfaction with care.
* Clinical and care staff demonstrated knowledge of high prevalence risks associated with individual consumer’s care and described strategies to minimise identified risks as outlined in consumers’ care plans relating to wounds/pressure injuries, falls risks and risk of malnutrition.
* The Assessment Team also reported clinical incidents including falls, behaviours, unplanned weight loss and infections were collated, and data was analysed to identify high impact risks across the service and at an individual level.

Therefore, based on the information before me, I find the service Compliant in this requirement.

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

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

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

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

The Assessment Team recommended this requirement not met based on the management of a consumer’s deterioration in November 2021 who subsequently was transferred to hospital, commenced on palliative care and passed away a few days later. The Assessment Team noted:

* For Consumer C, the service could not demonstrate the consumer was closely monitored over an approximately two-hour period from when they started to show signs of clinical deterioration and when the ambulance arrived. At the time, the Assessment Team noted the consumer did not have an advance care plan and was not receiving end of life care. Specifically, the Assessment Team noted:
* The service did not maintain contemporaneous records of events, during the period of deterioration to reflect the medical officer’s instructions and the consumer’s/representative’s wishes.
* Staff did not take all the consumer’s vital signs on two occasions (over an approximate two-hour period when these were taken) to ensure all clinical parameters were relayed to a general practitioner in a timely manner in line with the service’s clinical deterioration procedure.

The Approved Provider’s response refuted the Assessment Team’s findings and provided clarifying information as to the sequence of events and provided an extract of the consumer’s observations.

* It outlined the absence of one vital sign, would not have changed the outcome as the ambulance had been called and the consumer was comfortable and not distressed.
* In relation to the recording of contemporaneous notes, the Approved Provider reported the registered nurse was still on shift after working the morning shift. Notes written at this time had no impact on the consumer or their care, and the consumer received all care and was transferred to hospital in the morning.
* Clinical judgement was used and no specific instructions were noted from the medical officer except for transfer to hospital. It considered records of actions reflected all process of reporting escalation was adhered to in accordance with its procedure.

I have considered the Assessment Team’s findings and Approved Provider’s response. Based on the information before me, I have come to a different view to that of the Assessment Team and find the service Compliant in this requirement. This is based on the following reasons:

* I note staff had written notes in retrospect describing what actions have been taken after they contacted the hospital and were advised the consumer was receiving end of life care. Whilst I am of the view there is a potential for improvements in the service’s clinical documentation, based on the information before me, I do not have sufficient evidence to come to a view that Consumer C’s deterioration on this occasion was not effectively managed.
* Furthermore, I note the Assessment Team had provided evidence that the service had recognised and responded appropriately to Consumer C’s gradual deterioration in August to October 2021 and noted examples of where there was effective management of their deterioration through referrals and involvement of allied health professionals.
* I have also considered the totality of evidence contained within the Assessment Team’s report and note:
* The service was able to demonstrate other examples of consumers where deterioration or changes had overall been effectively managed; including timely referrals to other health professionals and providers based on consumers’ needs.
* Consumer feedback indicates they were overall satisfied with the provision of care including access to medical and health professionals when they need it.

Therefore, based on the information before me, I find the service Compliant in this requirement.

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

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

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

Overall sampled consumers considered they received the services and supports for daily living that were important for their health and well-being which enabled them to do the things they wanted to do. For example:

* Consumers said they were overall supported by the service to do the things they liked to do including participating in activities provided by the service and outings available in the wider community.
* Consumers confirmed they were supported to maintain relationships with family and friends and connections with the wider community.
* Consumers said they enjoyed the dining experience, were satisfied with the quality and quantity of food, and they could provide their feedback in person and in writing about all aspects of the menu and food service.
* Consumers provided feedback that the service maintained their equipment and felt safe using it.

The service was overall able to demonstrate each consumer received safe and effective services and supports for daily living that met the consumer’s needs, goals and preferences and optimised their independence, health, well-being, and quality of life. Information was obtained on entry and via care planning reviews to ensure consumers received services and supports for daily living to promote their emotional, spiritual and psychological well-being. Care plans showed information about what and who was important to each consumer, their background, life story and experiences, past and current interests, religious and other cultural practices, referrals to external providers when required as well as goals and preferences that assisted consumers to do the things they wanted.

Staff had access and were provided with information to assist them to coordinate services, and staff were familiar with what was important to consumers and could explain how they supported consumers to maintain their independence.

