Esperance Aged Care Facility

Performance Report

17 Eyre Street   
ESPERANCE WA 6450  
Phone number: 08 9072 3222

**Commission ID:** 7248

**Provider name:** Esperance Aged Care Facility Inc

**Assessment Contact - Site date:** 16 March 2022 to 17 March 2022

**Date of Performance Report:** 7 June 2022

# Performance report prepared by

Janine Renna, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* The Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site 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 Assessment Contact - Site report received on 19 April 2022, which accepts the Assessment Team’s findings and states a new Chief executive officer was appointed in January 2022 to deal with deficiencies identified at the Site Audit conducted on 4 May 2021 to 7 May 2021. The response includes the service’s Plan for continuous improvement to demonstrate planned actions are in place based on information in the Assessment Team’s report; and
* The Performance Report dated 9 August 2021 in relation to the Site Audit conducted on 4 May 2021 to 7 May 2021.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Assessment Team assessed Requirement (3)(a) in Standard 1 Consumer dignity and choice at the Assessment Contact. No other Requirements in this Standard were assessed.

Requirement (3)(a) was found Non-complaint following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate each consumer was treated with dignity and respect, with their identity, culture and diversity valued. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service does not meet Requirement (3)(a) in Standard 1. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Non-compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice. I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 1 Requirements

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate consumers were treated with dignity and respect, with their identity, culture and diversity valued.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in response to the non-compliance. This training was in relation to providing care in a dignified way, partnering with the consumer, elder abuse, clinical deterioration and pain management. However, due to the deficits identified at the Assessment Contact, the Assessment Team found these improvements were ineffective.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Documentation showed one staff member was dismissed prior to the Assessment Contact following an investigation of allegations they ignored consumers or spoke to them in a short, rude and argumentative manner, and refused to provide personal hygiene to consumers.
  + Notes in relation to the investigation included evidence that another staff member reported their concerns regarding the respective staff member to management on three occasions in six months prior to their dismissal.
* One consumer, who requires three staff to assist with transfers stated that, due to staffing levels, they need to wait until after breakfast to be attended to, which impacts their social needs. The consumer said they had not attended activities for over one week.
  + Staff confirmed they have to wait for staff from other areas to finish their tasks before the can attend to the consumer’s needs.
  + Management reported the consumer attends activities and commented that the consumer is robust and would not be missed.
* One representative stated they found their family member in an undignified manner two days prior to the Assessment Contact. The representative explained they found their family member sitting in their underwear eating lunch, with blood in their bed and their indwelling catheter on the floor.
  + The representative said their family member has no quality of life, as they are blind and cannot hear, and they just sit in their chair.
  + The consumer said there is no one to talk to and they feel lonely.
* One representative said their family member was impacted by poor continence care, as they were provided with inappropriate continence aids and ice cream buckets, instead of urinals, which the consumer would put their dentures in as they had poor vision.
* Staff reported one consumer has a psychogenic cough and regularly attends activities, however, was turned away from the cooking group this week due to their cough. Staff said the lifestyle team did not support the consumer’s needs or customise the activity to ensure the consumer was included.
* One consumer said their personal care is not provided in a dignified manner, as they are regularly left alone in the shower. The consumer said they are wobbly on their feet and feel helpless but have no choice but to wait for staff to return.
* One consumer said they often have to wait long periods for staff to respond to call bells and as a result, they attempt to self-ambulate. The consumer also reported their choices are not acknowledged, as they like to have showers at different times on different days, however, they are showered only when it suits staff.
  + The consumer sustained two falls in the week prior to the Assessment Contact from attempting to stand up from the toilet.
  + On one occasion, staff told the consumer they were too busy to wash them, and the consumer attempted to wash themselves in the basin.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

I have considered and acknowledge the service investigated and took action regarding allegations of disrespectful behaviour and refusal of care to one consumer by one staff member. However, evidence in the Assessment Team’s report shows staff raised concerns regarding the staff member’s behaviour with management on at least three occasions in the six months prior to the alleged incident. If immediate action was taken when staff initially raised concerns, the service could have prevented the consumer from being subject to undignified treatment and disrespectful behaviour.

I have also considered evidence in the Assessment Team’s report indicating consumers are not always treated with dignity and respect, including but not limited to, leaving one consumer to eat lunch in their underwear with blood in their bed and indwelling catheter exposed, providing ice cream buckets to consumers instead of urinals, leaving one consumer with poor mobility alone in the shower and not providing one consumer with support to attend activities. I also find management did not consistently demonstrate dignity and respect towards consumers when discussing their care needs with the Assessment Team.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Assessment Team assessed all Requirements in Standard 2 Ongoing assessment and planning with consumers.

All Requirements in Standard 2 were found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate:

* assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services;
* assessment and planning identified and addressed the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wished;
* assessment and planning was based on ongoing partnership with the consumer and others that the consumer wished to involve in assessment, planning and review of the consumer’s care and services, and included other organisations, individuals and providers of other care and services that were involved in the care of the consumer;
* the outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and services plan that was readily available to the consumer, and where care and services were provided; and
* care and services were reviewed regularly for effectiveness, and when circumstances change or when incidents impacted on the needs, goals or preferences of consumers.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service does not meet Requirements (3)(a) and (3)(d), and meets Requirements (3)(b), (3)(c) and (3)(e) in Standard 2 Ongoing assessment and planning.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Non-compliant with Requirements (3)(a) and (3)(d), and Compliant with Requirements (3)(b), (3)(c) and (3)(e) in Standard 2 Ongoing assessment and planning. I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 2 Requirements

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services. Specifically, while policies and procedures were in place to guide staff in relation to assessment and planning, they were not consistently followed, resulting in unmanaged pain and behaviours.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in response to the non-compliance. This training was in relation to assessment and support planning policies and included aspects of pain management, head to toe assessment and risk identification. However, due to the deficits identified at the Assessment Contact, the Assessment Team found these improvements were ineffective.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Documentation shows one consumer, with a suspected hip fracture from an unwitnessed fall, had their pain assessed on only five occasions in the three weeks following the fall, despite demonstrating signs of severe pain. The consumer’s pain score was not consistently recorded to inform care delivery, which resulted in interventions being ineffective when signs of pain were indicating severe.
  + Evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care demonstrates that despite demonstrating signs of severe pain, pharmacological management strategies commensurate to the level of pain were not introduced until two weeks after the fall.
* One consumer experienced acute deterioration and died approximately two hours following a fall. The representative stated, and documentation confirmed, there was a lack of assessment and monitoring of the consumer following the fall to ensure timely escalation of care and appropriate actions.
* Evidence in the Assessment Team’s report under Requirement (3)(a) in Standard 3 Personal care and clinical care demonstrates one consumer’s behaviour care plan had not been reviewed and updated following an increase in psychotropic medication and suicidal ideations. Additionally, psychotropic medication was administered without informed consent.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate 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.

