Performance

Report

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| Name of service: | Gawler Grande Views |
| Service address: | 3 Duffield Street GAWLER EAST SA 5118 |
| Commission ID: | 6894 |
| Approved provider: | Martindale ACF Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 12 April 2023 to 17 April 2023 |
| Performance report date: | 16 June 2023 |

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 Gawler Grande Views (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others; and
* the provider’s response to the Assessment Team’s report received 18 May 2023. The response includes commentary relating to the deficits identified by the Assessment Team and actions taken in response, as well as supporting documentation. The response also includes an Action plan outlining identified issues, actions required, persons responsible and progress/outcomes to address the deficits identified.

# 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.

**Standard 1 requirements (3)(b), (3)(d) and (3)(e)**

* Ensure consumers are:
* provided care in a culturally safe manner with their cultural preferences understood and diversity respected;
* supported to take risks and the consequences of these risks are discussed and agreed management strategies implemented in consultation with consumers and/or representatives; and
* provided information in a format which is easy to understand and communicated in a way which enables them to exercise choice.
* Ensure staff have the skills and knowledge to provide care and services to consumers in a way which ensures their cultural identity is recognised and valued.
* Monitor staff interactions with consumers to ensure care and services are delivered in a culturally safe manner at all times.
* Review processes, policies and procedures relating to supporting consumers to exercise choice and independence and take risks to enable them to live the best life they can.

**Standard 2 requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e)**

* Ensure consumer care plans are individualised, congruent with assessment information and reflective of consumers’ current and assessed needs and preferences.
* Ensure risks to consumers’ health and well-being are identified and appropriate management strategies developed and implemented to enable staff to provide quality care and services.
* Ensure consumers’ goals, needs and preferences relating to spiritual, cultural, emotional and social needs are identified and appropriate management strategies developed.
* Ensure consumers’ goals, needs and preferences for end of life care are identified, documented and regularly reviewed in consultation with consumers and/or representatives.
* Ensure assessment and planning processes are based on ongoing partnership with consumers, others the consumer wishes involved.
* Ensure outcomes of assessment and planning are effectively communicated with consumers and representatives and care plans are discussed with and made available to consumers and/or representatives.
* Ensure consumer care plans are reviewed for effectiveness and/or updated in line with the service’s processes, as well as in response to incidents and change in consumers’ circumstances. Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* 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)(a), (3)(b), (3)(c), (3)(d) and (3)(f)**

* Ensure staff have the skills and knowledge to:
* provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation wounds, fluid restrictions, diabetes, medications and chemical restraint;
* identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including medications, falls and weight loss;
* use restrictive practices in line with legislative requirements, including ensuring appropriate consents and authorisations are obtained;
* identify consumers at end of life and deliver care in line with their needs, goals and preferences to ensure comfort is maximised and dignity preserved;
* recognise changes to consumers’ health and well-being, including clinical deterioration, and implement appropriate monitoring and management strategies; and
* initiate timely and appropriate referrals to Medical officers and/or appropriate Allied health professionals in response to changes in consumers’ condition.
* Ensure sufficient stocks and supplies of wound dressings and nutritional supplements are maintained.
* Ensure policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, end of life care, management of deterioration and referral processes are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to best practice care, management of high impact or high prevalence clinical risks, end of life care, management of deterioration and referral processes.

**Standard 4 requirements (3)(a), (3)(b) and (3)(c)**

Ensure staff have the skills and knowledge to:

* implement safe and effective services and supports for daily living which meets consumers’ goals, needs and preferences and optimises their independence, health and quality of life;
* identify, assess, review and monitor each consumer’s emotional and psychological care needs and preferences and implement appropriate support measures, where required; and
* identify things of interest to each consumer, implement activity programs in line with consumers’ preferences and activity plans, engage them in activities of interest, monitor consumers’ level of engagement and review effectiveness of each consumer’s participation in the program.
* Review the activity schedule in consultation with consumers and representatives to ensure it is reflective and appropriate. Monitor consumers’ satisfaction of the program on an ongoing basis and initiate changes in response to feedback.
* Review laundry processes to ensure consumers’ clothing is washed and returned to them in a prompt manner and ensure sufficient supply of well-maintained linen is available.
* Ensure policies, procedures and guidelines in relation to supporting consumers’ emotional and psychological well-being and leisure and lifestyle are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to supporting consumers’ emotional and psychological well-being and leisure and lifestyle.

**Standard 5 requirements (3)(b) and (3)(c)**

* Ensure all consumers are able and supported to move freely to outdoor areas.
* Review cleaning processes, including staffing and supplies.
* Ensure monitoring processes are regularly undertaken to ensure the service environment and equipment is clean and well maintained.
* Continue to review the effectiveness of the new phone system.
* Review processes relating to entry key fobs to ensure staff have ready access to required areas.
* Ensure processes to monitor the safety, maintenance and suitability of equipment are regularly undertaken.

**Standard 6 requirements (3)(c) and (3)(d)**

* Ensure feedback and complaints are captured, including feedback and complaints received through meeting forums, and appropriate, prompt action is taken in response, including liaising with the complainant
* Ensure open disclosure processes are applied, where required, in response to feedback and complaints, as well as incidents.
* Ensure feedback and complaints are documented, including actions taken and follow-up with the complainant to ensure satisfaction is achieved.
* Review processes to ensure all feedback and complaints are captured to enable emerging trends and improvement opportunities to be identified.

**Standard 7 requirements (3)(a), (3)(c), (3)(d) and (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.
* Review workforce monitoring processes to ensure accurate data is considered and used to inform workforce planning.
* Ensure staff competency, skills and knowledge are assessed, monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training to address the deficiencies identified in all eight of the Quality Standards.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken and accurate records maintained. Where poor staff performance is identified, ensure performance management processes are implemented promptly, and past performance is considered.

**Standard 8 requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e)**

* Review processes relating to how consumers are supported and engaged in the development, delivery and evaluation of care and services and that feedback gathered through various avenues is considered in the development, delivery and evaluation of care and services.
* To ensure the governing body is aware of and accountable for the delivery of care and services, review communication and reporting processes from the service to the governing body and vice versa.
* 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, responding to abuse and neglect, supporting consumers to live the best life they can and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to minimising use of restrictive practices and open disclosure and in relation to the non-compliance identified in Standards 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care.

# 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. | 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. | 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

The Quality Standard is assessed as non-compliant as three of the six specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(b), (3)(d) and (3)(e) in Standard 1 Consumer dignity and choice not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied care and services are culturally safe for all consumers. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer A identifies with a certain religion with specific beliefs and while they are of a particular race, they do not culturally identify with this. An assessment has not been completed to identify the consumer’s cultural and spiritual needs and preferences and none of the staff sampled were aware of Consumer A’s spiritual beliefs and preferences. Consumer A said staff have not enquired about their beliefs or preferences and was not sure if they knew their needs.
* Consumer B has a severe cognitive impairment. An assessment updated in July 2022 indicates the consumer identifies with a certain religion with specific beliefs, particularly relating to certain foods. Consumer B’s religious dietary needs and preferences had not been identified or documented on the Dietary details form used by kitchen staff. Excluding the Lifestyle coordinator, no other staff, including kitchen staff, knew of Consumer B’s spiritual beliefs and how this would influence care and services. Clinical management acknowledged the consumer has been consuming these foods.
* Clinical management were not aware of the cultural and spiritual identity and preferences of Consumers A and B and acknowledged assessments had been omitted, were ineffective and had been poorly communicated.
* All staff sampled were not familiar with the term ‘cultural safety’. While knowledgeable of consumers, all struggled to identify consumers’ cultural identity, needs and preferences and provide examples of how care and services are influenced by and delivered in a culturally safe manner. Staff have not received any training in cultural awareness, diversity of cultural safety.

The provider’s response included, but was not limited to, completed a Cultural and spiritual assessment for Consumer A and updated the relevant care plan; reassessed Consumer B’s dietary needs and preferences which has been provided to catering staff; and mandatory training commencing May to mid-October 2023 includes cultural competence and culturally safe care.

I acknowledge the provider’s response. However, I find the service did not ensure provision of culturally safe care and services to consumers. In coming to my finding, I have considered the service has not sufficiently recognised or supported the cultural identity of Consumers A and B. Consumer A stated staff had not enquired about their beliefs and preferences and assessment processes have not been undertaken to identify Consumer A’s cultural and religious needs and preferences. While Consumer A has specific beliefs aligned with their religion, staff were not familiar with these beliefs. Assessment processes had identified Consumer B’s religion and beliefs, including specific dietary requirements, however, this information had not been communicated to catering staff. Staff, including kitchen staff, were not aware of Consumer B’s religious beliefs which has resulted in the consumer being served and consuming foods not in line with their religious beliefs. I have also considered staff demonstrated a limited understanding of what culturally safe care is. Staff struggled to identify consumers’ cultural identity, needs and preferences and were unable to provide examples of culturally safe care delivery. As such, I find that the service has not ensured each consumer’s unique cultural identity has been recognised, respected and supported or care and services have been delivered in a culturally safe way.