The Assessment Team observed consumers taking part in activities, and interacting with each other and staff (in chair exercise and fitness classes, chess, and indoor ball games). However, the Assessment Team observed for one consumer, services and supports for daily living were not consistently delivered in line with their assessed needs to optimise well-being and quality of life. Whilst I note the majority of consumers and representatives were satisfied with the supports and services provided; the ongoing effectiveness of individual supports and activities should continue to be monitored in meeting the needs of all consumers.

In relation to food services, the service demonstrated meals were varied and of suitable quality and quantity. Consumer preferences including likes, dislikes, specific dietary requirements and any food allergies had been identified and known by staff. There were processes to support feedback on meal services and this was used to initiate quality improvements in the consumer’s dining experience.

The service was able to demonstrate equipment provided for the care and services of consumers was safe, suitable, cleaned and well maintained. Staff were knowledgeable about how to use equipment and report faults. Maintenance requests were responded to in a timely manner and equipment was observed to be well maintained, clean and in safe condition.

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

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall sampled consumers felt safe and comfortable in the service environment. For example:

* All consumers interviewed advised they felt safe and at home in the service environment.
* Consumers said the environment was safe, clean, well maintained and they can access all areas of the service when they want.
* Consumers and representatives advised there were numerous communal areas, where they could interact with others or have private time together as all lounge and indoor and outdoor areas were observed to have comfortable furniture.

The Assessment Team noted the environment was welcoming and optimised consumers’ sense of belonging, independence, interaction and function. Corridors were observed to be clean, not obstructed by equipment and a lift for consumers and visitors to mobilise between floors. Outdoor courtyards were secured and observed to have well-maintained garden areas, with walking paths and plenty of shaded areas, tables and chairs for consumers and their visitors to use.

Consumers’ care assessments were undertaken by an allied health professional to ensure appropriate mobility aids were provided, in order to support consumers accessing both indoor and outdoor areas and activities within the service.

Cleaning and preventative maintenance schedules and procedures were in place to ensure equipment and furniture was clean and safe. Maintenance staff described how consumers were supported with any needs for repair or maintenance and how requests were prioritised. Staff could describe the process for reporting maintenance and cleaning of consumers’ rooms. The Assessment Team noted maintenance requests were responded to in a timely manner; equipment was observed to be well maintained, clean and in a safe condition, and the service’s fire systems were inspected regularly to ensure a safe environment in the event of an emergency.

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 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Overall sampled consumers considered were encouraged and supported to give feedback and make complaints, and that appropriate action was taken. For example:

* Consumers were able to describe how staff supported them to provide feedback or make a complaint.
* Consumers were aware of various ways to provide feedback and generally preferred doing so verbally.
* Consumers said staff were responsive to feedback and acted in a timely and appropriate manner to resolve their concerns.
* Consumers said changes were made at the service in response to their complaints and feedback.
* Consumers and representatives confirmed an open disclosure process was used and they felt their concerns were addressed.

The service provided a welcome pack on admission and the consumer information directory contained information about advocacy, language and external complaint services available. Written materials promoting feedback was also displayed at reception and on each floor of the service.

Staff were able to describe how they supported consumers to provide feedback or make a complaint. They were aware of advocacy, language and external complaints services and were able to provide consumers and representatives with guidance if needed. Care staff interviewed said they would try and resolve any immediate concerns however, they would also report any issues to the registered nurse and provide the consumer with a feedback form to complete.

The organisation had a compliments and complaints management policy and procedure including an open disclosure policy to guide staff practice. The service maintained an electronic feedback register which verified the service actioned issues raised and used an open and transparent process, to resolve complaints and issues raised. Staff interviewed demonstrated they understood open disclosure and how it was relevant in responding to feedback and complaints including when adverse events had occurred.

The service was able to demonstrate feedback and complaints were recorded in the electronic feedback system; these were analysed and opportunities for service improvement were identified and implemented.

The Quality Standard is assessed as Compliant as four of the four specific requirements have been assessed as 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) Compliant

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

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

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

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall sampled consumers considered they received quality care and services when they needed them and from people who were knowledgeable, capable and caring. For example:

* Consumers and representatives felt there were adequate numbers of staff, with appropriate skills, to deliver care and services in a way that met their needs, goals and preferences.
* Consumers and representatives advised they felt staff were well trained, knew what they were doing and were qualified to complete their designated roles.
* Consumers and representatives confirmed staff treated consumers with respect and were responsive to their needs. They said staff were kind, caring and gentle when providing care.

The service demonstrated its workforce was planned to enable the delivery and management of safe and quality care and services. A roster was adapted to respond to the changing needs and situations of consumers; staff confirmed they had sufficient time to undertake their duties and management said no complaints regarding staffing levels or call bells response times had been recently received.