I have considered that assessment and planning processes were ineffective and did not inform the delivery of care for two consumers who experienced falls, which resulted in unmanaged pain and delays in escalation of care. I have also considered that one consumer was administered psychotropic medication without informed consent being given, and their behaviour care plan was not reviewed and updated following an increase in psychotropic medication to guide staff in administering the medication safely.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate assessment and planning identified and addressed one consumer’s needs, goals and preferences when their condition changed. Additionally, end of life planning was not included in the service’s initial care planning processes and was only initiated once the consumer was entering their end of life stage.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service reviewed its systems, policies and processes in response to the non-compliance. Systems, policies and processes require staff to discuss consumers’ end of life wishes on entry or at any other time when the consumer and/or representative is ready.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Interviews with representatives and staff, and documentation showed that, for one consumer, end of life planning commenced within one month after entry and when the consumer entered their end of life stage, an End of life care pathway was commenced. The Assessment Team noted the End of life care pathway was comprehensive and informed staff of the consumer’s needs, goals and preferences. The representative reported satisfaction with the end of life care provided to the consumer.
* Staff demonstrated knowledge of consumers’ specific needs, goals and preferences and said consumers’ vital information recorded in care plans and handover sheet.

Based on the information summarised above, I find the service Compliant with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate all consumers and representatives were actively involved in the assessment, planning and review process.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the service demonstrated consumers and representatives were involved in assessment and planning processes to the extent they want to be.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Consumers interviewed said they were asked who they want involved in care planning discussions and who they would like the service to contact in relation to results of appointments, medical tests and incidents.
* All sampled consumer files showed consumer and/or representative engagement in assessment and planning processes.
* For all sampled consumers, documentation showed assessment and planning processes included involvement from other organisations, individuals and providers of care and services where required.

Based on the information summarised above, I find the service Compliant with Requirement (3)(c) in Standard 2 Ongoing assessment and planning with consumers.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and service plan that was readily available to the consumer, and where care and services were provided.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in relation to partnering with consumers in response to the non-compliance. However, due to the deficits identified at the Assessment Contact, the Assessment Team found these improvements were ineffective.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Documentation showed assessment and planning was not updated to include one consumer’s increased care needs following a fall which resulted in a fracture.
  + Staff were unable to describe what care the consumer required and were unable to locate any plan of care in the consumer’s care plan. Staff said the consumer does not always comply or understand staff requests when providing care and they were worried about causing the consumer pain if they do the wrong thing.
  + Management said the consumer’s care plan should have been updated and the representative should have been notified. Management was unable to confirm if either of these had occurred.
* One representative said they were unaware of the content of their family member’s care plan but knew one was available to access if desired. The representative said their family member’s care needs have never been explained to them.
* One consumer, who entered the service approximately six weeks prior to the Assessment Contact, was unaware of any assessments taking place since entry, except for wound care.
  + Staff said they did not know if the consumer had a care plan as they are new.
  + Documentation showed the consumer had numerous assessments undertaken since entry, however, they did not have a care plan to inform the delivery of care.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and service plan that was readily available to the consumer, and where care and services were provided.

I have considered that outcomes of assessment and planning had not been documented in a care and service plan for two consumers to guide staff in providing safe and effective care. For one of the two consumers, staff were worried about causing them pain if they did the wrong thing. I have also considered that outcomes of assessment and planning had not been communicated to one consumer and one representative.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate care and services were reviewed regularly for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals and preferences of consumers. Specifically, two consumers’ care plans were not updated following incidents of aggressive behaviours and discharge from hospital.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the service demonstrated care plans are reviewed at least every six months or when circumstances change.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Staff said care plans are reviewed every six months and there are no outstanding care plans that need to be reviewed.
* Documentation showed consumers’ six-monthly care plan reviews are monitored via spreadsheet.
* All sampled care plans were current and reflected consumers’ needs, goals and preferences, congruent with consumer and/or representative feedback. With the exception of one consumer, progress notes, incident reports and assessments showed care plans were reviewed and updated following incidents or change in condition.

Based on the information summarised above, I find the service Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Assessment Team assessed all Requirements in Standard 3 Personal care and clinical care.

All Requirements in Standard 3 were found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate:

* effective management of high impact or high prevalence risks associated with the care of each consumer;
* the needs, goals and preferences of consumers nearing end of life were recognised and addressed, their comfort maximised, and dignity preserved;
* deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition was recognised and responded to in a timely manner;
* information about the consumer’s condition, needs and preferences was documented and communicated within the organisation, and with others where responsibility for care was shared;
* timely and appropriate referrals to individuals, other organisations and providers of other care and services; and
* minimisation of infection risks through implementing standard and transmission based precautions to prevent and control infection, and practices to promote appropriate antibiotic prescribing.

The Assessment Team’s report provided evidence of actions taken to address some deficiencies identified at the Site Audit.

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(b), (3)(d) and (3)(e), and meets Requirements (3)(c), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Non-compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(e), and Compliant with Requirements (3)(c), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care. I have provided reasons for my finding under the specific Requirements below.

### Assessment of Standard 3 Requirements

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

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate best practice care was provided in relation to pressure injuries, chemical restraint, wounds, falls prevention and behavioural symptoms of dementia.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in response to the non-compliance. This training was in relation to understanding and responding to behavioural and psychological symptoms of dementia, preventing aggressive behaviour, skin care and documentation and collaboration.