For the reasons detailed above, I find requirement (3)(b) in Standard 1 Consumer dignity and choice non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied consumers are supported to take risks to enable them to live the best life they can. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer C said they enjoy partaking in a risky activity and goes outside ‘whenever I feel like it’ to partake in the activity, keeps related equipment in their possession and has been assessed to partake in the activity safely. However, the consumer was not aware of any risk mitigation strategies.
* A risk assessment dated October 2022 acknowledged issues in the past relating to the activity and indicated ‘no’ to safety equipment, ‘N/A’ to where equipment was stored and noted strategies as ‘discussed with (Consumer C) who wishes to continue (the activity) at this time’. Risks or mitigation strategies were not included and all care and clinical staff sampled were not aware of risk mitigation strategies relating to the activity.
* Consumer C uses a piece of equipment for daily unaccompanied outings and said they do not tell staff when they are going or returning, does not take a phone and was not aware of any assessments or risk mitigation strategies, however, was conscious of being a falls risk.
* A risk assessment identified Consumer C as a high falls risk and included strategies relating to keeping a safe pace when on the equipment. However, further risk assessment for use of the equipment or unaccompanied outings was not included and care and clinical staff were not aware of any risk mitigation strategies.
* One of two members of Clinical management were aware the consumer leaves the service using the equipment, however, said the consumer should sign in and out on the register at reception. Records showed the consumer had not signed the register on any occasion.
* Consumer A said they use a piece of equipment to go on unaccompanied outings and has alcohol stored in their room. The consumer said they consume alcohol when they want and signs in and out at reception when leaving/returning.
* There is no risk assessment for use of the equipment outdoors, outings in the community or for alcohol. Staff said they know when Consumer A is leaving/returning but were not aware of other risk mitigation strategies, and two staff were aware Consumer A consumes alcohol, however, said there is no information in the care plan to guide care.
* Clinical management said Consumer A does not need a Dignity of risk form for unaccompanied outings using the equipment as they have no cognitive impairment and is not deemed at risk and indicated the consumer was no longer consuming alcohol within the service.
* One staff member identified Consumer D had been caught partaking in a risky activity in their room on occasion. Clinical management denied this, however, provided a Dignity of risk form dated April 2023 for related to the activity. The form did not include risks or mitigation strategies, however, the consumer’s choice to partake in the activity was reflected in the care plan.

The provider’s response included, but was not limited to, completed a full reassessment of the consumer’s safety and any risk mitigation strategies in consultation with Consumer C; completed a full care plan review and Dignity of risk form for Consumer A and updated the summary care plan; and completed a Dignity of risk from for Consumer D.

I acknowledge the provider’s response. However, I find each consumer was not effectively supported to take risks safely. Risks associated with activities Consumer C chooses to partake in have not been effectively identified. While Consumer C described how they undertake one of the activities, the risk assessment was not congruent with the consumer’s feedback and staff could not describe any related strategies to mitigate associated risks. I acknowledge there does not appear to have been any incidents associated with this activity. However, the risk assessment completed in October 2022 indicates there have been issues in the past. As such, I find the insufficient assessment and implementation of strategies to mitigate associated risks potentially places the consumer at risk. Staff were aware Consumer C leaves the service unaccompanied using a piece of equipment, however, while they indicated the consumer should sign in/out, records demonstrated the consumer has not signed the register on any occasion. Additionally, staff were not aware of any risk mitigation strategies relating to use of the equipment and leaving the service unaccompanied.

While staff were aware of when Consumer A leaves and returns from unaccompanied outings, they were unaware of any related risk mitigation strategies. Apart from an assessment relating to the use of the equipment indoors, assessment processes did not consider other risk activities the consumer partakes in. And while four staff indicated Consumer D partakes in an activity which includes an element of risk, risk mitigation strategies had not been implemented.

I have further considered assessment and planning processes related to risks in my finding for requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

For the reasons detailed above, I find requirement (3)(d) in Standard 1 Consumer dignity and choice non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied information provided to each consumer is current, accurate and timely and enables them to exercise choice. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The food menu was not displayed in any location across the service. A kitchen staff member stated lifestyle staff would fill out the daily menu on the menu boards, but this had not been occurring.
* Consumers with cognitive capacity are shown the food menu once each week and are supported by care staff to complete options. A copy is not provided to the consumer.
* Staff said the menu occasionally changes due to supply issues and in these instances, an alternative food item is provided. Consumers are not involved in this process, however, are informed when the meal is served.
* A representative for a consumer who has a cognitive impairment and does not like fish, said ‘we’re never talked about meals, whatever is dished up is what (the consumer) gets’ and said they had never been engaged in a discussion about food. Two care staff were not aware of the consumer’s dietary preferences, however, said they consult the care plan when choosing meals for consumers.
* Three staff said they have observed carers completing menus for everyone due to time constraints, with one staff member saying, ‘half the time the residents don’t get to choose as the carer just circles for them, sometimes they don’t even get the menu’. A second staff member said, ‘I also think they’re (care staff) ordering stuff the resident don’t want, they’re making decisions for them’.
* A representative for a recently deceased consumer advised they had not been provided information on palliative care when requested to help inform their understanding and enable decision-making.
* A brochure included in the consumer welcome pack indicated consumers can pay for different tier packages for additional services. The fees were found to be automatically included in consumer contracts. Consumer and representative feedback indicated they had not been provided clear information about a daily fee charge for extra services. While members of management indicated consumers were being charged a daily fee for services, management, staff and the Directors confirmed these services are not provided.

The provider’s response included, but was not limited to:

* Purchased stands for each dining table to display menus. Lifestyle staff are completing menus in consultation with consumers and/or representatives.
* In relation to palliative care, sourced brochures to add to the admission pack training to staff on palliative care to be provided.
* Refunded fees paid for additional services to all consumers who have paid the fee. Review of additional services and costs to be undertaken and clear and relevant information will be discussed with all consumers to ensure informed decisions relating to additional services and costs.

I acknowledge the provider’s response. However, I find information provided to consumers is not consistently communicated in a way that is clear, easy to understand and enables them to make informed choices. In coming to my finding I have considered menus are not displayed or provided to consumers for reference. Changes to the menu are not effectively communicated to consumers, with consumers only being notified when meals are served. Additionally, consumers are not consistently supported to make informed choices relating to menu selection with decisions relating to meal choices being made by staff without consumer input. I have also considered consumers have not been provided sufficient information relating to a daily fee which has been found to be automatically included in consumer contracts. Feedback from a consumer and representative indicated they had not received sufficient information relating to this charge. Services associated with the daily fee are not being provided. As such, I find the evidence presented does not demonstrate the service has ensured consumers are supported or enabled to make informed choices or ensured consumers get the most out of their care and services.

For the reasons detailed above, I find requirement (3)(e) in Standard 1 Consumer dignity and choice non-compliant.

**In relation to requirements (3)(b), (3)(d) and (3)(e)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I have also considered that identified issues and actions included on the plan related to requirements (3)(b) and (3)(d) only consider the consumers highlighted in the Assessment Team’s report and do not include actions to address deficits in the service’s overall systems and processes relating to these requirements. As such, time will be required to establish efficacy, staff competency and improved consumer outcomes in relation to the requirements found non-compliant.

**In relation to requirements (3)(a), (3)(c) and (3)(f)**, all consumers sampled said they are treated with dignity and respect. A life story and social and emotional assessments are undertaken to understand each consumer and identify and address matters of importance, and staff sampled demonstrated familiarity with consumers’ preferences, needs and backgrounds. However, staff indicated insufficient staff numbers restricts their ability to provide the personal, clinical, emotional and social care and services consumers need to preserve their dignity and respect their culture. Staff were observed treating most consumers with dignity and respect, speaking to them with kindness and patience and supporting them to attend activities of their choosing.

Most consumers and representatives confirmed consumers are supported to remain independent, and communicate and exercise choice in relation to their own care, decide who is involved and make and maintain connections with others. Staff were knowledgeable of who consumers wanted involved in their care and were observed promoting choice and decision making in their everyday tasks.

There are processes to ensure consumers’ privacy is respected and personal information kept confidential. All consumers and representatives said staff respect consumers’ privacy and staff could describe elements from the service’s privacy policy and confirmed information is always kept confidential. However, I have considered the Assessment Team’s observations highlighted in Standard 5 Organisation’s service environment requirement (3)(c) where nurses station doors were observed to be open on all levels of the service indicating privacy and confidentiality of consumer information could potentially be compromised. The provider’s response to this specific requirement did not address this deficit. I would encourage the provider to review processes relating to security of consumer information to ensure privacy and confidentiality is maintained at all times.

For the reasons detailed above, I find requirements (3)(a), (3)(c) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

# 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

The Quality Standard is assessed as non-compliant as five of the five specific requirements have been assessed as non-compliant. The Assessment Team recommended all five requirements in Standard 2 Ongoing assessment and planning with consumers not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Inconsistencies in information relating to Consumer E’s mobility and associated risks were noted in the Functional, High prevalence high risk and Continence assessments completed in February and April 2023. Inconsistencies were also noted in information relating to assistance required with dietary needs in Functional and Nutrition assessments, a Dietary details form and a Speech pathology review completed in February to May 2023.
* Inconsistencies in information relating to Consumer F’s mobility and care required post a fracture in December 2022 were noted in Skin and High impact high prevalence assessments and a Physiotherapist review completed December to April 2023.
* There were inconsistencies in identified behaviours and strategies used by staff in Consumer F’s Behaviour support plan and assessment dated March 2023. Triggers and strategies identified in the plan were generic and did not include strategies recommended by specialist services or the current behaviours or strategies identified by care staff. Behaviour management strategies are not being monitored for effectiveness or used to inform care delivery.