The Assessment Team observed:

* Staff responding promptly to call bells.
* Staff interacting in a calm, caring and positive manner and were not observed rushing consumers. The complaints and compliments register for the previous three months showed no complaints regarding workforce interactions with consumers.
* Mealtimes showed the dining experience was not rushed and consumers requiring assistance were helped in a dignified way.

The service was able to demonstrate the workforce was recruited, trained, equipped, and supported to deliver the outcomes required by these standards. The service had policies and procedures to guide staff in recruitment and induction. New staff described the recruitment, onboarding, and induction processes and said they felt supported and well prepared.

Clinical and care staff completed both online and in person training on a regular basis. Staff were able to describe completing relevant training and being supported in their role. With regards to Serious Incident Response Scheme (SIRS) and incident management training, management reported care staff completed online and face to face training on how to identify and report, and clinical staff were also provided training on the reporting timeframes, escalation and investigation processes. Staff were able to demonstrate their understanding in these areas and how they applied their learnings to their roles.

The organisation had a suite of staff performance policies and procedures which guide staff and management in work practice processes including performance management and staff dismissal. The Assessment Team noted staff practice was monitored regularly and assessed through observation, analysis of incidents and feedback. Where gaps in practice were identified, this was managed appropriately. Staff interviewed stated they participated in probationary and annual performance reviews where they can discuss their performance and identify further training needs.

However, the Assessment Team recommended not met in relation to Standard 7 Requirement (3)(c) based on not all staff were competent in performing their roles in relation to high-risk medications. The Approved Provider provided a response in relation to these matters and based on the information before me, I find the service Complaint in Standard 7 Requirement (3)(c). The reasons for my decisions are outlined below.

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

## Assessment of Standard 7 Requirements

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

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

### 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) Compliant

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

The Assessment Team recommended this requirement as not met based on the service did not demonstrate that it had an effective system to ensure all staff were competent in the delivery of clinical care specifically relating to the following areas:

* Staff and management competency around their responsibilities for incident reporting requirements for schedule eight medications, to ensure timely reporting of variances and that a root cause analysis had occurred in relation to the medication incident described in Standard 3 Requirement (3)(b).
* Registered staff were not competent around their responsibilities to perform double-checking of schedule eight medications to minimise the potential risk of harm.
* Management had not monitored, reviewed or evaluated staff competency in relation to medication incident reporting requirements nor completed an incident report for Consumer B.

The Approved Provider refuted the Assessment Team’s findings and its response provided clarifying information regarding the service’s policy and the eight rights for checking schedule eight medications. Extracts of the drug of dependency register was also provided along with a range of medication management resources. It reported:

* There had been confusion by staff as they believed an incident report was not needed just verbal reporting and amending of the drug of dependence register by two staff. Their reasoning was the medication was not a critical incident, as it was not missing and the count was not incorrect (which they considered this pertained to tablets not volume of liquid, according to the policy). Education has been provided to staff recently to clarify the medication management policy.
* Staff did report the missing liquid medication via an incident form. Management conducted an investigation; the discrepancy was reported to management and management reviewed the possible causes with the supplying pharmacist at the time. The supply pharmacist agreed that volumes were difficult to be exact in determining and confirmed this was an ongoing issue with liquid medication.
* Senior management questioned management and reviewed the incident prior to the site audit and discussed possible causes. It reported statutory declarations of these discussion were available to confirm these discussions.
* There was no evidence of staff malpractice, records reflected staff adhered with the checking process from the DD register, however the origin of these errors was not confirmed.
* In response to these events the organisation had been proactive and taken remedial action which included but was not limited to:
* Registered staff have recently completed medication competency testing.
* Future service audits by the pharmacy, would focus on liquid medication auditing and education.
* The issue was added to the next scheduled Medication Advisory meeting.

In making a decision regarding compliance, I have considered the Assessment Team’s findings and the Approved Provider’s response. As a result, I have come to a different view and find the service Compliant in this requirement. My decision is based on the following reasons:

