Performance

Report

**1800 951 822**

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| Name of service: | Feros Village Byron Bay |
| Service address: | 29-33 Marvell St BYRON BAY NSW 2481 |
| Commission ID: | 0438 |
| Approved provider: | Feros Care |
| Activity type: | Site Audit |
| Activity date: | 4 October 2022 to 7 October 2022 |
| Performance report date: | 10 November 2022 |

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

**This performance report**

This performance report for Feros Village Byron Bay (**the service**) has been prepared by K. Reed, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment team’s report for the Site audit; the Site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved provider’s response to the Assessment team’s report received 01 November 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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

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

# Areas for improvement

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

* Consumers are to be treated with dignity and respect and can maintain their identity.
* Consumers need to be able to make informed choices about their care and services and live the life they choose.
* The organisation must undertake initial and ongoing assessment and planning for care and services in partnership with the consumer.
* Assessment and planning must have a focus on optimising health and well-being in accordance with consumers’ needs, goals and preferences.
* Consumers are to receive safe and effective personal and clinical care, in accordance with their preferences to optimise their health and well-being.
* Consumers receive services and support for daily living that optimise consumers’ independence, health, well-being and quality of life.
* The environment provided needs to be safe and comfortable to promote consumers’ independence, function and enjoyment.
* Feedback is regularly sought from consumers, the workforce and others and is used to inform continuous improvement for consumers and the organisation.
* The workforce needs to be sufficient, skilled and qualified to provide safe, respectful and quality care and services.
* The organisations’ governing body is accountable for the delivery of safe and quality care and services.

# Standard 1

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

Findings

This Quality Standard has been found non-compliant as five of six requirements have been found non-compliant. Deficiencies relate to:

* Consumers and representative feedback included examples of disrespectful treatment by staff.
* The service could not demonstrate that care and service delivery is culturally safe as consumers’ individualised needs relating to their culture and identity had not been identified. Staff did not demonstrate a shared understanding of consumers’ needs and preferences including in relation to their culture and identity.
* Consumers and representatives generally reported that they had not been involved in making decisions about consumers’ care and that care delivery was not in accordance with their preferences.
* The service did not demonstrate that consumers were supported to take risks in a way that minimised harm. The site audit report included information that risk assessments for consumers who self-medicate and for consumers who choose to smoke had not been completed.
* Consumers and representatives were dissatisfied with the information they received and provided examples of situations where information had been sought but not provided.

Consumers and representatives did not feel that consumers were treated with dignity and respect and felt that consumers were not encouraged to maintain their identity or supported to make informed decisions about their care and services. Consumers and representatives said they were not supported to make decisions about their care and services for example when they prefer to shower. They said the service did not support consumers to maintain relationships with others.

Consumers and a representative provided examples of disrespectful treatment from senior staff that they had either experienced or witnessed. One consumer advised a senior staff member had yelled at them and that on another occasion when they requested to dine in their room they were admonished and told to attend the dining room.

One consumer advised the Assessment Team that the service had not engaged with them about their specific cultural requirements and traditions. The Assessment Team reviewed this consumer’s care plan and confirmed that the consumer’s individualised cultural needs had not been documented.

The site audit report included information that care planning documentation relating to consumers’ choices and preferences was not available. Management advised that the care planning documentation available on the electronic care management system was incomplete as hardcopy care plans were removed before information was transferred into the electronic system. Staff interviewed including those who were new to the service and/or agency staff did not have a sound understanding of consumers’ needs and preferences including consumers’ cultural needs and how this would influence the care they provide.

Consumers and representatives generally reported that they had not been engaged in making decisions about the care and services provided to consumers with some consumers reporting they are not showered in accordance with their preferences. One representative who resides interstate provided feedback that their efforts to maintain communication with their family member had not been supported by the service.

The organisation could not demonstrate that consumers are provided with information that supports them to make informed choices. The site audit report included feedback that consumers and representatives were dissatisfied with the information they received and provided examples of this including a failure to receive newsletters.

The site audit report included information under this and other Quality Standards that consumers who choose to smoke tobacco, were not supported to do so safely and that consumers who self-medicate had not had risk assessments completed. The Assessment Team observed unsafe practices where risks associated with consumers’ choices had not been minimised.

The Approved provider in its response to the site audit report states the staff member responsible for the disrespectful treatment that was brought forward in the site audit report is no longer working at the service and that performance management processes are underway. The Approved provider says that the actions of this one staff member are not representative of the attitude and behaviours of the staff in their interactions with consumers. I accept this; however, this does not negate the lived experience of those consumers and representatives who had experienced disrespectful treatment. Additionally, the consumer outcome summaries captured in the site audit report document further examples of disrespectful treatment of consumers indicating that inappropriate staff behaviour was more widespread.

The Approved provider’s response states that actions have been taken to improve cultural safety at the service with cultural awareness training now included in the training suite with the organisation planning to ensure completion by all staff. In addition to this, a Reconciliation Action Plan has been developed and submitted to Reconciliation Australia. While I acknowledge the service has taken action to improve its performance in relation to the delivery of culturally safe care and services, these initiatives are recent, and the Approved provider has not evidenced how this will be monitored going forward to ensure the ongoing delivery of culturally safe care and services.

The Approved provider’s response refutes information in the site audit report that hard copy care planning information was not available and had been removed prior to the transfer of information into the electronic care management system. The response states that information was available to the Assessment Team.

The Approved provider’s response acknowledges that care related discussions have not consistently been documented and says that following the site audit, 100% of care plans have had a comprehensive review and now include consumers’ preferences and choices. The care plan review process included consumers and those representatives and/or significant others the consumer wanted involved. The review included an ‘About Me’ assessment which the Approved provider says has identified consumers’ individualised needs and preferences. The response states that care delivery, for example showering, is no longer being delivered in accordance with a shower list and that consumer choice now guides care delivery. Staff are being advised through handover processes that the care plans are the source of information relating to consumer preferences and choices.

To improve communication processes and to ensure consumers receive the information they need to make choices the Approved provider has conducted additional consumer meetings following the site audit and has committed to holding weekly consumer meetings until consumers are satisfied they can be reduced to monthly. Outstanding matters arising from previous meetings are being addressed and evidence of this was provided. Consumers and representatives have received a November 2022 newsletter and a revised activities plan has been developed in consultation with consumers.