In coming to my finding for this requirement, I have also considered the following evidence, as well as the provider’s response, highlighted in requirement (3)(d) in Standard 1 Consumer dignity and choice:

* A risk assessment for Consumer C acknowledged issues in the past relating a risky activity and indicated ‘no’ to safety equipment, ‘N/A’ to where equipment was stored and noted strategies as ‘discussed with (Consumer C) who wishes to continue (the activity) at this time’. Risks or mitigation strategies were not included on the assessment and all care and clinical staff sampled were not aware of risk mitigation strategies relating to the activity.
* A risk assessment updated March 2023 identified the consumer as a high falls risk and included strategies relating to keeping a safe pace when using a piece of equipment. However, further risk assessment for use of the equipment or unaccompanied outings was not included and care and clinical staff were not aware of any risk mitigation strategies.
* A Dignity of risk form for Consumer A did not include a risk assessment for use of a piece of equipment outdoors, outings in the community or for alcohol. Staff said they know when Consumer A is leaving/returning but were not aware of other risk mitigation strategies.
* A Dignity of risk form for Consumer D related to a risky activity did not include risks or risk mitigation strategies.

The provider’s response included, but was not limited to, completed a full care plan review for Consumers F and G, reviewed and updated assessments relating to Consumer F’s dietary needs to ensure congruency and commenced behaviour charting for Consumer G prior to initiating a referral to specialist services; and plan to review the admission checklist and provide staff training and support. The provider asserts Consumer F’s risk and Functional assessments are congruent.

I acknowledge the provider’s response. However, I find assessment and planning processes have not been consistently undertaken to enable risks to consumers’ health and well-being to be identified and appropriate management strategies implemented. Information was not consistent between assessments for specific areas of care, such as mobility and dietary requirements for Consumers E and G. Triggers and behaviour management strategies for Consumer G were generic and not reflective of those described by staff and strategies recommended by specialist services had not been included. I find the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers or their care and service needs.

I have also considered relevant risks to consumers’ safety, health and well-being have not been assessed, discussed with consumers and included in the planning of consumers’ care. Not all activities Consumers C, A and D choose to partake in which include an element of risk had been identified or strategies to mitigate risks developed in consultation with consumers. Staff sampled were not aware of strategies to minimise risks to ensure Consumers C, A and D’s safety while partaking in the activities. For one activity, information captured through the risk assessment process relating to one activity was not congruent with feedback provided by Consumer C. As such, I find the evidence presented demonstrates care plans are not tailored to consumers’ specific needs nor do they inform how, for each consumer, care and services are to be safely delivered.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied assessment and planning, including end of life planning, identifies and addresses consumers’ current needs, goals and preferences. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer G commenced on palliative care in March 2023. The representative was aware of the commencement of a Palliative care pathway but not of any care directives and had not discussed the consumer’s end of life or palliative needs and preferences with the service. There was no Advance care health directives assessment or care plan completed or evidence of interventions in place to maintain and support emotional well-being. Staff were unaware of Consumer G’s end of life needs, goals or preferences.
* Consumer H commenced palliative care in April 2023. An Advance care health directives assessment or care plan had not been completed. Progress notes did not evidence Consumer H or the representative had been consulted before commencement of the Palliative care pathway and there was no evidence of discussion regarding the consumer’s end of life needs, goals and preferences. Staff were able to describe the care currently being provided to Consumer H, however, were unaware of the consumer’s individual needs, goals and preferences.
* Two clinical staff described generalised care provided to consumers when they commence on palliative care, however, were unable to identify individual care needs for Consumers G and H.
* Clinical management were aware of gaps in practice relating to end of life assessment and planning and that staff were not following the assessment and care planning policy and procedure. They advised they have recently undergone an audit through End of Life Directions for Aged Care (ELDAC). The ELDAC report (which was not dated) indicated there was no process or procedure in relation to advance care planning; advance care planning is ad hoc and is often determined by the nurse; and there were no specific assessment tools regarding end-of-life care.
* There are no documented actions to be taken in response to the audit and or an entry corresponding to end of life care on the service’s Plan for continuous improvement (PCI).
* Assessments for spiritual, cultural, emotional and social needs had not been consistently completed in four of five care files sampled. One consumer stated, “I’m just so lonely’, ‘sometimes I feel frightened’, and ‘I just lie on my back all day and do nothing, very rarely someone comes in, I'd love them to come’. A current assessment had not been completed and there were no interventions in place to maintain and support the consumer’s emotional well-being and social needs.

The provider’s response included, but was not limited to:

* Updated Advance health care directives and discussion with Consumer E and their representative relating to end of life has occurred. Indicate previous discussions occurred in March 2023 and February 2023, including family conferences with the Medical officer.
* Strategies to address lack of documentation related to advance care health directives are being progressed, including review of the admission checklist; and related procedures and checklists have been reviewed to ensure advance care health directives are identified and documented.
* While the service has a robust suite of policies and procedures, pervious management had not rolled them out even though they had been asked to do so on more than one occasion. This is now progressing and included in mandatory training sessions.
* The ELDAC report will be considered and actions taken to implement best practice in palliative care/end of life care.

I acknowledge the provider’s response. However, this requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences. I find this has not occurred for the consumers highlighted. I have considered that for Consumers G and H, assessments were not initiated to identify current needs, and care plans were not reviewed and/or developed to guide staff in the delivery of the consumers’ care during the palliative stage. While Consumers G and H had commenced on Palliative care pathways, there was no indication the consumers and/or representatives had been consulted to understand what was important to the consumers or if their goals and preferences during the palliative stage could be met. Staff were unaware of the consumer’s individual care needs and preferences relating to palliative care. I have also considered that while an audit of the service’s end of life processes had been undertaken, there was no evidence that actions had been taken in response. The audit identified deficits relating to policies, procedures, assessment and planning.

Furthermore, assessment processes had not been undertaken to identify two consumers’ spiritual, cultural, emotional and social needs. One consumer expressed feeling frightened and lonely, however, interventions to support their emotional well-being had not been implemented.

As such, I find the evidence demonstrates care plans are not individualised and tailored to guide staff to provide care and services which are in line with each consumer’s needs and preferences and planned around what is important to them.

For the reasons detailed above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied assessment and planning is consistently based on an ongoing partnership with the consumer and others they wish to involve. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Only one of seven care files evidenced involvement of consumers or their representatives in assessment and planning, including during care plan reviews. Whilst progress notes documented representatives are informed of incidents, there was no evidence of consultation.
* One consumer and all five representatives sampled said they are not involved in assessment and planning processes. One consumer said they were involved in assessments when they first arrived but have not been aware of any other assessments or care plan reviews. One consumer stated they were not involved in their care planning and had requested their care plan multiple times but had never received it. One representative said that they were not made aware of a deterioration in the consumer’s weight and subsequent Dietitian review.
* Clinical staff said they communicate care needs with the consumers and their representatives if they are involved. One said they communicate more with the representatives when they visit and not always during a care plan review. Most clinical staff said they call the representative after they have completed the assessments and care plan review to check if the representative is happy with the care being provided.
* Care evaluation forms for four consumers demonstrated staff were completing the care consultation section with comments of “representative said they were happy with care being provided”.

The provider’s response included, but was not limited to; provided a refresher to the Clinical management team relating to consultation and documentation that occurs during a care review process; a review of the recording of assessment evaluation and identified needs, care planning and consultation with consumers and/or representatives is planned; and review the process and evidence that care plans have been discussed with the consumer and/or representative and a copy of the care plan offered.

I acknowledge the provider’s response. However, I find assessment and planning processes were not consistently based on ongoing partnership with the consumer and/or representative. In coming to my finding, I have placed weight on feedback provided by six consumers and/or representatives, all who indicated they had not been involved in assessment and planning of consumers’ care, including through care plan review processes or where changes to consumers’ condition had been identified. I have also considered the majority of consumer care files sampled lacked evidence demonstrating inclusion of consumers and representatives in assessment and planning processes. As such, I find this has not ensured consumers are supported and encouraged to make decisions about the care and services they receive and the way they are delivered.

For the reasons detailed above, I find requirement (3)(c) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied the outcomes of assessment and planning are effectively communicated and documented in a care and services plan that is readily available to the consumer. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Two consumers and five representatives said they have never seen a care plan or been offered a copy, with two stating they do not know what a care plan is.
* Representatives confirmed they are notified in the event of an incident occurring, however, are not notified of the outcomes of assessments and care planning. There was no evidence of communication with consumers or their representatives on the outcome of assessment and care planning in sampled care files.
* Care staff said they are able to access care plans and changes in consumers’ care needs are communicated through handover processes. However, four staff were unable to identify that a consumer was on palliative care.

I have also considered feedback from a consumer highlighted in requirement (3)(c) of this Standard indicating they had requested their care plan multiple times but had never received it.

The provider’s response for this requirement was the same as the response provided for requirement (3)(c) in this Standard.

I acknowledge the provider’s response. However, I find outcomes of assessments and planning were not effectively communicated to the consumer and documented in a care plan that was readily available to the consumer. In coming to my finding, I have placed weight on feedback from consumers and representatives indicating they have never seen a care plan, been offered a copy of the care plan and do not know what a care plan is, and are not notified of the outcomes of assessments and planning. As such, I find the evidence presented does not demonstrate consumers and/or representatives have been involved in discussions relating to consumers’ care and service provision nor has it enabled them to have an understanding and ownership of the care plan.

For the reasons detailed above, I find requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied care and services are reviewed regularly for effectiveness, when circumstances change or incidents impact consumers’ needs, goals and preferences. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Three of five consumer files sampled did not have an evaluation of care assessment and planning four to six monthly. The service’s policy and procedure indicates all care domains must be evaluated for effectiveness in meeting the consumer’s individualised care needs, choices and preferences, and all consumers must have an updated risk assessment using validated tools, including falls, skin/pressure ulcer, malnutrition and depression.
* Consumer I’s last care evaluation was in July 2022. Assessments relating to depression and nutrition were last completed in July 2022.
* Consumer E’s last care evaluation was in June 2022. Assessments relating to nutrition were last completed in May 2022 and depression in June 2022.
* Consumer J’s last care evaluation was in December 2022. Assessments relating to nutrition were last completed in December 2021 and depression in May 2020.
* Care and services are not reviewed following a change in circumstances.
* Consumer F had an unwitnessed fall in December 2022 and sustained a fracture. The risk assessment, identifying the consumer as a high falls risk, was not reviewed until four days later when a further falls incident occurred.