* The Approved Provider’s response included a copy of the Medication Management Advisory Committee meeting minutes for February 2022, which outlined education had been provided to registered staff following the site audit and all registered staff had completed a quiz on schedule eight medications. I am satisfied remedial actions that have been undertaken, the subsequent training and planned monitoring by way of auditing (by the pharmacy) would address the potential for recurrence of medication variations.
* I have also considered and given weight to the following matters including other information within the Assessment Team’s report:
* The service had self-identified two discrepancies in oral medications (schedule eight) and as a result its incident report documented it had undertaken follow up discussion/counselling with staff. Whilst there was limited documented evidence to support this had occurred, I note the Assessment Team had interviewed a registered nurse who confirmed there had a discussion of the incident related to schedule eight oral liquid medication for two consumers and requirements for measuring these medications.
* In relation to staff competency around their responsibilities for double checking medication for high risk medications, I note the Approved Provider’s response included extracts of the service’s drug of dependence which showed examples of two staff had signed the register. I am of the view that the completion of all appropriate checks, does not necessarily support the position of staff competency rather a potential compliance with medication procedures. However, I am satisfied that remedial actions completed prior to and subsequent to the visit would continue to support staff ongoing competency and monitoring of practices.
* In relation to the investigation, this has been further considered in respects to Standard 8 and the service’s overall incident management systems.
* Furthermore, I have considered the totality of evidence provided throughout the report which included:
* Seven consumers/representatives sampled stated they were confident staff were skilled and advised they delivered care and services that met their needs and they felt safe being cared for by staff at the service. I note other than one consumer reporting a delay in receipt of their schedule eight medication, no other concerns had been raised in relation to medication management.
* I note the Assessment Team had provided other examples of care and services being effectively managed for the consumers sampled.
* The service had an effective performance management system in place and had provided evidence of staff performance managed in relation to another incident that had occurred. I also note performance issues with the omission of medications during January 2022 were identified as relating to agency staff and actions were recorded at the Medication Management Advisory Committee meeting.
* The Assessment Team provided other examples of incidents that had been effectively reported and found staff interviewed understood incident reporting requirements consistent with their roles.
* Staff position descriptions outlined the core competencies and capabilities required for their role. Staff said they felt supported in their roles and management would provide additional training if they request it.

Therefore, based on the information before, I find the service Compliant in this requirement.

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

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

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

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

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Overall sampled consumers considered that the organisation was well run and that they could partner in improving the delivery of care and services. For example:

* Consumers and representatives interviewed said they considered the service was well run.
* Consumers said staff kept them well informed about matters affecting them and the wider service. They said management and staff were kind, caring and approachable and they were comfortable raising any concerns or suggestions. They were confident these would be resolved to their satisfaction and improvements to care; service delivery and the service environment would be made.

The service overall had effective governance systems in place, including policies, procedures, practices, and mechanisms to ensure the promotion of safe, inclusive quality care and services. Clinical, environmental and operational audits along with staff, clinical team and management and quality/governance meetings and Board meetings, were conducted to ensure quality care and service provided.

The Board received regular reports which included information relating to risks and incidents and feedback from consumers and representatives. Information regarding the service complaint trends and incident data was provided at the Board meeting for consideration.

The service demonstrated there were generally effective governance systems for ensuring:

* information was disseminated and accessible,
* improvement opportunities were identified (following complaints, feedback, incidents, audits) and consumers and representatives were engaged in the process,
* there were processes for financial reporting and management,
* the workforce had clear responsibilities and accountabilities,
* there was an effective system to track changes to aged care law and to communicate these, and
* there were effective feedback and complaint systems.

The organisation overall had a clinical governance framework which included policies and procedures for minimising restraint, an established approach to the support antimicrobial stewardship and a process of open disclosure that was implemented in response to an incident.

In relation to risk management, the service generally had effective systems in place to identify, record, escalate, report, monitor and review clinical incidents and incidents reportable under the Serious Incident Reporting Scheme (SIRS). However, the Assessment Team noted concerns in the effective management of schedule eight medications and acute deterioration. The Approved Provider provided a response in relation to the above matters.

Based on the information before me, I have come to a different view to that of the Assessment Team find the service Compliant in this requirement. The reasons for my decision are outlined below.

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

## Assessment of Standard 8 Requirements

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

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

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

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

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

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

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

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

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

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

The Assessment Team recommended this requirement as not met based the service not having effective risk management systems and practices. Specifically, the Assessment Team raised concerns regarding the service’s management of schedule eight oral medications to reduce potential harm, including the service’s risk management of acute deterioration (as outlined in Standard 3 and Standard 7).

The Assessment Team provided the following information:

* The service was also unable to demonstrate they had reviewed the incidents and implemented all appropriate strategies to minimise the reoccurrence thereby minimising the potential harm to consumers (which included Consumer A and Consumer B). This included:
* An investigation, including a root cause analysis of two medication incidents was not conducted as well as follow up to understand the impact on Consumer B.
* There was limited information regarding the investigation (including guidance and best practice procedures) and actions taken.
* Not all improvement actions had been undertaken as a result of the incidents that had occurred in mid-December 2021.
* Subsequent information reported by management verbally during the audit advised the likely cause of the discrepancy was incorrect drawage/medication running over the syringe.
* Risk of acute deterioration was not recognised and responded to in a timely manner for Consumer C or that there were effective mechanisms to guide staff in the service’s policy and procedures in relation to risk escalation, frequency of observations.