The Assessment Team found this training was effective in relation to wound care, pressure injuries, chemical restraint and management of behavioural and physiological symptoms of dementia. However, the Assessment Team was not satisfied the service demonstrated robust systems and processes are in place to ensure best practice care is provided to each consumer in relation to management of skin integrity, pain management and medication management.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* One consumer reported the service does not have appropriate equipment to shower them and aid with toileting, which results in not being washed and dried thoroughly, and having to open their bowels in their continence aid. The consumer said this makes them feel undignified.
  + Three staff said the service’s equipment was not appropriate for the consumer and as a result, they were unable to adequately attend to the consumer’s personal hygiene and generally opt to wash them on the bed despite knowing the consumer prefers showering. The staff said they made a request for more suitable equipment in October 2021 and are unaware of any action taken in response.
  + The consumer’s continence care plan states they are to be supplied with a bed pan for opening bowels.
  + The consumer’s care plan indicates they suffer from intermittent excoriation in their groin and requires clinical treatment.
  + Management confirmed equipment to facilitate the consumer’s showering had not been ordered. An order was placed on day two of the Assessment Contact.
* The representative for one consumer reported dissatisfaction with their family member’s care, as the consumer is depressed, has no quality of life and has suicidal thoughts. The representative said the medication administered for the consumer’s ‘mood’ is ineffective.
  + The Assessment Team spoke to the consumer who said they want someone to talk to and their goal is to walk again.
  + The Assessment Team identified the consumer had been prescribed psychotropic medication to manage their behaviours prior to entry. After entry, the consumer experienced a behavioural episode where they expressed suicidal ideations. In response, the representative took the consumer to their doctor, who increased their psychotropic medication.
  + There was no evidence demonstrating the effect of an increase in medication was monitored to ensure safety of the consumer.
  + There was no evidence indicating consent was obtained for the use of chemical restraint. One staff said they did not believe they had to obtain consent, as the consumer entered the service with the medication already prescribed.
  + There was no evidence indicating specialist services had been sought in relation to the consumer’s suicidal ideations or desire to walk again.
* One representative said their family member is not provided with physiotherapy interventions as often as needed. One staff confirmed individual physiotherapy interventions are not carried out in line with consumers’ assessed needs, as the service uses physiotherapists to fill shifts when carers are unavailable.
* One consumer and representative reported the consumer does not always receive assistance with showering, as staff are unavailable at times they want to shower. The consumer said they have gone three days without a shower and have attempted to wash themselves in a hand basin.
* On both days of the Assessment Contact, the Assessment Team observed medication preparation and administration that was not in line with best practice.
  + The Assessment Team observed nursing staff pre-pour fluid medication and pre-dial an insulin syringe without attaching consumer labels and remove medication from blister packs and place them into pill cups that had handwritten consumer labels attached.
  + The staff said this method of medication preparation saves time and reported care staff take medicated creams from the medication trolley and apply to consumers. The staff said they do not monitor the effectiveness of medicated creams.
  + Management were not aware care staff were applying medicated creams and reported care staff do not complete medication competencies.
  + The medication trolley was observed to be unlocked whilst unattended in an open nurses’ office.
* One representative reported dissatisfaction with their family member’s continence care, as they were not provided with appropriate continence aids to manage their continence in a dignified and effective way.
  + The representative said on entry, the consumer was provided with large and bulky inserts which caused leakage and discomfort. As the service refused to provide ‘pull ups’, family were supplying continence aids for the consumer.
  + The representative said the consumer was provided with ice-cream buckets instead of urinals and due to the consumer’s sensory impairment, they would place their dentures in these buckets.
  + The representative also stated they often found the consumer’s sensor alarm to be unplugged and walking frame out of reach.
  + Management said under current legislation, the service was under no obligation to provide ‘pull ups’, which is why the family was buying them. Management said the service’s urinals and continence aids have disappeared over time and confirmed the consumer was provided a bucket when urinals could not be found. Management also explained the consumer’s alarm mat was sometimes unplugged to prevent activations when they had visitors, however, staff would forget to return and connect the alarm mat.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate each consumer gets safe and effective care that is best practice, tailored to their needs and optimises their health and well-being.

I have considered that care provided to one consumer was not tailored to their needs and did not optimise their health and well-being, as appropriate equipment was not available to maintain their skin integrity, continence needs or dignity. The consumer suffered skin excoriation and said they feel undignified, as they are required to open their bowels in their continence aid due to the lack of appropriate equipment.

In relation to one consumer subject to chemical restraint, I have considered the service did not comply with its regulatory obligations as required under the *Quality of Care Principles 2014*, as informed consent was not obtained before psychotropic medication was administered, and the effect of an increase in medication was not monitored to ensure safety of the consumer. I have also considered that no action was taken to address the consumer’s suicidal ideations and improve their health and well-being.

In relation to concerns raised by representatives and consumers that consumers are not being provided with physiotherapy interventions or being showered as often as needed. While evidence presented in the Assessment Team’s report demonstrates the core deficiency is heavily aligned with Requirement (3)(a) in Standard 7 Human resources, I have considered that the service did not ensure that consumers received tailored care in line with their assessed needs, which poses risk to the consumers’ health and well-being.

I have also considered that medication preparation and administration was not undertaken in line with best practice, nor by persons with relevant qualifications to perform that role. The method of preparation observed by the Assessment Team increases the risk of medication errors and possible adverse impacts to consumers. Additionally, the effectiveness of medicated creams was not being monitored as they were being applied by persons without appropriate qualifications to do so.

In relation to concerns raised by one representative regarding their family member’s continence care. I have considered that the care provided to the consumer was not best practice, tailored to their needs and did not optimise their health and well-being, as the consumer was not being provided with appropriate continence aids. I have also considered that despite having sensory impairment, staff would often forget to connect their sensor alarm and place their walking frame within reach after visitors had left.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate high impact or high prevalence risks associated with behaviours were effectively managed. Additionally, behaviour incident reporting did not accurately reflect the incidents that were occurring, and staff were not provided training in managing behaviours.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in response to the non-compliance. This training was in relation to understanding and responding to behavioural and psychological symptoms of dementia, preventing aggressive behaviour, incident management system procedure and reportable incidents flowchart, restrictive practices and restraints, and how to access dementia support.

The Assessment Team found the service demonstrated effective management of high impact or high prevalence risks associated with care of consumers in relation to nutrition and hydration, pressure injuries and medications, however, failed to demonstrate that robust systems and processes are in place to effectively manage consumers’ pain.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Documentation showed ineffective pain management for one consumer who had a suspected fracture following a fall:
  + Following the fall, the consumer showed signs of pain when conducting activities of daily living, such as screaming and crying. However, this was not escalated to a medical officer in a timely manner to ensure adequate provision of analgesia commensurate to the consumer’s condition.
  + Six days after the fall, the consumer was reviewed by a medical officer, however, the consumer was not prescribed any additional analgesia, other than paracetamol which was already prescribed prior to the fall. That evening, the consumer recorded a verbal pain score of nine, where 10 is the worst pain ever experienced. In response to the pain, the consumer was repositioned which staff documented was causing more pain. Pain medication was not administered.
  + From six to 14 days after the fall, the consumer continued to experience pain and was documented to be ‘clutching at right thigh area’, ‘complaining of pain does not want to be touched’. During this period, regular paracetamol was administered and non-pharmacological interventions, such as repositioning and hot packs, were provided. The effectiveness of interventions was not monitored.
  + Fourteen days after the fall, the consumer was again reviewed a medical officer and analgesia was prescribed.
  + Nineteen days after the fall, the consumer was commenced on palliative care and continuous medication for pain and distress was provided.
  + The consumer passed away 22 days after the fall.
* Information and evidence in the Assessment Team’s report under Requirement (3)(d) in this Standard demonstrates staff did not consistently follow the organisation’s policies and procedures in relation to post falls management.
  + For two sampled consumers, documentation showed monitoring and observations were not undertaken at a frequency required under the organisation’s policies and procedures following unwitnessed falls.
  + There was no evidence demonstrating one consumer was monitored for a period of up to four hours after a fall. The consumer was subsequently transferred to hospital and passed away from injuries sustained in the fall.
  + In relation to the other consumer, the effectiveness of paracetamol was not evaluated, and pain charting was not commenced despite having mild pain.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate high impact or high prevalence risks associated with the care of each consumer were effectively managed.