A further fall was documented in April 2023. While the risk assessment was reviewed, no additional strategies were implemented. Staff confirmed Consumer F continues to have falls but said no new strategies have been implemented to prevent further falls or injury.

* Consumer H had an unwitnessed fall in April 2023. The incident form does not include an investigation of the incident or any new falls prevention strategies. The risk assessment was not reviewed post fall and staff were not aware of any new falls prevention strategies implemented.

The provider’s response included, but was not limited to, updated the care review schedule to reflect allocation for completion of care reviews due or overdue and contracted additional Clinical leads to assist with completion; reviewed and updated the procedure to reflect care plan reviews to be completed six-monthly and as required; completed comprehensive care evaluations, including reassessment of care domains, for Consumers I, E and J; and reviewed falls risk assessments and management plans for Consumer F.

I acknowledge the provider’s response. However, I find the service did not ensure care and services were regularly reviewed for effectiveness in response to incidents and changes in consumers’ care and service needs. I have considered prompt review of Consumer F’s falls risk was not undertaken following a fall resulting in a fracture in December 2022, or additional strategies implemented to minimise the consumer’s risk of falls following a further fall in April 2023. Similarly, Consumer H’s falls risk assessment was not reviewed post a fall in April 2023 and additional management strategies were not implemented. Additionally, I have considered care plans have not been regularly reviewed in line with the service’s process, with overdue care evaluations and out-of-date risk assessments identified in three of five care files sampled. As such, I find this has not ensured care plans are current, that care and services are being delivered in line with consumers’ current needs and preferences or that risks to consumers are minimised.

For the reasons detailed above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes for the requirement found non-compliant.

# 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. | 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. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as five of the seven specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(f) in Standard 3 Personal care and clinical care not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumer gets safe and effective personal and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of wounds, fluid restriction monitoring, diabetes, medications and the use of chemical restraint. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Wound management

* Consumer G’s Wound management plans were not consistently followed or the size of the wound documented in line with the organisation’s process.
* Consumer K’s Wound management plans showed photos were not consistently taken and did not include a measurement of size or daily checks, and dressing changes were not consistently undertaken in line with the plans. While the dressing regime for both wounds was changed in April 2023, this was not reflected on the Wound management plan.
* Consumer K said sometimes their wounds are not attended to as they run out of dressings. Consumer K said they are often given extra dressings by the nurse to keep in their drawer so wounds can be dressed appropriately, but this does not always occur and there have been times where they have run out.
* Consumer L has a stage 3 pressure injury. The Wound management plan for a 15 day period between February and April 2023 did not clearly indicate when the dressing was checked or changed and photographs were not consistently taken.
* Consumers said staff do not always have the appropriate wound dressings and wounds are not always redressed when they are needed. One consumer stated, ‘There’s not enough dressings packs to clean my feet. The bandages are not done, I don’t get daily cream on my legs and dressings are not always done as they’re short of staff.’ Another consumer confirmed staff change their dressing ‘when it is dirty every now and again, not every day’.
* Clinical staff confirmed there are not always wound dressings available, and they ‘have to make do’ at times.

Fluid restriction monitoring

* Consumer M is on a fluid restriction and twice weekly weighs. Fluid intake charts for a 13 day period in April 2023 showed one occasion where fluid intake exceeded the limit with no evidence of monitoring or actions taken. Weight chart for a 44 day period between March and April 2023 only recorded four weights, with an increase in weight noted. There was no evidence of monitoring or evaluation of fluid intake, or referral to the Medical officer.
* Consumer N is on a fluid restriction and weekly weigh. Fluid intake charts for a 13 day period in April 2023 showed the consumer had a maximum intake. Only three weights were recorded over a 44 day period between March and April 2023. There was no evidence of monitoring or evaluation of fluid intake.
* Clinical staff said they do not monitor fluid balances and one did not think anyone was on fluid restriction. Management were unaware of any process or procedure in place for monitoring fluid restrictions.

Diabetes management

* Consumer O was not administered regular insulin as prescribed at 8.00pm on one occasion in April 2023. The consumer’s blood glucose level (BGL) was noted to be above the acceptable range at 8.45pm. An incident report was not completed and the representative said they had not been made aware of any incidents. There was no evidence that as required inulin was administered or further monitoring occurred in response to the high BGL, in line with the Diabetic management plan. The BGL was not checked again until the next morning.
* BGL monitoring charting for a 13 day period in April 2023 included eight occasions where the BGL was above acceptable range. While as required insulin had been administered as prescribed, the BGL had not been rechecked within the timeframe outlined in the Diabetic management plan.
* Consumer K’s BGL was above acceptable range on 14 occasions over a 14 day period in April 2023. There is no evidence of consultation with the Medical officer. As required insulin was not administered on two occasions, in line with the Diabetic management plan. When as required insulin had been administered, the BGL was not been rechecked within the timeframe outlined in the Diabetic management plan.

Medication management

* Medication charts for Consumers O and P included phone orders taken by clinical staff which had not been endorsed by the Medical officer within the timeframe outlined in the service’s policy. The medications have continued to be administered without Medical officer approval for up to 12 days for Consumer O and 70 days for Consumer P.
* Clinical staff said medication charts are not followed up when required and medication charts have expired without commencement of a new chart for a few days.
* Clinical management stated a phone order should only be documented for two days on the electronic system. There is no current process to monitor this and ensure that phone orders are endorsed by the Medical officer in this timeframe.

Chemical restraint

* Six consumers, with a diagnosis of dementia, are prescribed psychotropic medication to manage behaviours. None had informed consent for the use of restraint. Of the consumers administered psychotropic medications, there was no evidence of consultation relating to the medication with the consumer or representative. A representative stated they knew the consumer had been commenced a new medication to manage behaviours, however, were not sure what it was or the risks involved.

The provider’s response included, but was not limited to:

* Reviewed all wounds and developing a Wound master log to monitor wounds across all areas. Clinical management have been assigned clear roles and responsibilities and will oversee wound management. Completed Wound assessments and updated management plans for Consumers G, K and L.
* A Clinical nurse was responsible for checking and ordering medical supplies and the Executive strongly believe there are and were adequate supplies of various dressings to ensure appropriate wound management. Executive managers have no hesitation in approving and ordering supplies and will ensure other products are ordered and supplied based on assessed need.
* Reviewing processes for monitoring consumers on fluid restrictions and planning to review best practice in relation to management and monitoring of fluid restrictions.
* There are clearly documented procedures for diabetes management, which along with best practice guidelines, have been used for the development of mandatory training. Monitoring is to be undertaken to ensure Consumers O and K’s Diabetic management plans are followed.
* Undertaking a review of the functionality of the electronic medication management system and monitoring and reporting processes, and reviewing the current policy and procedure for phone orders.
* Each Clinical lead has responsibility for specific areas and consumers and are working to review all chemical restraint and develop a robust psychotropic register. A review of consumers on psychotropics is in progress.

I acknowledge the provider’s response, however, I find each consumer has not been provided safe and effective clinical care that is best practice, tailored to their needs and optimised their health and well-being, specifically in relation to wounds, fluid restrictions, diabetes, medications and restrictive practices.

In relation to Consumers G, K and L, I have considered staff practices have not ensured wounds are effectively monitored or assessed to enable wound progression to be tracked or wound deterioration to be effectively identified and actioned. Wounds have not been attended in line with directives outlined in Wound management plans and photographs and measurements of wounds have not been consistently documented. For Consumer K, changes in the dressing regime have not been reflected in Wound management plans to ensure consistency of care and support wound healing. Feedback from consumers indicated wound treatments are not consistently undertaken. I have also placed weight on feedback provided by consumers and staff indicating there are often insufficient stocks and supplied of wound dressings which has the potential to impact wound healing.

While Consumers M and N are on fluid restrictions, fluid intake has not been monitored and regular weights have not been conducted as required. While fluid intake charts are maintained, the data collected is not monitored to ensure fluid intake does not exceed the daily limit, as confirmed by clinical staff. This has resulted in no actions being taken in response to Consumer M exceeding the daily limit on one occasion and recording an increase in weight. Management were also unable to describe any processes or procedures relating to how consumers on fluid restrictions are monitored.

In relation to Consumers O and K, I have considered Diabetes management plans have not been consistently followed, or appropriate action taken in response to BGLs outside of acceptable range, including ongoing monitoring of BGLs following administration of as required insulin or notifying the Medical officer.

Medications have not been administered or prescribed in line with best practice processes. Phone orders have not been endorsed by the Medical officer in line with the service’s policy, with medications continuing to be administered up to 70 days without a current order. This practice had not been identified through the service’s own monitoring processes.