The Approved provider in its response to the site audit report states that risk assessments have now been completed for those consumers who engage in risk taking behaviour and the response includes examples of risk assessments that have been completed following the site audit. I am satisfied however that while the service has taken action to improve its performance in this area, the service has not supported consumers to manage risks safely and improvements made are yet to be fully evaluated to ensure improved outcomes for consumers.

I note too that the Residential Services Annual Customer Survey Report submitted as an element of the Approved provider’s response indicates dissatisfaction with aspects of consumer dignity and choice (including discussions about risks to wellbeing) has been a concern since 2021 when the survey was conducted.

The Approved provider asserts that given the actions it has taken in response to the site audit report that Standard 1 is now Compliant. While I acknowledge that action is being/has been taken, the Approved provider has not demonstrated that consumers are now satisfied with the care they receive under this standard specifically in relation to their dignity, culture and choice, and how that is supported.

I have found that consumers’ privacy is respected, and their personal information is kept confidential. Consumers and representatives were satisfied their personal information was stored securely and could describe how staff ensured their privacy was respected during care delivery. Electronic information is password protected and computers were observed to be shut down when not in use. Staff were observed knocking on consumers’ doors and gaining consent prior to entering a consumer’s room. Information about how personal information is protected is included in the consumer handbook that consumers receive on entering the service.

# Standard 2

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

Findings

This Quality Standard has been found non-complaint as five of the five Requirements have been found non-compliant. Deficiencies relate to:

* Risks to consumers’ health and well-being was not considered in assessment and planning processes.
* Consumers’ current needs, goals and preferences have not been identified or addressed through assessment and planning.
* Assessment and planning have not been based on an ongoing partnership with the consumer or others, including other organisations.
* Care and service plans have not been made available to the consumer of their representative.
* Regular review of care and services has not occurred including when circumstances have changed for the consumer.

The risks to consumers’ health and well-being was not considered in assessment and planning processes. Risk assessments have not been completed for consumers who prefer to self-administer medications, consumers with wandering behaviours and consumers with restrictive practices in place. Eight of eight consumers whose documentation and profile was included in the site audit report had deficits in assessments.

For three consumers who preferred to self-administer their medication, assessments had not been completed to ensure the capacity and the safety of the consumers to perform this task. Assessment processes had not been undertaken to ensure the constant supply or the safe storage of medication. Consumers who required oxygen therapy had not been assessed regarding the need for oxygen, care planning directives did not contain evidence to guide staff in the administration of oxygen or the cleaning and changing requirements of oxygen equipment. Three consumers were identified with challenging behaviours including wandering from the service and aggression, assessments had not been undertaken to identify triggers, or strategies listed to decrease the risk of the behaviours to guide staff practice.

Consumers’ wishes regarding advance care planning and end of life preferences had not been identified or documented. Consumers provided feedback they had not been involved in discussions regarding their end of life care. For a named consumer who exhibited challenging behaviours, care planning did not address their current needs and strategies to manage the consumer’s behaviours were not listed to guide staff practice. For a consumer who entered the service for respite care, interim care planning and assessments were incomplete including an assessment of behaviours, this consumer was observed wandering on a road outside of the service unsupervised, three days after entering the service.

Consumers and representatives were unaware of the opportunity to partner in the assessment, planning and review of consumers’ care and services, and therefore they were not involved or asked to be involved in planning. Registered staff were unaware how consumers or representatives could be involved in ongoing assessment and planning to meet consumers’ needs and preferences.

Most consumers and representatives were not aware of the existence of a care plan, and therefore the outcomes of consumers’ assessments and planning had not been communicated to them. Registered staff could not advise how they would access a copy of a care plan if it was requested. Regular review of care plans has not occurred to determine the effectiveness of care planning guidelines. Incidents have occurred for some consumers including wandering episodes, however this has not prompted a review of care planning documentation.

The Approved provider’s response to the site audit report proposes compliance has been achieved in Requirement 2 (3) (a) as following the site audit 100% of care plans have been reviewed, including risk assessments for consumers who prefer to self-medicate, consumers requiring oxygen therapy, consumers with wandering behaviours, consumers with restrictive practices and consumers who chose to smoke. While the response indicated 100% of care plans have been reviewed, the behaviour support care plan submitted for a named consumer who left the service three times unescorted does not contain information relating to the consumer’s absconding behaviours or strategies to reduce the risk of the consumer leaving the service unescorted in the future.

The Residential Services Annual Customer Survey Report submitted as an element of the Approved provider’s response indicates dissatisfaction with aspects of ongoing involvement in care and services (including consumer involvement in setting goals and assessment and planning) has been a concern since 2021 when the survey was conducted.

Adherence to the organisation’s policies and procedures was re-established in relation to care planning, this occurred through education, internal auditing using an electronic care management system, and establishing a ‘resident of the day’ program and schedule for care plan reviews. The plan for continuous improvement indicates the commencement of case conferencing within the care review cycle will be completed by the end of February 2023.

In relation to Requirement 2 (3) (b), the Approved provider has proposed compliance has been achieved through the completion of actions taken since the completion of the site audit. Actions have included the review of 100% of care plans in collaboration with consumers and their representatives, this review included self-determined goals for end of life planning. The goals, preferences and end of life plans were updated and communicated with team members.

Since the site audit, the Approved provider has stated they have engaged all consumers and their representatives in the care planning process and therefore proposes Requirement 2 (3) (c) is compliant. The Approved provider submitted an email sent to a representative, asking them to complete a life history assessment as evidence to support improvement actions in this Requirement. Further information was contained in the November 2022 newsletter, thanking consumers and their representatives for assistance in the development of care plans, and informing consumers and representatives they have the ability to have a copy of their care plan if they wished. The Approved provider has proposed this action alongside the introduction of an electronic care management system to monitor compliance with care plan reviews and assessments has resulted in compliance for Requirement 2 (3) (d). A care plan review report was submitted to reflect the consumers’ care plan domains had been reviewed between 04 October 2022 and 01 November 2022. However, I am unable to ascertain from the care plan review report if the domains of care recorded in the report reflect the complete domains of care for each consumer. The plan for continuous improvement indicates the completion date for assessments and care plans to be reviewed and completed and checked for quality is 15 November 2022, and education for staff regarding the availability of care plans will not be provided until 10 December 2022. The Acting Facility Manager has also been tasked via the plan for continuous improvement to review all care plans to ensure they are reflective and consistent with changes to consumers’ needs. The planned action date for completion was recorded as 30 November 2022. The care plan review cycles have been reinstated and are being monitored both locally and organisationally for ongoing compliance. The Approved provider has indicated in its response ongoing improvement is needed for Requirement 2 (3) (e).