I have considered that risks associated with pain were not effectively managed because for one sampled consumer, the service could not provide evidence of pain assessment and actions whilst there was documented evidence in the progress notes of the consumer showing signs of severe pain.

I have also considered that post falls risks were not effectively managed, as for two consumers, monitoring and observations were not undertaken at a frequency in line with the organisation’s policies and procedures. I have considered that as one consumer was not appropriately monitored, staff failed to identify their injury in a timely manner and the consumer subsequently died following hospital transfer. The representative expressed dissatisfaction with the consumer’s post falls management and felt staffs’ failure to monitor the consumer contributed to their death.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate 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 did not consistently engage a palliative care provider to support consumers.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the service demonstrated the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* One representative provided positive feedback about palliative care provided to their family member and said their comfort was maximised by using specialised equipment and administering timely pain relief in collaboration with the medical officer and an external palliative care service.
* Documentation, including assessments, progress notes, referrals to relevant health professionals shows the consumer’s end of life care was delivered in line with the consumer’s and representative’s wishes and organisation’s policies and procedures.
* Staff provided examples of how they ensured the consumer’s comfort was maximised at the end of life stage.

Based on the information summarised above, I find the service Compliant with Requirement (3)(c) in Standard 3 Personal care and clinical care.

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition was recognised and responded to in a timely manner.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in relation to unexpected deterioration in response to the non-compliance. However, the Assessment Team found this training was ineffective, as the service was unable to demonstrate systems and processes were robust to ensure 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 provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Consumer A:
  + Documentation showed the consumer was assessed and neurological observations were undertaken immediately following the incident. The consumer was found to be ‘within acceptable parameters’.
  + The consumer’s vital and neurological observations were not closely monitored during the first hour after the incident, as required under the organisation’s policies and procedures.
  + Documentation showed the consumer was not reviewed again until four hours after the initial assessment. This assessment was triggered by staff expressing concern over uncontrolled bleeding from the consumer’s arm and heightened pain. The consumer was subsequently transferred to hospital and passed away shortly after.
  + The representative expressed dissatisfaction with the service’s management of the consumer’s deterioration and felt that a lack of close monitoring and delay in escalation and hospital transfer contributed to their death.
* Consumer B:
  + Documentation showed the consumer experienced four falls within a four-day period. Following each fall, monitoring and observations were not completed as per the organisation’s policy.
  + Two days after the consumer’s first fall, the representative requested an x-ray due to their condition and pain. A pain assessment was subsequently undertaken, which identified mild pain, and paracetamol was administered. The effectiveness of the paracetamol was not undertaken, and pain charting was not commenced.
  + Six days after the consumer’s first fall, the consumer was noted to be sleepy and had a decreased appetite. Staff were requested to monitor the consumer half hourly, however, they were not monitored again that day.
  + Over the course of five days, documentation showed the consumer developed a moist cough and had increasing drowsiness which impacted their ability to eat, drink and receive medication. Despite having these symptoms, observations were not recorded, food and fluid charting was not commenced, and a clinical review was not undertaken. During this period, the representative asked staff to arrange a medical officer review. The medical officer did not conduct a medical or clinical review but initiated a referral to a geriatric psychologist who reviewed the consumer’s medication.
  + As the representative requested an in-depth clinical review, the consumer was transferred to hospital and subsequently passed away.
  + Management said they were unaware the consumer was unwell and only became aware when they were informed of their passing.
  + The representative reported dissatisfaction with the service’s management of the consumer’s deterioration and felt if they had not requested assistance, nothing would have been done.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate 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.

I have considered that one consumer experienced acute deterioration following a fall and within approximately five hours they passed away. The representative expressed a high level of dissatisfaction around lack of monitoring of the consumer following the fall that from the representative’s view, contributed to the consumer’s death. Documentation showed staff did not follow the organisation’s policies and procedures, as the consumer was not monitored for several hours after the fall to ensure timely escalation of care and appropriate actions are taken in response to deterioration.

I have also considered that one consumer demonstrated signs of clinical deterioration with increased falls and increased drowsiness. The service did not monitor and assess the consumer to ensure their deterioration was identified and responded to in a timely manner. The consumer’s representative was required to request assistance from the service on three occasions to have the consumer assessed. The consumer was hospitalised at the representative’s request due to their deterioration. The consumer subsequently died in hospital.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate information about the consumer’s condition, needs and preferences was documented and communicated within the organisation, and with others where responsibility for care was shared.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 demonstrated the service provided training to staff in relation to documentation and collaboration, in response to the non-compliance. However, the Assessment Team found this training was ineffective, as the service was unable to demonstrate systems and processes were robust to ensure effective communication of information within the organisation.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Two care staff who provide lifestyle supports said they were not familiar with aspects of consumers’ care that do not relate to lifestyle supports, they do not receive handover at the beginning of their shift, if they need to know anything in relation to consumers they review care plans and progress notes. They were unable to describe whether there have been any changes to consumers they need to be aware of to provide safe and effective care.
* One staff said communication is ‘terrible’, ‘non-existent’ and ‘requires improvement’. The staff said there is no handover process and they need to review consumer information through multiple sources to understand what work needs to be undertaken. The staff said it would be extremely hard for a new person to understand what needs to be done.
* Management said this is not a usual practice and would investigate further, as there is an expectation that all staff receive handover at the beginning of each shift.
* Consumer files sampled demonstrated information about consumers’ conditions, needs and preferences is not consistently documented and communicated within the organisation following a change in a consumer’s condition.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate 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.

I have placed weight on statements by staff that there are no handover processes to inform them of consumers’ conditions, needs and preferences. In order to provide safe and effective personal and clinical care, staff need to review care plans and progress notes, which is inefficient and poses a risk of delays in attending to consumers’ immediate needs.

I have also considered that care plans did not include up-to-date information to guide staff in providing care and services consistent with their needs.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services. Specifically, referrals to external services were limited and the service attempted to manage consumer needs without seeking input from external organisations for guidance and support.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the service demonstrated it has connected with external organisations and providers of other care and services to ensure consumers are referred to and assessed by a relevant health professional in a timely manner.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Consumers and representatives indicated consumers were generally referred to a specialist promptly when required and the consumer’s health and well-being had improved as a result of the referrals.
* Care planning documents sampled showed evidence of others, including medical officers, allied health professionals and other providers of care and services where needed.
* One staff provided an example of referrals made to a speech pathologist, dietitian and hospital in response to deterioration.