I have also considered restrictive practices, specifically use of psychotropic medications, have not been used in line with legislative requirements. Six consumers prescribed psychotropic medications to manage behaviours do not have the required consents and authorisations have not been completed.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied high impact or high prevalence risks associated with the care of each consumer, specifically in relation to medications, falls and weight were effectively managed. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Medication management

* Consumers J, L and E are prescribed time sensitive medications to manage symptoms related to a diagnosed condition. Medication charts for a one month period between March and April 2023 showed medications have been administered at least half an hour late on 40 occasions for Consumer J and 22 for Consumer E. Medication charting for a two week sampled period for Consumer L showed medications were administered late on 27 occasions.
* Two different medications due at 6:00pm and 8:00pm were administered together to Consumer J on two days. On one occasion, Consumer J did not receive the medication at 8:00am and an unwitnessed fall was recorded at 40 minutes later. Additional monitoring was not implemented following these incidents, no incident reports were completed and management were unaware of these incidents occurring.
* The representative said Consumer J’s medications are not given on time and has raised this with staff. The representative said staff lack an understanding of the diagnosed condition and was told education would be provided, however, this has not yet occurred.
* Consumer L did not receive their medication at 8:00am on one day as prescribed and had an unwitnessed fall at 9:00am.
* Despite at least 89 occasions being identified where time-sensitive medication was administered late in a one month period, the service’s medication incident report from January to April 2023 only included 13 medication incidents.
* All clinical staff sampled said medication incidents are due to insufficient staffing, high use of agency staff and lots of consumers with similar names. One clinical staff said they are unable to administer time-sensitive medications on time as they are rostered to commence work at 8:00am when the medications are due to be administered.
* Clinical management said medication incidents will only be logged if staff tell them they have made an error. They said the electronic management system does not alert them when medication is administered late, only when missed, and this is not regularly reviewed or monitored. Furthermore, there is no process for monitoring medication administration on a regular basis.

Falls management and prevention

* Staff identified Consumer L as a high falls risk with multiple recurrent falls. Falls prevention interventions on the Functional and High impact high prevalence assessments are generic and not effective in reducing the consumer’s falls. The consumer has had 20 falls from February to April 2023 with risk of falls and the risk assessment not updated following each fall in line with the service’s falls policy. Neurological observations have not been conducted at the recommended frequency, in line with the service’s policy or best practice. While the consumer has been reviewed by Allied health services and the Medical officer following falls, no new strategies had been identified or trialled.
* Staff were unable to identify individualised or new interventions for managing Consumer L’s falls risk. Staff said insufficient staffing is a big contributor as they are unable to supervise consumers and intervene in time.
* Management were not aware of investigations being completed post fall to identify the potential cause and implementation of strategies to mitigate the risk.

Weight management

* Consumer G lost 4.06kg over a one month period between December 2022 to January 2023. Interventions to monitor and manage weight loss were not implemented until March 2023, at which time the consumer had lost a further 5kg.
* Consumer E had a gradual weight decline from November 2022 to April 2023, with delays in implementing monitoring and risk management strategies. Fortified drinks and a high energy high protein diet were commenced in February 2023, however, referral to a Dietitian, commencement of food and fluid charting and increased frequency in weight monitoring did not occur, in line with the service’s policy. A further 5kg loss occurred between January and February 2023. A Dietitian referral was initiated and occurred in March 2023.
* Clinical staff said they are sometimes not able to fortify foods or give consumers supplements as they do not have stock. They said when they do get stock, they do not get enough, and they quickly run out. They said they do not know how to refer consumers to Allied health and have to notify Clinical managers for this to occur.

The provider’s response included, but was not limited to:

* Plan to review Enrolled nurse staffing levels and consideration is to be given to amend starting times to ensure timely medication administration.
* Provided a medication management competency package to clinical staff. Policies and procedures have a robust medication management manual, with some aspects requiring review and updating. Consumer J’s medication administration times are being reviewed daily and the General practitioner has reviewed Consumers E and L’s medications.
* Falls prevention and management is included in mandatory training and there are comprehensive falls prevention and management, including post falls, procedures, along with a cue card to guide and direct staff.
* The service did and does consistently have stock of fortified products. Dietitian reviews have been undertaken and strategies implemented.
* Clinical management have been advised they have a robust procedure to follow in relation to nutrition and hydration and weight monitoring. The Dietitian is providing training on nutrition, hydration and weight management, and consumers with weight loss of concern are included in the High risk resident register.

I acknowledge the provider’s response. However, I find for the consumers highlighted, effective management of high impact or high prevalence risks, specifically in relation to management of medications, falls and weight, was not demonstrated.

In relation to Consumers J, L and E, I have considered time sensitive medications have not been consistently administered on time which has the potential to impact consumers’ health and well-being. Risks to the consumer’s health as a result of the delayed medications had not been considered as this aspect of medication administration is not regularly monitored and staff had not identified these instances as incidents requiring reporting.

I have considered that while Consumer L had 20 falls between February and April 2023, there was no indication falls management strategies had been reviewed or new strategies implemented to minimise risks to the consumer’s safety, in line with the service’s process. Additionally, where neurological observations were conducted, these were not consistently undertaken at the recommended frequency. I find such practices do no ensure changes to consumers’ condition to be effectively monitored and identified and prompt action taken in response.

In relation to Consumers G and E, appropriate measures were not implemented in response to weight loss, including timely referral to Allied health professionals. Timely interventions were not implemented in response to Consumer G’s identified weight loss, and while Consumer E was commenced on a high energy high protein diet and fortified drinks, strategies to monitor the effectiveness were not implemented, in line with the service’s process. Both consumers recorded a further loss of weight when they were next weighed.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the needs, goals and preferences of consumers nearing end of life are recognised and addressed, their comfort maximised, and their dignity preserved. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

* Consumer G commenced palliative care in April 2023. The consumer stated they experience pain ‘most of the time’, it is worse at night and makes them ‘want to scream’. The consumer was observed yelling out for help and in pain throughout the Site Audit. However, staff have been predominately administering Consumer G medication for anxiety, rather than pain relief and pain management has not been reassessed or reviewed.
* Four care staff did not know the consumer was palliating nor could they describe any changes in the consumer’s care needs. An End of life pathway includes care to be provided, however, this had not been consistently followed.
* Consumer H commenced palliative care in April 2023. Staff were unable to describe the care being provided to the consumer and the End of life care pathway has not been consistently followed.
* A representative of a consumer who passed away in January 2023 said overall, palliative care provided by the service was a terrible experience for the family and consumer. They said the consumer was in excruciating pain and staff did not always attend, and there were issues with the Medical officer reviewing and updating pain management. They said at one point, the consumer was placed on an infusion pump which broke and another infusion pump was not available, leaving the consumer without pain relief for some time.

The provider’s response indicates the service has a detailed procedure outlining how to use the infusion pump with diagrams and pictures, however, clinical staff did not refer to this procedure. The response also referred to actions highlighted in requirement (3)(b) in Standard 2 ongoing assessment and planning with consumers relating to palliative and end of life care, as well as the ELDAC project.

I acknowledge the provider’s response. However, I find the needs goals and preferences of consumers nearing the end of life had not been effectively recognised and addressed to ensure their comfort was maximised and dignity preserved. In coming to my finding, I have considered evidence highlighted in Standard 2 requirement (3)(b) demonstrating assessment processes have not been effectively undertaken to ensure the needs, goals and preferences of consumers nearing the end of life have been identified and recognised, compromising staffs’ ability to ensure appropriate care, in line with consumers’ needs and preferences. Four care staff were unaware that Consumer G was palliating, and while Palliative care pathways had been commenced for Consumers G and H, care was not consistently provided in line with the pathway and staff could not describe how the consumers’ care needs had changed. I have also considered timely response has not been initiated to ensure consumers’ comfort and dignity is maintained during the palliative phase. Consumer G was observed yelling out and in pain throughout the Site Audit and the consumer indicated they experience pain ‘most of the time’. However, pharmacological interventions have focussed predominately on the consumer’s anxiety and not management of pain. I have also considered feedback from a representative indicates the service’s response a consumer’s needs, specifically pain management, were not timely to ensure comfort and dignity were maintained.

For the reasons detailed above, I find requirement (3)(c) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied deterioration or a change in a consumer’s physical condition is recognised and responded to in a timely manner. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* A Rapid escalation response plan for Consumer E states staff are required to follow the Rapid escalation response if oxygen saturations are below 94% on room air. Observation charting for a 55 day period between February and March 2023 identified oxygen saturations were below 94% on six occasions. There was no evidence of follow up monitoring two hourly in the observation chart or of monitoring and escalation to the Clinical nurse or Medical officer, in line with the Rapid escalation response plan.
* Consumer Q sustained an unwitnessed fall in January 2023 reporting pain, increasingly getting worse. No Registered nurse was rostered to assess, and progress notes by an Enrolled nurse recorded that the Residential services manager was informed and an ambulance was requested. Observations at the time of the incident indicate the consumer’s blood pressure was extremely high and oxygen saturations were low. Whilst observations were repeated half an hour later with similar readings, no further escalation or more frequent monitoring occurred.

The provider’s response indicated the service has a procedure to guide and direct staff in the change in health status monitoring and reporting and this is included in mandatory training. The provider also stated the Clinical management team have clear roles and responsibilities for clinical governance and oversight of clinical care, including daily progress note review and follow-up. The action plan included, but was not limited to, reminding staff of their roles and responsibilities relating to the Rapid escalation response plan; and monitoring staff practice and documentation and addressing areas where staff practice can be improved.

I acknowledge the provider’s response. However, I find changes or deterioration in Consumers E and Q’s condition were not effectively recognised or responded to promptly. I find staff have not monitored Consumer E’s oxygen saturations, in line with the Rapid escalation response plan. Oxygen saturations below desired range had not been followed up, including escalation to the Clinical nurse and Medical officer. For Consumer Q, additional monitoring or escalation did not occur in response to a change in condition following a fall. A such, I find the evidence presented demonstrates Consumers E and Q’s condition was not effectively monitored or escalated to ensure deterioration and/or change in clinical condition was effectively recognised and promptly responded to.