In reaching my decision of Non-compliance for the Requirements in this Standard, I have concluded at the time of the site audit, ongoing assessment and planning for care and services was not in partnership with the consumer or reflective of consumers’ needs goals and preferences. As listed above the service has taken immediate action to commence rectification actions to address the deficits identified in the audit report. I acknowledge the commitment of the provider; however, it is my decision these improvement activities are either in their infancy or have not been completed and therefore have not been tested for their effectiveness or sustainability.

# Standard 3

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

Findings

This Quality Standard has been found non-compliant as seven of seven requirements have been found non-compliant. Deficiencies relate to:

* Consumers did not receive safe and effective care.
* High impact and high prevalence risk were not managed effectively, including behaviours, oxygen therapy, medication management and catheter care.
* Consumers have not been consulted regarding their end of life preferences.
* Deterioration in consumers’ condition was not acted upon in a timely manner.
* Information relating to consumer care was not documented or shared when required.
* Referral have not been made in a timely manner.
* Infection related risks have not been minimised. Outbreak management resources were insufficient to guide the service should an outbreak occur.

Consumers have not received safe and effective care and services. Two consumers were returned by police officers after wandering away from the service on three separate occasions. Staff were not aware the consumers had left the service unescorted. Behaviour support plans had not been completed for the two consumers to decrease the risk of further wandering. A consumer experienced chest pain and shortness of breath requiring oxygen on two occasions, however documentation does not support the consumer’s medical officer was informed of the incidents or authorised oxygen usage for the consumer. A consumer who has care planning directives that state they are unsuitable to administer their own medication was observed to have medication in their room, which were also not secured properly. For a consumer that requires a urinary catheter, documentation does not support their catheter was changed in accordance with directives and was changed a month later, increasing the risk of infection for the consumer.

High impact risks to consumers were not managed effectively. Incidents have not been recorded to identify high impact risks to consumers including challenging behaviours and episodes of consumers leaving the service unescorted. One consumer returned from hospital with directives to restrict and monitor their fluid intake, this was not implemented, and the consumer was noted by their medical officer to have ankle swelling six weeks after leaving hospital.

Consumers and their representatives were not consulted regarding their end of life needs and preferences and therefore, consumers were not confident their end of life care would be in alignment with their preferences. Staff did not demonstrate a shared understanding how to provide end of life care or where they could locate information to deliver care to palliative consumers.

Deterioration to consumers was not responded to in a timely manner. A consumer who experienced a large amount of blood in their urine was not seen by a medical officer for a period of four days. The consumer had limited monitoring over the four-day period and was provided with simple pain relief on one occasion during this period.

Information relating to consumers was not shared with others responsible for care delivery to consumers. Physiotherapy staff were not informed of consumers who fell, to facilitate reassessment and review. Medical officers were not consistently notified of changes to consumers’ condition including when a consumer experienced chest pain and shortness of breath. Care planning documentation was incomplete and individual directives for consumers were not captured in care planning directives including the application of compression stockings for a named consumer. Consumers’ preferences relating to their end of life care were not captured or documented. For one consumer who had been reviewed by a behavioural specialist, information from the review was not available to guide staff practice, the consumer displays challenging behaviours.

Referrals did not occur in a timely or appropriate manner, this caused delay for consumers to be reviewed and treated. One consumer who experienced a large amount of blood in their urine was not referred to medical staff for a period of four days. One consumer was referred to an aged care specialist in March 2022, however an appointment was not made, and the consumer has not seen the specialist. This consumer has left the service four times unescorted and has displayed aggressive behaviours.

The outbreak management plan in place to manage and prevent outbreaks did not contain sufficient or relevant information to successfully manage an outbreak, including a COVID19 outbreak. The outbreak management plan was not reviewed after the service experienced an outbreak earlier in 2022. Staff have not completed mandatory training and competency assessments in relation to infection control. Care planning documentation for consumers requiring specialist equipment did not provide instructions relating to the cleaning or replacement of equipment. One consumer with a urinary catheter had documented evidence their catheter was changed a month after the prescribed changing date, increasing the risk of infection for the consumer.

The Approved provider’s response to the site audit includes information that indicates all assessments and care plans have been completed and are located on the electronic care management system. Registered nurses have completed the care plans and a clinical consultant is completing a quality review of the care plans and assessments. Consumers with high impact or high prevalent risks were reviewed as a priority, risk assessments and care plans for consumers who smoke, self-administer medication, require behaviour support or restrictive practice, require specialised nursing care were submitted as part of the Approved provider’s response. End of life planning conversations commenced with consumers, care planning has been completed in collaboration with consumers and copies of care plans have been offered to all consumers and representatives.

While I acknowledge the service has stated it has completed assessments and care plans for consumers involved in high risk activities. The medication assessment for two named consumers submitted as part of the Approved provider’s response were signed by the consumers, however, the self-medication checklist was blank.

The Residential Services Annual Customer Survey Report submitted as an element of the Approved provider’s response indicates dissatisfaction with aspects of personal and clinical care (including consumer knowledge of the content of their care plan and end of life support) has been a concern since 2021 when the survey was conducted.

Communication of consumers’ care needs to team members is occurring at handover and is reinforced with a review of a consumer each day of the month. The acting Facility manager is attending handovers to ensure consistency and transfer of information. The Approved provider in its response has proposed the actions taken as listed above have returned Requirements 3 (3) (a), 3 (3) (b) and 3 (3) (c) to compliance. The service’s plan for continuous improvement indicates incident management processes will be reviewed with a completion date recorded as 30 November 2022. Education is to be provided to registered staff across a number of topics relevant to Standard 3, including behaviour support plans, risk management, high impact and high prevalence risk, end of life care, clinical deterioration and falls management. The completion date for the provision of education recorded in the plan for continuous improvement is 10 December 2022.

In relation to recognising the deterioration in consumers, the Approved provider has acknowledged ongoing improvement is required in this Requirement. An incident escalation protocol has been established and education is to be provided regarding consumer deterioration, the completion date for the education is 10 December 2022. As all consumer care information has been uploaded into the electronic care management system, the Approved provider has indicated this process will ensure information can be transferred and shared between relevant parties. The service’s plan for continuous improvement indicates a clinical handover sheet was to be developed, however, this was not evidenced in the Approved provider’s response.