Based on the information summarised above, I find the service Compliant with Requirement (3)(f) in Standard 3 Personal care and clinical care.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate minimisation of infection related risks through implementing standard and transmission based precautions to prevent and control infection and practices to promote appropriate antibiotic prescribing.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found the service demonstrated it has effective systems in place to minimise infection related risks.

The Assessment Team provided the following information and evidence collected through interviews, observations and documentation, which are relevant to my finding in relation to this Requirement:

* Documentation showed implementation of infection risk management strategies and appropriate antibiotic prescribing in relation one consumer’s wound.
* The service has a dedicated infection prevention and control (IPC) lead who conducts regular audits, education, and reviews of infection related risks and supports staff with outbreak management, policy reviews and updates and maintenance of immunisation data. However, due to staffing shortages, the IPC lead has been unable to fulfil their responsibilities since December 2021 due to staffing.
* Staff were able to articulate the importance of obtaining infection sensitivities prior to prescribing antibiotics. They could also describe practices to decrease prescribing of antibiotics, including providing effective perineal care, encouraging oral fluids, daily application of moisturiser to maintain skin integrity and using best practice wound care principles.
* The Assessment Team observed personal protective equipment and suitable disposal mechanisms outside the door of one consumer in isolation. Staff explained their responsibilities when entering and exiting the consumer’s room.
* Staff were observed to be wiping down equipment with disinfection wipes between consumer use.
* The Assessment Team observed staff appropriately donning face masks, changing face masks when damp or soiled and not touching face masks once applied.

Based on the information summarised above, I find the service Compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# STANDARD 5 Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Assessment Team assessed Requirements (3)(a) and (3)(b) in Standard 5 Organisation’s service environment at the Assessment Contact. As no other Requirements in this Standard were assessed at the Assessment Contact, an overall rating of the Standard has not been provided.

Requirements (3)(a) and (3)(b) were found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate:

* the service environment was welcoming and easy to understand, and optimised each consumer’s sense of belonging, independence, interaction and function; and
* the service environment was safe, clean, well maintained and comfortable, and enabled consumers to move freely, both indoors and outdoors.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit.

The Assessment Team has recommended the service meets Requirements (3)(a) and (3)(b) in Standard 5. I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Compliant with Requirements (3)(a) and (3)(b) in Standard 5 Organisation’s service environment. I have provided reasons for my finding under the specific Requirements below.

## 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate the environment was easy to understand and optimised each consumer's sense of belonging, independence, interaction and function.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 included evidence of actions taken by the service in response to the non-compliance, which include:

* Older areas of the service have been decommissioned, with consumers relocated to new areas.
* Dementia Support Australia specifications, such as different coloured toilet seats, have been implemented in bathrooms in new areas of the service.

The Assessment Team provided the following information and evidence collected through interviews and observations, which are relevant to my finding in relation to this Requirement:

* Consumers and representatives were happy with the environment, as it feels homely, consumers are able to decorate their rooms and they are able to navigate it with ease.
* Staff demonstrated an awareness of how consumers like to have their room set up and provided examples of how they have supported consumers to make their rooms comfortable.
* Consumers’ rooms were observed to be personalised. The environment includes communal outdoor areas and an area for chickens and gardens.
* While the Assessment Team noted a lack of signage to assist with navigation, management reported a company has been engaged to implement wayfinding cues, which was estimated to be completed in May 2022.

Based on the information summarised above, I find the service Compliant with Requirement (3)(a) in Standard 5 Organisation’s service environment.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate the environment was safe, clean, well maintained and comfortable.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found that while some dirty areas and clutter were observed, most areas were observed to be safe, clean and well maintained, consumers were happy with the cleanliness of the environment and systems are in place to ensure preventative and reactive maintenance is actioned.

The Assessment Team provided the following information and evidence collected through interviews, observations and documentation, which are relevant to my finding in relation to this Requirement:

* All consumers and representatives were happy with the cleanliness of consumers’ rooms and communal areas and said maintenance issues are actioned appropriately. Consumers confirmed they can access all areas of the service environment.
* Staff were able to describe the process for raising maintenance requests and reporting hazards. Maintenance staff explained preventative and reactive maintenance processes.
* Maintenance request logs demonstrated one outstanding job, however, management reported the failure to complete this request was an oversite and it would be attended to immediately.
* Most areas were observed to be clean, safe and well maintained. Some general cleaning was identified, such as stains on carpet in one corridor, a dirty floor in one consumer’s room and equipment was cluttered in some areas.
  + Management said they were aware the carpets were behind in their scheduled clean and have arranged an external carpet cleaning service to attend to the carpets.
  + The consumer whose floor in their room was dirty said they were satisfied with the cleanliness of their room. Staff said they regularly check the consumer’s room but were unable to do so at the time of the Assessment Contact due to being short staffed.
  + Staff said they try to place equipment away immediately, but it cannot always occur as they are short staffed.

Based on the information summarised above, I find the service Compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Assessment Team assessed all Requirements in Standard 7 Human resources.

All Requirements in Standard 7 were found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate:

* the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services;
* workforce interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity;
* the workforce was competent, and members of the workforce had the qualifications and knowledge to effectively perform their roles;
* the workforce was recruited, trained, equipped and supported to deliver the outcomes required by these Standards; and
* regular assessment, monitoring and review of the performance of each member of the workforce.

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(c), (3)(d) and (3)(e) and meets Requirement (3)(b) in Standard 7 Human resources.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Non-compliant with Requirements (3)(a), (3)(c), (3)(d) and (3)(e), and Compliant with Requirement (3)(b) in Standard 7 Human resources. I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 7 Requirements

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate adequate staffing numbers to ensure quality care and services are delivered to consumers.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found that while the service addressed some of the issues identified during the Site Audit in May 2021, they were not effective, and the service was unable to demonstrate there are sufficient staffing numbers to ensure quality care and services are delivered to consumers.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Seven consumers and five representatives said there is not enough staff and provided examples of how this impacts the care and services consumers receive. For example, being left alone in the shower and delays in care which result in missing social activities.
* Most staff said they are regularly short staffed and busy and at times, which results in consumers being left in the shower, delays in activities of daily living, inability to undertake cleaning, best practice care not always being provided, and consumer records not being updated.
* Staff said there is only one physiotherapy assistant who works once per week and as a result, there is no one that can conduct an assessment or urgent review any other day.
* Staff said they cannot undertake desired training, as there is no one available to cover their shifts.
* Rosters did not list clinical staff and included staff who were no longer employed by the service or were on workers compensation. The roster did not detail staff roles and the Assessment Team could not identify which staff related to hospitality roles.
* Rosters demonstrated 26% of shifts were vacant across multiple areas of the service. Management said they were trying to recruit staff and are impacted by their remote location; however, they did not advise of any actions being implemented to improve recruitment.
* Management was not able to provide a call bell report for the two weeks prior to the Assessment Contact. Management said call bell data is not being analysed and was not able to describe their approach and evidence of improvements.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate 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.