For the reasons detailed above, I find requirement (3)(d) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(f)**

The Assessment Team were not satisfied timely and appropriate referrals to individuals, other organisations and providers of other care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Consumer K has two chronic wounds, both identified in February 2022. There was no evidence of referral to a Wound specialist. Progress notes did not include any evidence of consultation with the consumer about a Wound specialist review or any indication this had been considered. The consumer did not know about the option for a Wound specialist review.
* Management said they had discussions regarding referral to a Wound specialist with Consumer K but have not undertaken this due to the consumer’s reluctance to pay for it. Management said if a wound is complex and requires specialist input then a referral would only be considered if the consumer is willing to pay.
* Care files showed lengthy delays in referrals to Allied health professionals.
* Consumer E experienced significant weight loss from November 2022. Interventions were not implemented until February 2023, with referral to a Dietitian not occurring until March 2023.
* Consumer E first recorded swallowing difficulties in February 2023. The consumer’s diet was downgraded six days later. More difficulty with swallowing and pocketing food was noted six days later with a further diet downgrade implemented. Referral to a Speech pathologist did not occur until 41 days after the initial swallowing difficulties were noted with the Speech pathology review occurring 12 days after the review was initiated.
* Consumers, representatives and staff stated there are lengthy delays to see the Medical officer.
* One consumer displayed symptoms of a urinary tract infection in March 2023 which was confirmed by pathology testing. The Medical officer did not review pathology results until 13 days later at which time, the consumer commenced antibiotics.
* One consumer said they have a growth which has been bleeding for three weeks but has been unable to see a doctor. The consumer said, ‘it takes forever’.
* Clinical staff confirmed it can take some time to get the Medical officer to review a consumer at the service. They confirmed they now have access to a virtual telehealth service, however, this can take hours to occur and they do not always have the time to sit through the long process for the consumer.

The provider’s response included, but was not limited to:

* The service has one General practitioner who provides services to consumers. There are no other practices in the local area willing to provide services. Communication processes with the General practitioner will be reviewed to ensure effective and timely referral.
* A review of referral processes and use of the referral form is in progress.
* One consumer’s access to specialist services has been impacted by the Public Trustee and agreement to pay for the review. This has now been rectified.

I acknowledge the provider’s response. However, I find timely and appropriate referrals were not initiated in response to changes in consumers’ condition. I have considered Consumer K has not been provided access to specialist services to assist with wound management with management indicating this is due to the consumer’s reluctance to pay for it. However, I find the provider has not acted in accordance with their responsibilities as outlined in the *Quality of Care Principles 2014* in relation to initiating referral to specialist services for Consumer K*.* I have also considered that despite weight loss and swallowing difficulties, Consumer E was not referred to appropriate Allied health specialists in a timely manner to ensure care provided was meeting their current needs in relation to nutrition and hydration. Furthermore, I have considered feedback from clinical staff stating it can take some time to get Medical officers to review consumers at the service, and while they have access to telehealth, they don’t always have time to sit through the ‘long process’. While these barriers are known, there is no indication actions have been taken to address these, potentially compromising consumers’ ability to receive care and services that align with their needs, goals and preferences and improves their health and well-being.

For the reasons detailed above, I find requirement (3)(f) in Standard 3 Personal care and clinical care non-compliant.

**In relation to requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(f)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

**In relation to requirements (3)(e) and (3)(g),** information about a consumer’s condition, needs and preferences was found to be generally documented and communicated within the organisation. Care and clinical staff described how they are kept informed of consumers, including through ready access to consumers’ care plans and handover processes. Three consumers confirmed staff were knowledgeable about recent changes to their condition.

Infection related risks are minimised through implementation of effective infection control methods and staff practices promote appropriate antibiotic prescribing and use. Care staff were knowledgeable of infection control processes and discussed strategies implemented to minimise antibiotic use. Care files sampled demonstrated pathology is collected prior to treating symptoms of infection and preventative strategies are implemented. Consumers and representatives were satisfied the service minimises infection related risks and said recent infection outbreaks were well managed.

For the reasons detailed above, I find requirements (3)(e) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as three of the seven specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(a), (3)(b) and (3)(c) in Standard 4 Services and supports for daily living not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied each consumer gets safe and effective services and supports for daily living that meets their needs, goals, and preferences, specifically in relation to dietary choices and laundry services. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

* Consumer R prefers to have a specific diet which has been identified on the Dietary details form. Consumer R stated this choice is not always supported and they have received products not in line with the diet request on multiple occasions. One care staff was not aware of Consumer R’s diet choice and a kitchen staff member stated Consumer R has the diet choice when circumstances suit them, and has observed the consumer eating products not in line with the diet choice.
* Consumers, representatives and staff were not satisfied laundry services met consumers’ needs and preferences. Feedback included:
* There always seems to be a back log in the laundry and consumers don't often have clean clothes available to wear.
* A consumer has not been able to attend outings with family due to lack of clean clothes available.
* There are not enough staff to attend to laundry tasks and at times the consumer has nothing to wear, not even underpants.
* Items of clothing go missing every day causing great financial expense and is undignifying for the consumer. On a recent occasion, the consumer was only wearing a pyjama top and continence aids at midday due to lack of clothing.
* Four staff stated there is often no clean clothes for consumers resulting in them wearing dirty clothes or not enough clothing.
* Staff also provided feedback relating to linen supplies, stating there was never enough linen, including towels and flannels, and available linen is old and of poor quality. Staff also stated on several occasions, they cut up towels to use as flannels and use bed sheets as towels because there is no supply, resulting in consumers having bed baths instead of showers due to a lack of supply. This practice was observed by the Assessment Team.

The provider’s response included, but was not limited to, additional laundry hours have been facilitated by an external agency and laundry staff are being recruited; undertaken a full linen audit and provided additional linen; provided information on the daily audit process for identification and removal of worn and/or damaged linen to laundry staff; completed a review of laundry staff processes which identified issues with staff practices and a need to review working hours, which is in progress; and review of consumers’ dietary needs to be undertaken over the next month.

I acknowledge the provider’s response. However, I find effective services and supports have not been consistently provided to improve or enhance consumers’ quality of life, specifically in relation to dietary choices and laundry services. I have considered Consumer R’s dietary choices, have not been consistently supported. Despite documentation available outlining Consumer R’s dietary preferences, a kitchen staff member was ambivalent of the consumer’s dietary choices, and indicated while there had been an issue with the supplier in obtaining food items in line with Consumer R’s dietary preference, they had not explored other avenues for obtaining these foods. I have also considered laundry services have not been provided in a way which enhances consumers’ well-being and quality of life. I have placed weight on feedback provided by consumers, representatives and staff relating to the laundry services and the resulting impacts. I have also considered consumers are not receiving care in line with their preferences or which enhances their well-being due to insufficient supply and poor quality of linen, which I consider demonstrates a lack of dignity and respect.

For the reasons detailed above, I find requirement (3)(a) in Standard 4 Services and supports for daily living non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied services for daily living promote each consumer's emotional, spiritual and psychological well-being. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

* Consumer S reported they were lonely as they do not have a family and care staff do not have time to talk to them. The consumer said they do not like attending activities as there is nothing that suits them but, occasionally they will talk to the lifestyle staff and sometimes this helps.
* A care staff said Consumer S was probably depressed as they often felt lonely and did not like attending activities, and stated this had been the case since the beginning of the year. Consumer S was observed alone in their room on three days of the Site Audit.
* Lifestyle staff stated Consumer S likes to stay in their room, is invited to activities but always declines, and as such they will spend one-to-one time with the consumer weekly to promote well-being and involves Consumer S in pet therapy whenever the pet dog visits.
* The Lifestyle care plan did not include goals of care and there was no information relating to how the consumer’s emotional and psychological well-being was supported.
* Despite having resided at the service since 2016, the consumer had only been referred to an external service on one occasion in March 2023 and had not been reviewed at the time of the Site Audit.
* Consumer G was on a Palliative care pathway, however, the consumer’s emotional and psychological well-being had not been recognised or responded to. Consumer G was observed to be distressed on all four days of the Site Audit and stated they were frightened, lonely and just wanted someone to talk to.
* A Current assessment of the consumer’s spiritual, cultural, emotional and social needs had not been completed and there were no interventions documented to guide staff. Staff could not describe any changes to Consumer G’s care needs or emotional support to be provided. On one occasion, staff were observed closing the consumer’s door in response to them calling out.
* Three consumers stated they were religious and interested in attending church, but the service did not have church services available. Since January 2023, the Living well weekly program contained only one religious aspect; 'Songs of Praise', which occurred on Sundays. A lifestyle staff member did not know which consumers were interested in this activity or whether they are supported to watch it as they do not work on Sundays.

The provider’s response included, but was not limited to, recruited additional lifestyle staff to facilitate time for the Lifestyle coordinator to undertake care reviews; planning to undertake a review of consumers with depression and initiate referrals; and conducting a review of services offered by external religious and spiritual providers to facilitate additional religious activities. Additionally, Consumer S and G’s emotional, spiritual and religious needs have been assessed and care plans updated.

I acknowledge the provider’s response. However, I find the service had not ensured each consumer was provided services and supports for daily living to promote emotional, spiritual and/or psychological well-being. Observations by the Assessment Team relating to Consumers S and G indicate staff practices do not consistently support consumers’ emotional and psychological well-being. Consumers S and G expressed feelings of loneliness and/or being frightened, however, assessments to identify their spiritual and emotional needs had not been undertaken nor consideration of strategies to support them, with staff observed to close Consumer G’s door in response to them calling out. As such, I find observations and feedback provided by consumers demonstrates staff do not have a clear understanding of consumers’ goals, needs and preferences or that day-to-day interactions consistently promote empathy, compassion and connection between consumers and the workforce. This has the potential for consumers to experience a reduced sense of purpose, meaning and community.