I note also in the consumer meeting minutes, medical officers who previously attended the service have ceased site visits. It is noted that new medical officers will be coming to the service, however, a date has not been provided and information has not been included in the Approved provider’s response how consumers will be supported with medical officer coverage in the interim.

Consumers who have sustained falls in September and October 2022 have been referred to the physiotherapist for review. Staff have been reminded to report falls as incidents to facilitate review by the physiotherapist. A review of the process for referral to all Allied health services is being undertaken. The Approved provider in its response has concluded Requirement 3 (3) (f) requires ongoing improvement.

The outbreak management plan has been reviewed and is now consistent with national guidelines. Cleaning regimes are now in place and included in relevant care plans for specialised services including oxygen and catheters. A training record for 15 staff members was submitted as part of the Approved provider’s response which indicated mandatory infection control training had occurred for the 15 members of staff. It is unclear if this represents all staff employed at the service. A staff survey completed in 2022 indicated 19 participants were provided with the survey.

In reaching my decision of Non-compliance for the Requirements in this Standard, I have concluded at the time of the site audit, consumers did not receive safe and effective care and services. I do not have confidence consumers who have absconded from the service have had strategies put in place to keep them safe. Education for staff on a range of topics relating to Standard 3 will not be completed until 10 December 2022. The service has an absence of medical officers who are willing to visit the service, this concerns me in relation to the deterioration of consumers. As listed above, the service has taken immediate action to commence rectification actions to address the deficits identified in the audit report. I acknowledge the commitment of the provider; however, it is my decision these improvement activities are either in their infancy or have not been completed and therefore have not been tested for their effectiveness or sustainability.

# Standard 4

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

Findings

This Quality Standard has been found non-compliant as six of seven requirements have been found non-compliant. Deficiencies relate to:

* Consumers were not receiving services and supports for daily living that optimised their independence, well-being and quality of life. Care planning information relative to this requirement was incomplete and did not accurately reflect consumers’ current needs and preferences. Staff were not familiar with consumers’ individualised needs goals and preferences.
* Consumers were dissatisfied with the way the service supported their emotional and spiritual well-being.
* Consumers felt that they were not supported to participate in the life of the community both within and outside the service.
* Information about consumers was not communicated within the organisation and staff reported not having an understanding of consumers’ needs and preferences.
* The service was not able to demonstrate that consumers were being referred to other providers of care and services relevant to services and supports for daily living.
* Consumers were generally dissatisfied with the variety of their meals.

Consumers and representatives were generally dissatisfied with services and supports for daily living. Consumers and representatives said consumers were not engaged in leisure and lifestyle activities and that the activities on offer are not reflective of consumers’ individual needs and preferences.

Consumers emotional, spiritual and psychological well-being was not supported as consumers reported being bored and having to keep each other engaged due to the lack of things to do. One consumer said they stay in their room due to lack of activities. Consumers advised that family members had to assist them to maintain their religious/spiritual journey as the service offers no support or services for them to be able to practice their faith or their spiritual beliefs.

Consumers and representatives advised consumers do not feel supported to participate in their communities within and outside the service due to the limited activities offered.

Consumers and representatives said that whilst the service had a bus, that bus trips that had previously taken consumers into the community had been removed from the activity program. Staff said that previously the bus would take consumers to the local shops once per week, however advised this was no longer occurring. Maintenance staff confirmed that the service does have a bus however, stated there is no-one at the service who can drive it, other than a staff member who was on leave. The Assessment Team reviewed the activities calendar and identified that a bus trip to the local shops was the only outing the service offered. Consumers reported they had made suggestions about including activities of interest to the program, but nothing had changed.

Consumers said the meals were of suitable quality and quantity however were dissatisfied with the variety and said the menu has not changed for some time. Consumers provided feedback that included the meals are ‘predictable’ and the menu has not changed for ‘many years.’ Catering staff confirmed the menu had not changed significantly for a number of years. Additionally, the consumers’ meeting minutes stated that the service was considering removing some menu options from the existing menu and this was confirmed by catering staff as being under consideration.

Care planning information demonstrating consumers and needs and preferences in relation to aspects of services and supports for daily living was not available. Management staff advised that hardcopy care planning documentation had been removed prior to transferring the information into the electronic care management system and archived. They said that this resulted in some information being incomplete. The Assessment Team found that information was not available to demonstrate effective communication of consumers’ needs and preferences both within the organisation and with others where responsibility for care is shared.

Documentation available did not evidence referral to other organisations or providers of care relating to services and supports for daily living and consumers and representatives could not advise of referrals that had been made.

The Approved provider’s response to the site audit report includes an acknowledgement that the lifestyle program at the service was disrupted at the time of the site audit and was addressed as soon as management became aware. The Approved provider states that an activities plan was developed weekly and that the lifestyle assistant is supported by a team of volunteers; examples of the weekly activities plan were included in the response. The Approved provider says that fishing and bus outings have now been added to the activity program at the consumers’ request.

The Approved provider’s response states that consumers’ care plans have been reviewed and are now completed and have been improved to reflect consumers’ personal preferences. It said that the organisation is continuing to review consumers’ individual preferences to ensure they receive the required support to ensure their spiritual well-being and to practice their faith.

The Approved provider refutes information brought forward by the Assessment Team that hardcopy leisure and lifestyle care had been archived. The Approved provider states that leisure and lifestyle care plans were available in a designated folder but does acknowledge that information was incomplete. I am not able to form a view as to whether or not leisure and lifestyle care plans were available. I am however satisfied that staff did not demonstrate a shared understanding of consumers’ needs and preferences and management staff said that care planning documentation in relation to activities and lifestyle had not been reviewed for some time. Further, the Approved provider in its response has acknowledged that information available was incomplete and actions to improve and review assessment and care planning have been initiated following the site audit.

The Approved provider’s response states that action is being taken to provide consumers with information and encourage them to be partners in care and service delivery; plans are to distribute information through newsletters and consumer meetings. There is also a commitment to improve communication and referral processes. The Approved provider states that there are providers involved in consumer care on an ongoing and periodic basis and provided some limited examples of this. The Approved provider acknowledges however that the management and communication of information and referral processes are areas requiring ongoing improvement.