I have considered consumer, representative and staff feedback demonstrating there is not enough staff to meet consumers’ needs, which has resulted in delays in care, consumers being left in the shower unattended, cleaning not being undertaken, best practice care not always being provided, and consumer records not being updated. I acknowledge that management are aware of and are actively recruiting to fill positions, however, there was no evidence of strategies in place to address difficulties in attracting staff due to the service’s remote location. I have also considered call bells are not monitored to plan the workforce, address any impact delays in call bell responses have had to consumers and monitor consumers’ use of call bells.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate workforce interactions with consumers were kind, caring and respectful of each consumer’s identity, culture and diversity.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found that the service was able to demonstrate this Requirement is met.

The Assessment Team provided the following information and evidence collected through interviews, observations and documentation, which are relevant to my finding in relation to this Requirement:

* Consumers and representatives said staff are kind, caring and gentle when providing care.
* Staff were observed knocking on consumers’ doors when entering and interacting with consumers in a gentle and positive manner.
* Management provided an example of disciplinary action taken in relation to allegations of abuse against one staff member.

Based on the information summarised above, I find the service Compliant with Requirement (3)(b) in Standard 7 Human resources.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate staff were competent to effectively perform their roles.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found that while the service has a system to ensure the workforce has the qualifications and experience to perform their role, gaps in the knowledge, training, and competency of staff were not always identified.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Four staff interviewed were not able to demonstrate they are competent or have the appropriate knowledge, understanding and application of the use and minimisation of restraint and could not demonstrate they follow the organisation’s policies and procedures.
* Assessment and planning are not conducted in a timely manner for consumers when there has been a change of care needs or on entry, resulting in staff not having the information to provide care and service in accordance with their care needs.
* Staff did not identify two consumers’ clinical deterioration, resulting in lack of monitoring and delays in escalation.
* Staff were observed not following safe or best practice medication principles. Two staff reported that staff administer medicated creams without having completed a competency.
* As demonstrated under Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care, deficits in staff knowledge and competency were identified in relation to continence care, skin integrity, pain management and post falls management.
* Management said staff appraisals, feedback and training attendance to monitor staff competency, however, staff training attendance was not monitored and 73 of 124 staff appraisals were outstanding.
* Management told the Assessment Team ‘we cannot confirm competency of our workforce’.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

While the service has processes in place to monitor staff competency, these processes were not being followed, as staff training attendance was not being monitored and a significant portion of performance appraisals were outstanding. I have considered that deficits in staff knowledge and competency in relation to assessment and planning, continence care, post falls management, skin integrity, pain management, clinical deterioration and use of restraint were identified by the Assessment Team and not the service through their monitoring processes. I have placed weight on a statement from management that they cannot confirm competency of their workforce.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(c) in Standard 7 Human resources.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate that the workforce was recruited, trained, equipped and supported to deliver the outcomes required by these Standards.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. The Assessment Team found that while the service has a system in place to recruit and provide orientation to staff, they were unable to demonstrate they effectively monitor staff training or ensure all staff are supported or equipped to deliver care and services in line with the Quality Standards.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Five staff could not provide examples of restrictive practices and/or recall undertaking training in relation to restrictive practices.
* All staff said since the Site Audit conducted on 4 May 2021 to 7 May 2021, there has been an overload of online training, which has resulted in training fatigue and failure to retain the information.
* Clinical staff said they would like to attend further training to better educate themselves in their role, however, it was not possible due to current staffing levels.
* Three staff said they are not equipped with information to provide care that meets consumers’ needs. Examples were provided in relation to two consumers’ care plans that were not completed or updated to guide staff in providing safe and effective care.
* Training records show all staff have not completed 16 mandatory training modules, including, but not limited to, restrictive practices and restraint, tissue viability - pressure injuries, clinical assessment and topical medication competency.
  + Deficits in these areas of care were identified by the Assessment Team. Refer to Requirement (2)(a) in Standard 2 Ongoing assessment and planning with consumers and Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care for further information.
  + Management reported the clinical manager was responsible for following up staff non-attendance of training, however, they have since left and this process is not being carried out.
  + Management could not account for staff non-attendance of training which was not investigated and managed while the clinical manager was at the service.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

I have considered that training records show staff have not undertaken mandatory training in relation to multiple areas of care, which were aligned with deficits identified by the Assessment Team as described under Requirement (2)(a) in Standard 2 Ongoing assessment and planning with consumers and Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care. I have also considered that the service’s monitoring processes did not identify staff had not undertaken all mandatory training.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(d) in Standard 7 Human resources.

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate that a performance appraisal process had been implemented and staff were unable to describe how performance discussions with management assisted them to develop and improve their skills.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 did not include evidence of actions taken by the service in response to the non-compliance. However, the Assessment Team found that regular assessment, monitoring, and review of each member of the workforce was not being undertaken.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* All staff interviewed said they have not had a performance appraisal in the past 12 months. One staff said they have been employed at the service for three years and have never had a performance appraisal with management to discuss their performance and future goals.
* The service’s Plan for continuous improvement had a planned action documented during August 2021 to set a schedule for staff appraisals as a matter of urgency. Management did not give any indication of when this would be completed.
* Complaints data showed a written complaint made during February 2022 from one staff member regarding another staff member’s performance had not been addressed at the time of the Assessment Contact. Management acknowledged this should have been investigated.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have considered that performance appraisals for staff have not been undertaken in the last 12 months, and while management are aware they are behind, there is no plan in place to ensure they will be completed in a timely manner. I have also considered that a complaint regarding the performance of one staff made at least two weeks before the Assessment Contact had not been addressed.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(e) in Standard 7 Human resources.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Assessment Team assessed Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance. No other Requirements in this Standard were assessed at the Assessment Contact.

Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 were found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service did not demonstrate:

* the organisation’s governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery;
* effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance and regulatory compliance;
* effective risk management systems and practices, including but not limited to, managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and supporting consumers to live the best life they can; and
* a clinical governance framework, including, but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure.

The Assessment Team has recommended the service does not meet Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service Non-compliant with Requirements (3)(b), (3)(c) and (3)(e), and Compliant with Requirement (3)(d) in Standard 8 Organisational governance. I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 8 Requirements

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate the organisation’s governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 provided evidence of actions taken by the service in response to the non-compliance, which include:

* engagement of a consultant for a period of six months to ensure the service was working towards providing safe and quality care and services;
* trending analysis of pertinent data and risks tabled at monthly Board meetings; and
* recruitment of a Chief executive officer in January 2022.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Monthly Board meetings are held to discuss risks and operational matters and develop action plans, however, developed action plans remain in draft form and have not been agreed upon, finalised or implemented.
* A Strategic plan has been developed but not finalised to include objectives and associated actions that need to be taken.
* It was unclear whether continuous improvement is tabled at Board meetings. The service’s Plan for continuous improvement did not demonstrate any updates since the consultant left.
* Monthly key performance indicators are collated; however, no analysis, evaluation or appropriate monitoring is made, which results in limited data being reported to the Board.
* The Clinical governance and risk committee Agenda does not show that clinical risks have planned action, completion dates or outcomes.
* Changes implemented as a result of consumer feedback, experience and incidents were unable to be demonstrated.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I acknowledge that the organisation’s governing body engaged a consultant to ensure the service was working towards providing safe and quality care and services, however, once the consultant had completed their tenure, the Board could not demonstrate they continued to ensure improvements were implemented.