I have also considered consumers’ spiritual and/or religious needs have not been effectively supported. The only religious support/activity noted on the Living well program was a television program which lifestyle staff did not know which consumers were interested in or supported to watch. As such, I find the evidence presented does not demonstrate staff understand, value and support consumers’ religious and/or spiritual well-being.

For the reasons detailed above, I find requirement (3)(b) in Standard 4 Services and supports for daily living non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied consumers get services and supports to participate in their community within and outside the service, have social and personal relationships and do the things of interest to them. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

* Five consumers and representatives stated there are not enough activities provided. Feedback included there is not enough staff to support engagement in activities of choice; not supported to participate in the community; feel like a prisoner because I never get out of the service and would like to go out on bus outings and enjoy life; the consumer is often sitting alone in the common area or in their room and looks bored whenever I visit; there is no garden to access, and care staff just don’t have the time to take consumers out as they are too busy; and consumers used to go for outings but this does not occur anymore.
* All five consumers and/or representatives indicated they had raised concerns with management or during consumer meeting forums, however, no action had been taken and they have not seen any improvements.
* The Lifestyle coordinator is the only lifestyle staff member. The service has two volunteers, each of them visit the service once per week.
* The Lifestyle coordinator said there is no specific activity plan for consumers living in the memory support unit and as they are the only lifestyle staff member, they had little time to perform activities in this area. They stated consumers in the memory support unit are bored, however, could not demonstrate how consumers in this area are currently supported to undertake things of interest to them.
* No activities were observed to be occurring in the memory support unit on all four days of the Site Audit and staff confirmed activities are not provided and consumers are bored, restless and wander about without a purpose.

The provider’s response indicated they acknowledge previous management have not been responsive to concerns raised by consumers and representatives. The response stated the new General manager is responsive and addressing concerns and complaints to ensure satisfaction with actions taken and will attend resident meetings and ensure issues raised are added to the log and addressed. The provider’s response also stated, but was not limited to, the activities planner has been reviewed and a survey completed to identify consumers’ preferences and wishes regarding activities, with the information gathered to feed into the Activity planner.

I acknowledge the provider’s response. However, I find consumers have not been assisted to participate in activities of interest to them. In coming to my finding, I have placed weight on feedback provided by consumers and representatives indicating there are not enough activities provided and the examples and resulting impacts described. I have also considered there is no specific activity program for those consumers residing in the memory support unit, with the Lifestyle staff member indicating they have little time to undertake activities in this area. This was supported through observations made by the Assessment Team and feedback from staff. As such, I find that the service has not ensured services and supports, specifically the lifestyle program, has been tailored to meet the unique needs of the consumers or provide them with a with a sense of purpose and identity.

For the reasons detailed above, I find requirement (3)(c) in Standard 4 Services and supports for daily living non-compliant.

**In relation to requirements (3)(a), (3)(b) and (3)(c)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

**In relation to requirements (3)(d), (3)(e), (3)(f) and (3)(g),** information about consumers’ conditions, needs and preferences was generally found to be communicated within the organisation. Staff described how they are kept up-to-date with consumers’ changing needs and preferences and consumers and representatives said staff know consumers’ needs and care is delivered in line with their preferences. Consumers confirmed they are referred to other services to meet their needs. Staff described how they work with other organisations and individuals to support consumers’ care and needs, with outside organisations utilised to provide support to consumers through activities and visits. However, clinical staff acknowledged referrals are not always followed up by staff in a timely manner due to time constraints.

Overall, consumers and representatives were satisfied meals provided were of suitable quality and quantity, and stated while alternative options are always the same, they are tasty. Professional input into the menu has been sought to determine the nutritional value of the meals provided and meals were observed to be nicely presented. Consumers were observed enjoying their midday meals and most meals were consumed. Staff engagement during mealtimes was welcoming, with consumers receiving the assistance they required.

There are processes to ensure equipment, required to support delivery of services is safe, suitable, clean, and well-maintained. Care staff described how they maintain equipment following use, as well as processes to report maintenance issues. Consumers said equipment is clean and well maintained and issues are fixed promptly.

For the reasons detailed above, I find requirements (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living compliant.

# 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

The Quality Standard is assessed as non-compliant as two of the three specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(b) and (3)(c) in Standard 5 Organisation’s service environment not met.

**Requirement (3)(b)**

The Assessment Team were not satisfied consumers are able to move freely, both indoors and outdoors. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The memory support unit is located on level one and has no direct outdoor access. Multiple staff stated due to lack of staffing they are not able to take consumers residing in the memory support unit to the ground floor courtyard, so consumers do not leave the memory support unit environment. Even consumers who are non-ambulant, require assistance, and who live outside the memory support unit are not able to be assisted in accessing outdoor areas.
* Consumers and/or representatives said the environment is not always clean and rooms had a bad odour at times, and staff indicated issues with cleanliness and supply of cleaning products.
* Five care staff said the environment is not clean, citing sticky floors, toilets not cleaned and the carpet in the memory support units smells, even though it is cleaned weekly.
* Multiple staff said there are not enough cleaning staff, with one care staff saying they have now been asked to undertake cleaning and laundry tasks which takes away from their time to attend to consumers.

The provider’s response indicated that the ongoing function of the memory support unit has been reviewed, with a decision that this will cease as consumers move out of the area. New admissions are currently not being taken and when admissions recommence, any consumers requiring a memory support unit will not be suitable for entry as the service will not have a memory support unit going forward. Outdoor activities will be considered and facilitated for consumers in the memory support unit, suitable to their Behaviour support plan. Additionally, cleaning hours and supplies are to be reviewed, additional hours to be rostered and cleaning schedules reviewed and updated.

I acknowledge the provider’s response. However, I find the service environment was not clean and well maintained, nor were consumers able to freely access outdoor areas. It is an expectation of this requirement that the service environment promotes free movement of consumers, including to outdoor areas. In coming to my finding, I have placed weight on feedback from staff who indicated consumers residing in the memory support unit and consumers in other areas requiring staff assistance, are not assisted to access outdoor areas. I have also considered feedback from consumers, representatives and staff indicating the service environment is not consistently clean or well-maintained which has been impacted by workforce shortfalls and insufficient cleaning supplies.

For the reasons detailed above, I find requirement (3)(b) in Standard 5 Organisation’s service environment non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied furniture, fittings and equipment, specifically the phone system and entry key fobs, were well-maintained. The Assessment Team’s report provided the following evidence gathered through interviews, observations and documentation relevant to my finding:

* Multiple staff raised concerns regarding the phone system and not being able to respond or effectively communicate with other staff, especially in the event of an emergency, such as falls, behaviours or other medical emergencies.
* Staff said they would have to leave the consumer(s) unattended to get help as phones don’t work and gave examples of this occurring.
* Phones were noted to not hold any charge for more a few minutes before going flat.
* The Directors who said a new phone system is due to be implemented in a two to three week timeframe.
* Staff said they leave the nurses’ station doors open so agency staff can access these areas as entry key fobs often don’t work for agency staff causing issues when they need to access the electronic system. Staff said sometimes they can’t access certain rooms due to key fobs not consistently providing appropriate access to these areas.
* Nurses’ station doors were observed to be open on all levels of the service, and other doors were either propped open or left ajar to provide entry.
* Multiple staff raised concerns regarding cleaning supplies which impacts their ability to keep equipment clean and their inability to access ancillary rooms due to entry key fobs not working.

The provider’s response indicated a new phone system has been installed and dedicated phones for consumer use are located on each floor.

I acknowledge the provider’s response. However, I find equipment used in the provision of consumers’ care and services was not well maintained. Phone system deficits have not ensured effective communication between staff, potentially placing consumers at risk. Additionally, issues with entry key fobs has not ensured staff have ready access to cleaning supplies to maintain cleanliness of equipment.

For the reasons detailed above, I find requirement (3)(c) in Standard 5 Organisation’s service environment non-compliant.

**In relation to requirements (3)(b) and (3)(c),** I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

**In relation to requirement (3)(a),** while the service environment was not considered to be welcoming by one representative and some staff, consumers did not express dissatisfaction. Consumers said they like their rooms and are able to personalise their rooms to their taste. While the environment was observed to be sparse and difficult to navigate, particularly the memory support unit, consumers were observed mobilising within the building with ease and familiarity. The service has a café on the ground floor and a central courtyard with seating areas, and consumers and visitors were observed enjoying these public areas.

For the reasons detailed above, I find requirement (3)(a) in Standard 5 Organisation’s service environment compliant.

# Standard 6

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

Findings

The Quality Standard is assessed as non-compliant as two of the four specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met.

**Requirement (3)(c)**

The Assessment Team were not satisfied appropriate action has been taken in response to feedback and complaints. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The complaints register included nine complaints in the last six months, specific details of complaints were not included in the register, rather a high-level statement of what the complaint was about, and actions taken in response to the complaints were not noted. Only four of the complaints were resolved within the timeframe outlined in the service’s procedure.
* There are no mechanisms to monitor progress of complaints to ensure they have been actioned as the service’s procedure does not require staff to log complaints in the Complaints register.
* Complaints raised at consumer meeting forums were not included in the Complaints register, even when they had not been resolved.
* A representative said they have made verbal complaints to management over the last 12 months and there is no follow up or action. None of these complaints were included in the Complaints register.
* A consumer stated they had raised concerns at resident meetings. None of these complaints had been included in meeting minutes or the Complaints register.
* A representative stated they had approached management multiple times regarding missing clothing items, management stated they would investigate but it never occurred, and they did not receive an apology. This complaint was not included in the Complaints register.
* A representative stated it takes several complaints for the service to take action. The representative raised a formal complaint with an external advocacy service as they felt the internal complaint system was not always actioned. Following the complaint with the external service, management had followed up and provided a response.
* The complaints register only shows the complaint made to the external service, there is no mention of the complaints made internally. Management stated feedback and complaints are documented in progress notes once the complaint has been resolved. There was no record of complaints regarding the issues raised in the progress notes since March 2023.
* A representative raised a complaint in January 2023, however, felt this had not been resolved and is waiting on management to respond. The representative stated the frequent change in staff and management causes difficulty in managing ongoing complaints. The complaints register shows a complaint was made in January 2023 and resolved 12 days later. Actions taken were not noted and there was no record of complaints from the representative in care documentation.
* Staff have not received training in open disclosure and several staff sampled could not describe what open disclosure was.