The Approved Provider refuted the Assessment Team’s findings and provided clarifying information (as outlined in respects to other requirements) including about its governance processes. Its response outlined:

* There were governance processes in place with included monthly reporting to site managers, executive staff, the CEO and the Board. This included but was not limited to incident reporting, critical risk reports and legislative compliance.
* There was evidence of verbal and formal documented reporting of incidents. It asserted staff followed the service’s policies and procedures and referred to the relevant state government guidelines for its investigation.
* The service had remediated all possible scenarios for the medication discrepancies including:
* The service had enhanced medication labels and now completes extra weekly schedule eight liquid checks.
* Staff education of incidents has clarified the process relating to additional liquids which were verbally reported to management and medication competency testing has occurred.
* The service had provided clarification of information regarding the events that had occurred for Consumer C.

This requirement requires that there are effective risk management systems and practices in place, which includes an effective incident management system. The Commission has published best practice guidance on ‘Effective incident management systems’ which describe the key elements of an effective incident management system that includes a focus on prevention.

Based on the information before me, I am not persuaded by the robustness of the service’s incident process, in this instance, (relating to variances in medications) to adequately demonstrate it had fully investigated and understood all relevant risks – actual and potential. However, in coming to a decision about compliance, I have relied upon and given weight to the following areas:

* In relation to medication management (as outlined in Standard 3 Requirement (3)(b)), both variances had been self-identified by the service prior to the site audit and an initial investigation was conducted. Although the quality of investigation and subsequent reports of the causative factors varied (initially switched bottles and then measurement issue), the service had recognised the need to minimise further risk and had commenced remedial action which included:
* Removal and replacement of bottles; improvements to labelling covers and devices sourced from the pharmacy to minimise medication loss.
* The incident report documented staff had been counselled and a registered nurse interviewed demonstrated knowledge of the incidents and actions implemented by the service.
* I also note consumer and representative feedback, overall was positive about the care delivered by the service. While the service was not able to demonstrate it had captured information about considering the risk of harm to consumers following the initial incident report, senior management verbally reported this had been considered during the site audit. Whilst I do not have sufficient information about this, as considered in Standard 3 Requirement (3)(b), I note the Assessment Team’s review of clinical documentation for Consumer B did not identify the consumer had experienced any obvious harm.
* Furthermore, the incident had been subsequently discussed at the February 2022 Medication Management Advisory Committee meeting and had outlined additional education had been provided to staff and outlined the process of ongoing monitoring of liquid medications. While I am satisfied the remedial actions taken and outlined by the service will reduce the risk of further recurrence, the organisation is still required to undertake ongoing reviews of its governance systems in order to ensure these remain effective.
* In relation to the management of clinical deterioration for one consumer, I have considered this information and found Standard 3 Requirement (3)(d) Compliant.
* I have also considered the totality of evidence in relation to the organisation’s risk management system, including its incident management system and note the Assessment Team also found:
* All information relating to care and services, incidents and any other changes were documented via the electronic care management system.
* Opportunities for continuous improvement were generally identified via incidents, audits, compliments and complaints, staff and resident meetings, hazards and changes to policies procedures.
* Critical incidents were reviewed by the Board and executive team (who reviewed the service incidents on an ongoing basis and at the end of each month); the organisation and service considered what areas needed to be reviewed, actioned and improved.
* Staff interviewed understood the serious incident scheme and the service’s incident management system consistent with their roles, and advised they were kept informed of regulatory changes via email, daily handover, education sessions, staff meeting and discussions with management.
* The service had systems in place to identify, record, escalate, report, monitor and review clinical incidents and incidents reportable under the Serious Incident Reporting Scheme (SIRS). A review by the Assessment Team noted:
  + Immediate actions were taken by staff to minimise harm to consumers.
  + Consumers impacted by the incident were assessed, monitored and provided with appropriate support.
  + The incidents were correctly identified, escalated and investigated, with a process of open disclosure conducted with consumers and representatives.
  + The incidents were reported to the Commission in the legislative timeframe.
  + Risk management strategies were implemented, and their effectiveness monitored and reviewed.
* The service also had practices and procedures in place including a Dignity of Risk and Choice Policy and Procedure, which included an assessment of the risks associated with the consumer’s choices and the implementation of strategies to minimise these risks.

Therefore, based on the information before me, I have come to a different view and find this requirement Compliant.

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

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

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.