With respect to catering services, the Approved provider’s response acknowledges that catering services require ongoing improvement. The response states that a Hospitality Consultant has been engaged to review the menu and the menu has been sent for review to a dietitian. Focussed discussions about the food are occurring at consumers’ meetings and consumers’ dietary requirements are being reviewed as an element of the care plan review process.

The Assessment Team brought forward deficiencies under this standard in relation to the provision of equipment for one consumer. While most consumers and representatives advised they were generally satisfied with consumers’ access to equipment that assists with their daily living activities this was not the case for one consumer. Following the site audit the service has addressed the consumer’s request for equipment to support their independence and this is now in place. I have given weight to the fact that the service has addressed the consumer’s request and that most consumers were satisfied with the provision of equipment and am satisfied that consumers generally have access to suitable equipment that supports consumers’ lifestyles.

# Standard 5

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

Findings

This Quality Standard has been found non-compliant as two of three requirements have been found non-compliant. Deficiencies relate to:

* Consumers who choose to smoke tobacco did not have a designated smoking area to do so and the practice of smoking outside their rooms impacted other nearby consumers.
* Consumers’ free movement between the inside and outside environment was restricted.
* Consumers were dissatisfied with the outdoor furniture at the service as it was not suitable, and concerns raised with management had not been actioned.
* Consumer requests for furniture, fittings, maintenance and cleaning are not actioned or responded to.

Consumers and representatives described the service as welcoming and easy to navigate around with clear signage. They reported that outdoor areas are well maintained with colourful garden beds and shaded areas. Most consumers and representatives were satisfied with the cleanliness of their rooms and common areas and furniture available inside the service.

The Assessment Team observed consumers sitting in an outdoor area enjoying morning tea with a volunteer, and other consumers with their dogs.

The site audit report included information that several consumers at the service smoke tobacco. The service did not have a designated smoking area and consumers who smoke did so outside their rooms and on their verandas. This practice impacted other consumers who reside nearby. Those consumers reported the smoke and the smell of cigarettes ‘wafts’ into their room and they need to close their windows and doors.

The Approved provider’s response to the site audit report states that a designed smoking area has been established and consumers who smoke are encouraged to use this new area.

The site audit report identified that the service consists of four cottages. Two doors in the corridors of each cottage enabled consumers to exit the cottage, however, the doors were locked to prevent entry from outside into the cottage. The Assessment Team observed several consumers with mobility assistive devices exit through the doors and become locked out of the cottages. These consumers then navigated their way around the perimeter of the cottage to the main entry door of the cottage. The main doors to the cottages were held open with a chain that was looped around the handle on the door and tied off on the handrail adjacent to the pathway.

The Approved provider’s response to the site audit report stated that the doors in the cottages are now only locked from external entry between 6pm and 6am as part of the service’s lockdown procedure.

In response to the main doors to each cottage, the Approved provider’s response confirmed the doors are chained open for ease of access, however, stated the chains should be fitted on the wall, not the handrail and this has been reinforced with staff. The response proposed to change the door mechanism to avoid the use of a chain and included evidence of a purchase order for new door mechanisms.

The site audit report identified consumers/representatives were dissatisfied with the outdoor furniture at the service because the tables were heavy and not fit-for-purpose and chairs were difficult to move and use. Consumers had raised these concerns via feedback forms, discussions with management and consumer meetings. While management noted outdoor chairs would be replaced, no action had been taken in relation to the matter and no timeframe was identified.

Generally, specific consumer requests for furniture, fittings, maintenance and cleaning were not actioned or responded to. Management advised that these had been delayed due to refurbishment at another of the organisation’s services.

The Approved provider’s response to the site audit report acknowledged that consumers had expressed dissatisfaction with the outdoor furniture and there had been a delay in addressing their concerns. The response provided evidence that new outdoor furniture (armchairs and lounge) had been purchased and evidence of October 2022 consumer meeting minutes that identified other concerns and requests raised by consumers in relation to furniture, fittings and equipment had been discussed and actions had been taken or were proposed.

In reaching my decision of Non-compliance with Requirements 5(3)(b) and 5(3)(c), I have concluded at the time of the site audit, the service environment was not comfortable and did not enable consumers to move freely between indoor and outdoor areas, and furniture, fittings and equipment were not suitable for consumers.

As identified above, the service has taken immediate action to commence rectification actions to address the deficits identified in the site audit report. I acknowledge the commitment of the Approved provider; however, it is my decision these improvement activities are either in their infancy or have not been completed and therefore have not been tested for their effectiveness or sustainability.

# Standard 6

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

Findings

This Quality Standard has been found non-compliant as three of four requirements have been found non-compliant. Deficiencies relate to:

* Consumers and their representatives reported they do not feel encouraged, safe or supported to provide feedback and make complaints
* The service does not take appropriate action or respond to feedback and complaints.
* Open disclosure is not used when things go wrong or incidents occur.
* Feedback and complaints are not adequately documented, reviewed or used to improve the quality of care and services.

Consumers, representatives and staff provided examples of how consumers are made aware and have access to advocacy and language services and external complaints mechanisms. This was consistent with information in the consumer handbook.

However, consumers and their representatives did not feel encouraged, safe or supported to provide feedback and make complaints. Consumers provided negative feedback about consumer meetings as a forum to provide feedback and complaints and said nothing changes. Several consumers also expressed concerns about management’s approach to feedback and complaints. For example, one consumer described an incident of inappropriate behaviour and response by the Facility manager in response to feedback they provided. Another consumer described management as unapproachable and was fearful of retribution if they were to make a complaint. A third consumer said they would not consider making a complaint as management does not listen or respond.

A recent consumer/representative satisfaction survey conducted by the service found almost half the respondents did not feel encouraged or supported to provide feedback or make complaints. There was no evidence of actions or strategies taken by the service to respond to this survey finding.

While staff said they would advise management about consumer feedback or complaints raised with them, they were unable to provide any examples of when this had occurred.

Management described feedback forms and consumer meetings as avenues for consumers and representatives to provide feedback or make complaints, however, no evidence of completed feedback forms was provided and consumers reported that consumer meetings were an ineffective forum to raise feedback and complaints.

During the site audit and following feedback from the Assessment Team, the service’s plan for continuous improvement was updated with actions to improve the service’s feedback and complaints processes, including reviewing the process and the feedback and complaints register, increasing the number of feedback boxes around the service, informing consumers/representatives about available feedback and complaint mechanisms, educating staff on feedback and complaints, continuous improvement and open disclosure and analysing and trending feedback and complaints as part of the clinical indicators.