There is no evidence the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. On the contrary, the organisation’s governing body has not ensured timely implementation of the service’s Strategic plan and action plans in relation to risks and operational matters, and continuous improvement based on consumer feedback, experience and incidents.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(b) in Standard 8 Organisational governance.

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

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate organisation wide governance systems were effective in relation to information management, continuous improvement and regulatory compliance.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 provided evidence of actions taken by the service in response to the non-compliance, which include development of governance frameworks in relation to clinical governance, regulatory compliance, risk management, privacy and confidentiality, and incident reporting and management.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

Information management

* Consumer information, such as hospital discharge and external consultant letters, consent forms and pathology results, is stored in separate hard drives that not all staff have access to.
* Specialist information is not consistently recorded in consumer care plans to ensure required care is delivered.
* Staff interviewed said they can access consumer information via the service’s documentation system, however, it is not always current or up-to-date and does not provide them with the necessary information they need to provide safe and effective care.
* All staff do not receive a handover at commencement of each shift.
* The Psychotropic medication register does not include information regarding why the medication is required, alternatives, decision date for use, consent and frequency of monitoring.
* Staff said they cannot access policies and procedures easily when required.

Continuous improvement

* The majority of items listed on the service’s Plan for continuous improvement were identified from the Site Audit conducted on 4 May 2021 to 7 May 2021 and did not include any improvement ideas or opportunities that related to audit outcomes, critical incidents or consumer and representative feedback.
* Action items with completion dates of August 2021 as stated in the Plan for continuous improvement had not been reviewed or notations added to explain any required extension to achieve outcomes.
* Three of five staff were unaware of the continuous improvement process, what their responsibilities are or how they can assist consumers and representatives to provide feedback.
* Management said the service handles continuous improvement very badly, with opportunities for improvement not identified and the Plan for continuous improvement not kept up-to-date.

Financial governance

* Management advised that annual budgets were being drafted at the time of the Assessment Contact, which will include staffing, running costs and capital expenditure.
* Information in relation to equipment budgets and planned purchases was unable to be provided, as management said they are still in draft form.
* Staff said they were invited to contribute to a ‘wish list’ over 12 months ago in relation to equipment required to undertake their duties safely. Staff who contributed said they have had no feedback in relation to their contributions.

Workforce governance, including the assignment of clear responsibilities and accountabilities

* The service’s Organisational chart has not been reviewed to incorporate the Chief executive officer and does not provide clear responsibilities and accountabilities.
* Five staff said they were unsure who to report their concerns to since the Clinical manager has left.
* Management said they do not know how they can ensure there are enough staff to provide the required care to consumers. The master roster shows over 100 vacant shifts per fortnight across the service. One staff said staff work longer hours to cover vacancies, however, this does not occur for all shifts.
* Management said they do not have clear or concise data of the service’s roster and vacant shifts. Reports from rostering software were unable to be generated to identify workforce gaps, trends, times and days of unfilled shifts.
* Staff training records demonstrate that all staff have not completed mandatory training as per the service’s policy. Training records are sent to be Board as part of the monthly report, however, outstanding matters have not been addressed.
* Management reported 49% of staff had annual performance appraisals completed.

Regulatory compliance

* Management said the service connects with an industry peak body to track changes to aged care laws, however, they were unable to articulate which peak body the service connects with and could not provide evidence or information about how updates are disseminated to staff. Staff could not articulate how they are informed or made aware of industry changes.
* The service was unable to demonstrate that it minimises and monitors the use of chemical and environmental restraint in line with *Quality of Care Principles 2014.* Management were not aware that consumers in the service were subject to environmental restraint and one consumer had no informed consent for the use of psychotropic medication. Staff reported they had requested further training in relation to restraint, however, training records do not indicate this has occurred.
* The service’s human resources and governance systems are not consistent with regulatory requirements. The service does not monitor professional registrations and staff are required to manually calculate hours worked to ensure they do not breach their contractual agreements.

Feedback and complaints

* Consumers and representatives said they rarely get feedback when lodging concerns and since there has been a change of management, they do not know who to report their concerns to.
* Management said the service has a very poor system and they struggle to close out complaints as they do not like the uncomfortable process involved.
* Two staff said they raised concerns regarding work performance of a colleague at least two weeks before the Assessment Contact and had not heard anything from management.
* Management were unable to identify any recent opportunity for improvement through feedback and complaints processes.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate organisation wide governance systems were effective in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

I have considered that information management processes are not effective in ensuring staff have the information they need to complete their duties in a satisfactory manner, as all staff do not have access to consumer information, specialist information is not incorporated into all care plans, consumer information is not always up-to-date, all staff do not receive handover at commencement of each shift, psychotropic medication registers do not include sufficient information to guide staff in minimisation of restraint, and staff said they are unable to access policies easily.

In relation to continuous improvement, processes are ineffective as opportunities for improvement are not identified from internal audits, feedback and complaint or critical incidents. Additionally, regular review of the Plan for continuous improvement is not undertaken to ensure items are completed or implemented as planned.

In relation to financial governance, I have considered that annual budgets, including equipment and planned purchases are in draft form.

I have considered that the service does not have workforce governance systems in place to ensure the service has sufficient ongoing staff to provide consumers quality care and services. Systems were unable to provide information in relation to vacant shifts, rostering, workforce gaps, trends, and times and days of unfilled shifts to enable effective planning to be undertaken. Additionally, workforce governance processes were not effective in ensuring competency and training of staff, as while training records are provided to the Board, issues relating to mandatory training and performance appraisals not being completed had not been addressed.

I have also considered that the service was unable to articulate which peak body they connect with to track changes to aged care laws or provide evidence to show how this information is disseminated to staff. Documentation and interviews with management show the service has not complied with regulatory obligations in relation to restraint and human resources.