Consumers and representatives reported that the service does not take action or respond to feedback and complaints. They described feeling as though they are not heard and that their complaints are not taken seriously. This was consistent with the service’s recent consumer residential satisfaction survey that found almost half of respondents did not feel the service take appropriate action or respond to feedback and complaints.

The service does not practice open disclosure when things go wrong or incidents occur. For example, the service failed to practice open disclosure in relation to the following incidents involving two consumers with a range of complex diagnoses who left the service unsupervised and were located and returned to the service by police on three of the four occasions. The service failed to disclose these incidents to the consumers’ representatives. One consumer described an incident of inappropriate behaviour and response by the Facility manager following feedback they provided about a significant error made by the service in relation to their personal information and said no apology was offered for the error or inappropriate behaviour. While management said open disclosure had been practised in this instance, no documentary evidence was provided. A consumer’s representative was not contacted regarding two clinical episodes experienced by the consumer that required care staff intervention.

Consumers and representatives advised their feedback or complaints are not used to improve the quality of care and services. They provided examples of where feedback provided had not been actioned and therefore had not resulted in any change or improvement.

The Assessment Team reviewed the service’s comments and complaints register, incident registers and residential leadership meeting minutes and found feedback and complaints are not consistently recorded, and where complaints and feedback are documented, there was no evidence of action taken or how feedback/complaints are used to improve the quality of care and services.

The Approved provider’s response to the site audit report attributed the deficiencies in the service’s complaints management under this Quality Standard to a failure on behalf of the Facility Manager, who is currently suspended pending the outcome of an investigation. The response stated that the Acting Facility Manager and Executive Manager are now responsible for overseeing all complaints and that the planned improvement actions identified during the site audit to address consumer and representative reluctance to raise feedback and complaints have been completed. The response also said that the residential satisfaction survey results would be reviewed, communicated with consumers and improvement plans developed to address areas in the results.

The Approved provider’s response identified a range of improvement actions required in relation to requirements 6(3)(a), 6(3)(c) and 6(3)(d), including increasing access to and information about the service’s feedback and complaints mechanisms, including feedback and complaints as an agenda item for meetings and recording discussion in meeting minutes, staff training in complaints management and open disclosure and analysing, trending and reviewing feedback and complaints and recording improvement actions on the service’s plan for continuous improvement.

In reaching my decision of Non-compliance with Requirements 6(3)(a), 6(3)(c) and 6(3)(d), I have concluded at the time of the site audit the service’s feedback and complaints system and processes were ineffective.

As identified above, the service has taken immediate action to commence rectification actions to address the deficits identified in the site audit report. I acknowledge the commitment of the provider; however, it is my decision these improvement activities are either in their infancy or have not been completed and therefore have not been tested for their effectiveness or sustainability.

# Standard 7

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

**Findings**

This Quality Standard has been found non-compliant as five of five requirements have been found non-compliant. Deficiencies relate to:

* Insufficiency of staff.
* Interactions with consumers was disrespectful.
* The workforce did not have the knowledge to effectively perform their roles.
* The workforce was not supported through onboarding process or trained to effectively deliver the outcomes required by the standards.
* Performance appraisals for each staff member was not undertaken.

The site audit report provided information that the service did not have a Facility manager appointed at the time of the site audit. The Approved provider advised a temporary Facility manager had been appointed to the position, however, was unexpectedly unavailable for work at the time of the site audit leaving a registered staff member who was on their second shift at the service in charge. The Approved provider advised the Executive manager assumed responsibility for the site until the Facility manager could return to the site. The Approved provider’s response includes that an interim Facility manager has now been appointed, in addition to two Registered support officers, and an external clinical consultant have been appointed from the 10 October 2022, 3 days post site audit.

The site audit report provided information the service did not have rostered staff available to deliver lifestyle services to consumers at the service. Consumers reported there was not enough lifestyle staff to provide activities and they expressed feeling bored and having to keep each other engaged due to the lack of things to do. One consumer said they stay in their room due to lack of activities. Maintenance staff confirmed there is no-one at the service who can drive the bus to assist consumers to participate in activities, other than a staff member who was on leave. Consumers reported the current lifestyle assistant works two days per week, the activities schedule has reduced, and the lifestyle assistant had taken leave resulting in no activities being available for consumers for two weeks. The site audit report brought forward information that Executive management were unsure at the time of the site audit about who was overseeing the activities whilst the lifestyle staff were on leave, however the Approved provider’s response states the lifestyle assistant is supported by a team of volunteers. This information was unsubstantiated with corroborating evidence. The Approved provider’s response as well as review of the service’s plan for continuous improvement indicates the service were aware of staff shortages and have commenced taking action including additional recruitment and oversight in the rostering of competent and qualified staff. Review of consumer meeting minutes provided within the Approved provider’s response acknowledged staffing levels continue to be an issue for the service. The Approved provider’s response recognises ongoing improvement is required in Requirement 7 (3) (a).

Consumers expressed staff were not kind and caring and the site audit report brought forward evidence of a number of incidents that had occurred between staff and consumers which did not support Requirement 7 (3) (b). The Approved provider’s response included information from a consumer survey conducted two months prior to the site audit which indicated most consumers were satisfied that staff are kind, caring and respectful. However, consumers and a representative provided examples of disrespectful treatment from staff towards consumers. One consumer stated a staff member had yelled at them and that on another occasion they had been denied their choice to dine within their room. The Approved provider’s response included information that the only disrespectful treatment from staff towards consumers was by the suspended Facility manager. The Approved provider says that the actions of this one staff member are not representative of the attitude and behaviours of the staff in their interactions with consumers, however consumers still experienced this disrespectful treatment. Additionally, the consumer outcome summaries captured in the site audit report document further examples of disrespectful treatment of consumers indicating that inappropriate staff behaviour was more widespread such as considering feedback from a consumer about an incident as more of a behaviour than an incident when a staff member had a near miss with the administration of medication, and where a consumer had asked staff to assist in contacting their representative however their requests were ignored. I am not satisfied the Approved provider has considered the consumer’s experience brought forward within the site audit report and there were no actions listed within the plan for continuous improvement provided seeking quality improvement for this requirement.