In relation to feedback and complaints, due to the recent change in management, representatives were unsure who to report their concerns to. I have placed weight on management’s feedback that the service has a ‘very poor system’ and they struggle to close out complaints. Four staff said they recently submitted complaints to management and have not received any feedback in return.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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.*

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate risk management systems and practices were effective in managing high impact or high prevalence risks associated with the care of consumers.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 provided evidence of actions taken by the service in response to the non-compliance, which include implementation of a Consumer clinical risk matrix and a Risk management framework policy. However, the Assessment Team found these improvements were ineffective in managing all clinical high impact risks of consumers, specifically in relation to deterioration.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* In relation to recognising and responding to acute deterioration, policies and procedures were not consistently followed by staff, appropriate monitoring and escalation plans had not been established, and roles, responsibilities and accountabilities were not always understood by staff.
  + Documentation showed three consumers were not appropriately monitored following falls to ensure timely identification of deterioration, one consumer’s pain was not assessed despite screaming and crying, and escalation to a medical officer did not occur in a timely manner.
* A monthly Clinical indicator report is used to identify risks and drive continuous improvement initiatives. This report is discussed at Clinical quality risk committee meetings and management provided an example of how risks to consumers due to staffing numbers were identified at a Board level, which resulted in two wings being shut down and no new consumers being accepted.
* Policies and procedures are in place to guide staff in relation to identifying, managing and reporting elder abuse. The incident management system demonstrated allegations of elder abuse were reported in line with regulatory requirements. Staff were able to describe what constituted elder abuse and provided an example of how they applied the organisation’s elder abuse policy and procedure. Staff confirmed they were provided training as part of their induction.
* Documentation showed consumers are supported to make choices and where they include an element of risk, those risks are discussed with the consumer and representative, informed consent is obtained and mitigation strategies implemented.
* An incident management system is in place to record and manage incidents. The Assessment Team noted incidents for sampled consumers were reported, managed, escalated and finalised in line with regulatory requirements. Staff said they have received training in relation to reporting of different types of incidents.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service demonstrated risk management systems and practices were effective in managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents.

I have considered that while evidence in the Assessment Team’s report indicates areas for improvement regarding risk management systems associated with deterioration, it is not proportionate to consider this Requirement Non-compliant based on these deficiencies alone. Evidence in the Assessment Team’s report relating to identifying and responding to deterioration has been considered under Requirement (3)(e) in this Standard, as the deficits also align with failures in the organisation’s clinical governance framework.

Based on the information summarised above, I find the service Compliant with Requirement (3)(d) in Standard 8 Organisational governance.

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

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

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

This Requirement was found Non-compliant following a Site Audit conducted on 4 May 2021 to 7 May 2021, where it was found the service was unable to demonstrate a clinical governance framework was in place to guide staff, management and the Board in roles and responsibilities to ensure good clinical governance is maintained.

The Assessment Team’s report for the Assessment Contact conducted on 16 March 2022 to 17 March 2022 provided evidence of actions taken by the service in response to the non-compliance, which includes development of policies in relation to incident reporting and management. However, the Assessment Team found these improvements were ineffective in relation to minimisation of restraint and open disclosure.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Regulatory obligations in line with the *Quality of Care Principles 2014* were not met, as there was no evidence that behaviour assessments, discussions with consumers and representatives were conducted or informed consent was obtained for 13 consumers subject to environmental restraint.
  + Management said the entire service is secure due to COVID-19 restrictions, however, this has not been formally communicated with consumers and representatives.
* The service has a register detailing psychotropic medication use, however, details are not entered in their entirety making it difficult for the service to identify who is chemically restrained and when reviews, reductions or cessations have been conducted.
* One representative expressed dissatisfaction they had not received contact from the service to discuss the lead up to their family member’s death, what could have been done better or why no medical attention was provided prior to their hospitalisation.
  + Management advised they struggle with difficult conversations and do not understand the entire process of open disclosure or how to ‘close the loop’.
* As stated in the Assessment Team’s report under Requirement (3)(d) in this Standard, policies and procedures in relation to recognising and responding to acute deterioration were not consistently followed by staff, appropriate monitoring and escalation plans had not been established, and roles, responsibilities and accountabilities were not always understood by staff.
  + Documentation showed three consumers were not appropriately monitored following falls to ensure timely identification of deterioration, one consumer’s pain was not assessed, and escalation to a medical officer did not occur in a timely manner.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the service did not demonstrate the organisation’s clinical governance framework was effective in relation to minimisation of restraint, open disclosure, and recognising and responding to deterioration.

I have considered that the service did not recognise 13 consumers were subject to environmental restraint and as a result, their regulatory obligations under the *Quality of Care Principles 2014* were not met, as behaviour assessments were not undertaken, discussions with consumers and representatives were not conducted and informed consent was not obtained.

I have also considered that the service cannot effectively monitor consumers subject to chemical restraint, as while a psychotropic medication register is maintained, it does not include sufficient information to identify who is chemically restrained and when reviews, reductions or cessations have been conducted.

In relation to open disclosure, I have considered that one representative expressed dissatisfaction they had not been contacted by the service to discuss events leading up to their family member’s death, what could have been done better and an explanation regarding what medical attention was given prior to their hospitalisation. I have placed weight on statements from management that they struggle with difficult conversations and do not understand the entire process of open disclosure or how to ‘close the loop’.

The organisation’s clinical governance framework failed to identify that staff were not following policies and procedures in relation to acute deterioration. Three consumers experiencing deterioration were not monitored and as a result, escalation to a medical officer did not occur in a timely manner and for one consumer, pain was unmanaged. I consider this failure poses a risk to other consumers’ health and safety.

Based on the information summarised above, I find the service Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# Areas for improvement

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

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

* Ensure consumers are provided care and services in a way which ensures they are treated with dignity and respect, with their dignity, culture and diversity valued.
* Ensure staff have the skills and knowledge to provide care and services to consumers in a way which ensures they are treated with dignity and respect and values their culture and diversity.
* Ensure staff interactions with consumers are monitored to ensure kind, caring and respectful interactions are maintained at all times.

**Standard 2 Requirements 2(3)(a) and 2(3)(d)**

* Ensure staff have the skills and knowledge to initiate assessments, develop and/or update care plans, and regularly review consumers’ care and service needs.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

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

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to medications, skin integrity, chemical restraint, post falls management and activities of daily living;
  + recognise changes to consumers’ health and well-being, including clinical deterioration and implement appropriate monitoring and management strategies;
  + develop and/or implement appropriate pain management strategies and monitor effectiveness of strategies to ensure impact to the consumer is minimised; and
  + ensure information relating to consumers’ personal and clinical care needs is documented and effectively communicated to others.
* Ensure policies, procedures and guidelines in relation to best practice care and management of high impact or high prevalence clinical risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care and management of high impact or high prevalence risks.

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

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.
* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in five of the eight of the Quality Standards.

**Standard 8 Requirements 8(3)(b), 8(3)(c) and 8(3)(e)**

* Review the organisation’s governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers.
* Review the organisation’s clinical governance framework in relation to the use of restraint and recognising and responding to deterioration.