The site audit report provided information that a number of shifts for registered and enrolled staff had not been filled in the two weeks prior to the site audit. Where registered staff were not available for shifts, the service advised medication competent staff were rostered with support of an on-call registered nurse. At the time of the site audit, the service was unable to demonstrate staff working at the service were adequately qualified to deliver medication. The Approved provider’s response included a document for staff rostered in November 2022 who the Approved provider lists as medication competent, however I am not satisfied this information is sufficient to demonstrate that the staff rostered for the period identified during the site audit were appropriately trained in medication management. The Approved provider’s response included information that the process for ensuring medication competent staff are rostered when clinical staff are unavailable has been reviewed and a checklist has been drafted to assist the rostering coordinator. The site audit report brought information forward that due to staff shortages other staff have been working outside of their role descriptions to assist consumers to deliver care and services including the preparation and delivery of meals. The Approved provider’s response advises in the absence of the lifestyle staff, volunteers within the service have supported consumers. However, consumers stated the workforce has been unable to meet their social, cultural, spiritual, psychological support needs and in addition one consumer reported they had ‘little faith’ in staff at the service regarding the delivery of care.

The site audit report brought forward evidence that staff have not completed training in relation to competency for the management of oxygen therapy, antimicrobial stewardship, serious incident response scheme and open disclosure. The site audit report evidenced consumers have been administered oxygen by care staff, the service was unable to demonstrate that staff are identifying and reporting serious incidents and open disclosure was not being practiced when things go wrong including for incidents where consumers had left the service on a number of occasions without the knowledge of the service and where disrespectful treatment had occurred for consumers. This information was supported by the Approved provider’s response which acknowledges that mandatory training has since been completed by all staff. Review of training records provided shows staff have now completed training in infection control and serious incident reporting scheme, open disclosure and incident reporting. Information contained within the service’s plan for continuous improvement acknowledged that staff had not completed the required training and that the Approved provider’s response acknowledged that the requirement requires ongoing improvement. The Approved provider’s response states oxygen therapy has been added to a training calendar that has been introduced to the service, although no evidence of this was provided within the Approved provider response or the plan for continuous improvement.

The site audit report brought forward information demonstrating the service had a qualified infection prevention and control lead was unavailable at the time of the site audit. The Approved provider’s response includes evidence of this qualification and is accepted, however further evidence that staff are recruited, trained and supported to delivery outcomes required by the standards is considered that new staff were not supported upon commencement at the service where a new registered staff member was delegated the role as the person in charge where other staff were unexpectedly unavailable. Management at the time of the site audit acknowledged the staff member would be unable to be supported until 10 October 2022, 3 days post site audit. The Approved providers response includes that a short-term staff information and orientation checklist is currently under development and acknowledged that the requirement requires ongoing improvement.

The site audit report brought forward evidence that regular assessment monitoring and review of the performance of each member of the workforce has not been undertaken by the service in excess of 18 months. Review of provided documentation included a ‘staff pulse survey’ conducted in 2022 however this included the response of six staff members and was not reflective of an assessment of each staff member. The Approved provider’s response acknowledged the information brought forward within the site audit report and has now implemented as a quality improvement within the service’s PCI that all members of the workforce will undergo a performance appraisal by 15 December 2022.

It is my decision the service did not meet the requirements at the time of the site audit and has not demonstrated further evidence within the Approved provider’s response to support this Standard is compliant. Improvement actions are either in their infancy or yet to be tested for effectiveness or sustainability.

# Standard 8

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

Findings

This Quality Standard has been found non-compliant as five of five requirements have been found non-compliant. Deficiencies relate to:

* Consumers and representatives did not consider the service to be run well and said they are not encouraged or engaged to partner in the development, delivery, evaluation or in the improvement of care and services within the service.
* The service did not consistently engage consumers in aspects of their care and services.
* The organisation was unable to demonstrate the organisation’s governing body promoted, was accountable for, or monitored the delivery of safe and quality care and services.
* Organisation wide governance systems and risk management systems were not effective
* The clinical governance framework did not achieve positive clinical results.

Management advised that consumer engagement occurs through consumer meetings and verbal feedback. However, consumers and representatives expressed dissatisfaction with how the service engaged with them in the development, delivery and evaluation of care and services. The Approved provider acknowledged in its response to the site audit report, delays occurred in actioning consumer requests brought forward at consumer meetings over the past two months.

The site audit report identified care planning documentation did not document the consumers’ needs and preferences in relation to the delivery of care and services, and consumers and representatives expressed dissatisfaction with the lack of participation in care planning processes. I note the Approved provider states actions have been undertaken since the site audit, including the review of all consumer care planning documentation in consultation with consumers and their representatives in conjunction with the implementation of an electronic care management system which will assist the service to monitor compliance with care plan reviews and assessments.

Consumers and representatives were dissatisfied with feedback processes and said they provide information and suggestions to management including in relation to the lifestyle program offered by the service, however, these issues were not addressed. Consumers and representatives said they were not encouraged to provide feedback and complaints, and some said they felt uncomfortable in doing so as they were fearful of reprisal.

The organisation was unable to demonstrate the organisation’s governing body promoted, was accountable for, or monitored the delivery of safe and quality care and services. Management was not able to demonstrate documentation or evidence of how the organisation was accountable for quality and safety within the organisation and was unable to demonstrate where the governing body was informed of or had effective oversight of clinical indicators, incidents, complaints, or workforce issues. Care planning documentation identified that all incidents were not reported, investigated or analysed to inform the delivery of safe and effective care and services or to identify areas for improvement.

The Approved provider in its response proposed Requirement 8(3)(b) requires ongoing improvement. Management advised the plan for continuous improvement, provided to the assessment team, was not current or updated and internal and external audits had not been conducted for some time. Management acknowledged staff performance appraisals for 2021 had not been conducted and appraisals for 2022 have not been commenced. Staff performance appraisals have been scheduled as a matter of priority and will be completed by December 2022. The service was unable to provide complete records of all staff related to staff completion of required education and training including the serious incident response scheme, the Quality Standards, infection control, incident management and restrictive practices. The Approved provider stated this was an error in producing the staff training records and all staff are now compliant with mandatory training requirements. The Approved provider submitted a staff training register as part of its response indicating 15 staff members had completed training relevant to their roles. It is unclear if this represents all staff employed at the service. A staff survey completed in 2022 indicated 19 participants were provided with the survey.

The service was unable to demonstrate effective organisation wide governance systems and risk management systems and practices including in relation to information management, continuous improvement, workforce governance, feedback and complaints and regulatory compliance. This is reflected by an extensive finding of Non-compliance under each of the Quality Standards.

In relation to information management, the site audit report identified that while staff had access to the service’s electronic care management system, assessment and care planning information (and associated documentation) did not consistently reflect accurate information to guide and inform the delivery of personal and clinical care or to support the monitoring of care delivery. Staff reported not having sufficient time to provide or receive communicated information in relation to changes in consumers’ condition to guide care and service delivery.

In relation to continuous improvement, the organisation’s systems and processes failed to identify the extensive non-compliance that has been found across all eight Quality Standards. The service’s plan for continuous improvement identified that it did not include quality improvement activities arising from consumer feedback and that it had not been updated regularly. The site audit report advised that management had updated the plan for continuous improvement, during the site audit and committed to reviewing the continuous improvement process, monitoring the implementation of the actions on a weekly basis for the next eight weeks, and then monthly thereafter.

In relation to workforce governance, the service did not demonstrate sufficient staff with the required skills and knowledge were allocated to meet consumers’ needs and preferences. Consumers and representatives were dissatisfied with staffing levels, and staff raised concerns about their ability to perform their roles. This is consistent with findings in Standard 7, as all Requirements under Standard 7 are Non-compliant.

With respect to regulatory compliance, the site audit report found that compulsory reporting requirements are not always met as a review of care planning documentation identified non-reporting of incidents under the serious incident reporting scheme regulatory requirements.

With respect to restrictive practices legislation, information brought forward by the site audit report demonstrated that the service did not consistently obtain informed consent from consumers or substitute decision-makers prior to the commencement of restrictive practices.

In relation to feedback and complaints, consumers expressed concerns about fear of reprisal and the service was unable to demonstrate effective governance systems in place to ensure complaints are dealt with in a timely and appropriate manner and an open disclosure process applied when things go wrong. The service did not demonstrate that feedback and complaints are used to improve care and services. This is consistent with the findings in Standard 6 as the majority of Requirements in Standard 6 have been found Non-compliant.

With respect to financial governance, management advised they had not requested changes to the budget or expenditure within the past three months.

The organisation was unable to demonstrate it had effective risk management systems and processes, including the management of high-impact and high-prevalence risks associated with the care of consumers. The site audit report demonstrated the service did not have effective risk management systems and practices. Consumer assessment and care planning documentation did not include consideration of risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

Clinical risks to consumers have not been identified and addressed including in relation to medication and oxygen therapy and evidence of this was included in the site audit report. Whilst management advised clinical quality indicators are reviewed and analysed during monthly Clinical Governance committee meetings to identify risk and risk mitigation strategies, committee minutes did not document identified risks or risk mitigation strategies arising from the review of key clinical quality indicators.

The service’s risk management framework stated internal and external audits are to be conducted and provided to the Board for assurance that risk management and systems are operating effectively and adequately. However, management advised that internal and external audits have not been conducted for some time. Management updated the plan for continuous improvement during the Site Audit, to include an action to reinstate the internal and external audit process.

The service did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer. In some instances, incidents had not been captured in incident reporting mechanisms and the service did not demonstrate that representatives are informed when incidents occur.

The organisation did not have effective clinical governance systems and processes in place to support the delivery of safe and quality clinical care and results in satisfactory clinical outcomes for each consumer. This is further evidenced by Non-compliance is all Requirements in Standard 2 and 3.

Management advised that a clinical governance framework was recently reviewed and implemented at the service.

The organisation had policies and procedures in relation to open disclosure and antimicrobial stewardship. However, the service did not demonstrate that open disclosure practices have been followed when things go wrong. Management were not able to provide examples of how care and service delivery had been influenced by these policies.

The organisation had a policy in relation to minimising the use of restrictive practices and staff did not consistently demonstrate an awareness of consumer needs relevant to restrictive practises and behavioural support. The Site Audit report demonstrated that the service was not complying with the legislative requirement to conduct an assessment and gain consent prior to the commencement of restrictive practices.

The Approved provider, in its response, acknowledged the service has areas for improvement and advised actions taken to return to compliance under this Standard including weekly consumer meetings have been commenced and will continue until or unless consumers request less frequent meetings. The Meeting agenda included ‘food, furniture, and fun’ and outcomes of meetings and future events will be circulated via monthly newsletters.

The Approved provider’s response to the site audit includes information that indicates consumer lifestyle and care planning documentation has been reviewed, updated in partnership with consumers and is now available to staff, within the electronic care management system. Consumers who choose to, are provided a copy of their care documents.

The Approved provider states the lifestyle program is reviewed weekly and displayed in each area of the service.

Staff have been scheduled to attend performance appraisal meetings by December 2022 and identified gaps in staff training/training records have been rectified and all staff has completed required training modules.

The plan for continuous improvement, updated during the site audit, continues to be monitored and updated to reflect actions taken or planned.

The Approved provider states a review of roster and workforce has occurred, resulting in increased remuneration and/or conditions and additional rostered hours to ensure shift overlapping and adequate handover between shifts.

In relation to workforce governance, the Approved providers’ response advises that the service had a nominated Infection prevention control lead and is providing ongoing education for staff regarding the serious incident response scheme. The Approved provider’s response identified Human resource action has commenced for staff identified as not following organisational policy and expectations and the service is undertaking investigation and reporting of previously non-reported incidents that are reportable under the serious incident response scheme.

In relation to requirement 8(3)(d), the Approved provider accepts the site audit report findings and has implemented additional staff education and onsite oversight to improve the application of the incident management system. The clinical governance committee meets monthly to review and track quality indicators, complaints and incidents and Quality indicator auditing is underway for November 2022.

The Approved provider states that the organisation/service has an effective clinical and care governance framework and a clinical and care governance board committee; that they had identified, prior to the site audit, that deficiencies were being investigated, are now part of a Human resource matter and does acknowledge the service was not able to evidence open disclosure processes had occurred.

In coming to my decision of compliance with this Standard, I have considered the information in the site audit report under this and other standards alongside the Approved provider’s response.

As identified above, the service has taken immediate action to commence rectification actions to address the deficits identified in the site audit report. I acknowledge the commitment of the provider; however, as deficiencies have been identified under all eight of the Quality Standards and these improvement activities are either in their infancy or have not been completed and therefore have not been tested for their effectiveness or sustainability. Therefore, it is my decision that each Requirement and therefore Standard 8 is non-compliant.

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