The provider’s response indicated they acknowledge previous management have not always been responsive to concerns raised by consumers or representatives. The new General manager is responsive to concerns and complaints and is addressing them to ensure consumers and representatives are satisfied with actions taken. A new Complaints management log has been developed and the General manager will attend resident meetings and ensure issues raised are added to the log and addressed. Additionally, the new General manager has been in contact with family members and consumers to discuss concerns and action appropriate strategies, including open disclosure.

I acknowledge the provider’s response. However, I find the service did not demonstrate a best practice system for managing and responding to complaints. In coming to my finding, I have placed weight on feedback from consumers and representatives which demonstrates appropriate follow up and action of complaints is not consistently undertaken. While complaints have been raised, including through consumer meeting forums, these have not been captured on the Complaints register to enable appropriate response and actions to occur. Only nine complaints had been captured on the Complaints register over a six-month period, with only four resolved within the required timeframe. I have also considered open disclosure processes may not be consistently applied when things go wrong. Staff were not familiar with the term open disclosure and indicated they had not received training in open disclosure. One representative indicated they had not received an apology in response to a complaint raised. As such, I find the evidence demonstrates appropriate and timely action is not taken in response to feedback and complaints, or complaints are monitored to identify improvement opportunities to the care and services provided.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied feedback and complaints are monitored, analysed, and used to improve the quality of care and services provided. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The PCI, last updated in March 2023, was not reflective of feedback provided and items on the PCI did not reflect actions, improvements taken or completion dates.
* Management stated complaints were not always logged on the Complaints register and when they receive a complaint, it is often resolved with the consumer and/or representative and recorded in progress notes.
* Management stated there were no formal processes to identify and analyse trends in feedback and complaints. An example of when feedback or complaints were used to improve the delivery of care and services was not provided.
* The PCI did not include feedback provided from the Food focus and resident meetings.
* At Food focus meetings in February and March 2023, consumers indicated they would like staff to be provided with more education on completing menus, with the action indicating the Residential services manager would look into it. There was no evidence this had occurred.
* At a resident meeting in March 2023, consumers stated that they were not receiving their medication at the correct time. The Assessment Team identified this was an ongoing issue.

The provider’s response indicated the Complaints management procedure has been reviewed and updated to include feedback from resident meetings is added to the Feedback log and feedback is analysed, trended and opportunities for improvement identified and added to the PCI.

I acknowledge the provider’s response. However, I find feedback and complaints were not reviewed and used to improve the quality of care and services. In coming to my finding, I have considered while a Complaints register is maintained, complaints data is not consistently captured and documented on the register and there is no formal process to monitor and analyse feedback and complaints to identify trends and enable improvements to the quality of care and services to be identified and implemented. While a PCI is maintained it did not include any improvement initiatives derived from consumer meeting forums. Issues raised by consumers at a meetings relating to menus and medications have been identified as ongoing by the Assessment Team. As such, I find the service has not actively used avenues available to them to enable improvements to the quality of care and services to be identified.

For the reasons detailed above, I find requirement (3)(d) in Standard 6 Feedback and complaints non-compliant.

**In relation to requirements (3)(c) and (3)(d)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

**In relation to requirements (3)(a) and (3)(b),** consumers and representatives sampled were aware of how avenues available to them to make complaints and provide feedback and felt comfortable to do so. Consumers are supported to provide feedback and make complaints through consumer meeting forums, as well as provision of feedback forms which were observed to be available at the service’s entrance. Resident meeting minutes included information on feedback forms and where to locate them. Staff described how they assist consumers to provide feedback, including by utilising feedback forms or verbally providing consumer feedback directly to the management team.

Consumers and representatives were aware of external agencies who could assist them in raising concerns. Information relating to internal and external feedback and complaints mechanisms and advocacy was observed on noticeboards and there are processes for accessing interpreting services, when required. The Complaints register was noted to include complaints made to external agencies, including the Commission and advocacy services.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

The Quality Standard is assessed as non-compliant as four of the five specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied the workforce that is planned and deployed to enable delivery and management of safe and quality care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Clinical and care said there were not enough staff to provide consumers adequate care and services and supports for daily living. Feedback from staff included:
* Consumers are provided washes instead of showers; inability to reposition and change continence pads, especially overnight resulting in soaked sheets and skin integrity issues; unable to provide adequate meal supervision or assistance and meals are often cold; delays in medication administration and responding to clinical incidents and deterioration; consumers not assessed properly post fall when there is no Registered nurse; not enough cleaning staff resulting in rooms not being properly cleaned; and only one staff rostered in the laundry impacting timeliness of getting consumers up and dressed and consumers sometimes left in soiled clothes.
* Considered the memory support unit to be ‘dangerous’ due to lack of staff and no working phone. This results in consumers requiring two staff assistance with continence not being attended, behavioural episodes not being adequately managed and consumers with mobility impairments not being adequately supervised, resulting in falls.
* Consumers and representatives described impacts resulting from insufficient staff, including late administration of medication; delays in wound treatments; delays in attending outings and activities; delays in call bell response times resulting in near misses and one consumer stating they no longer call for assistance; and not being able to go outside as staff are too busy and don’t have time to take them there.
* A call bell report for a 15 day period between March and April 2023 did not include the total number of call bell alerts, percentage of responses within or exceeding the key performance indicator or analysis of the data. The data showed there have been at least four response times exceeding 12 minutes every day, with an average of one to two responses over 20 minutes daily.
* There has been no follow up of response times exceeding the key performance indicator in line with the service’s procedure. Clinical management confirmed a call bell report is emailed daily, however, said they have not had time to analyse or investigate delayed call bell responses since the Residential services manager left in April 2023, and the data has not recently been used to inform workforce planning.
* A master roster was designed with assistance of an external Consultant, based on acuity and an occupancy of 90 consumers. Management said the master roster is five years old and not reflective of current needs. Management said the roster allocation had until recently been completed by head office who had no idea what was happening on the ground and would not share information, such as who was on leave and what shifts were vacant. The master roster available was not an accurate reflection of available shifts and included a greater number of staff than has been rostered according to the allocation sheet.
* Two to four weekly meetings between the Chief executive officer (CEO), Residential services manager and the Directors include discussions relating to call bell data, incidents and risks. Minutes for February 2023 included workforce governance as an agenda item, including staff turnover, training and performance appraisals. However, comments only discuss trends in bed occupancy and the need to see the master roster.

The provider’s response indicated they acknowledge previous management have not made efforts to recruit to facilitate a workforce to enable delivery and management of safe and quality care and services even though the Executive consistently prompted them regarding applicants from advertisements. The response stated recruitment has been a priority for the new General manager and a review of the roster and vacant shifts has been progressed.

I acknowledge the provider’s response. However, I find the service did not demonstrate there were adequate numbers and mix of staff to deliver safe and quality care and services. In coming to my finding, I have placed weight on feedback provided by the majority of consumers and representatives indicating insufficient staffing numbers to provide quality care and services has resulted in impacts to consumers’ health and well-being. I have also considered feedback provided by staff indicating staffing levels are not sufficient to support the effective delivery of care and services to consumers and the resulting impacts to consumers described by staff. Processes to monitor the sufficiency of the workforce have not been effectively undertaken, with call bell data not used to identify staffing shortfalls nor used to inform workforce planning. Furthermore, the master roster is not an accurate reflection of the current workforce situation.

In relation to meetings, I consider this evidence is more aligned with overall workforce governance monitoring processes. As such, I have considered this evidence in my finding for requirement (3)(c) in Standard 8 Organisational governance.

For the reasons detailed above, I find requirement (3)(a) in Standard 7 Human resources non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied members of the workforce are competent and have the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Training records included staff competency assessments relating to hand washing and use of personal protective equipment. No other assessments had been completed, including in relation to medications for clinical staff or medication competent carers.
* None of the staff sampled said they had been competency assessed in any area of work, including medication management. Clinical management and the Directors acknowledged staff have not been routinely competency assessed, with Directors stating staff are expected to be competent in their roles owing to having the relevant qualifications.
* As identified in Standards 1, 2 and 3, some members of staff lacked the knowledge relating to provision of culturally safe care, effective use of assessment and planning, supports for daily living and adequate clinical care, including in relation to wound, falls and diabetes, end of life care, and clinical deterioration. Staff were unable to describe their regulatory obligations in relation to restrictive practice and the Serious Incident Response Scheme (SIRS). Poor staff practice had not resulted in performance review, staff training or further competency assessment and monitoring.
* A high number of medication errors for multiple consumers were identified, including late administration of time-sensitive medication, omissions, double dosing and administration of the wrong medication to the wrong consumer.
* Clinical and care staff confirmed they witness medication errors frequently and said this was a result of staff shortages, heavy reliance on agency staff and staff incompetence. None of the clinical staff said they had received any training in medication management and this had not been discussed or raised, including at staff meetings.
* Clinical management were aware medication errors were occurring, however, could not identify specific staff with knowledge gaps, confirm such staff had received additional training and support or were consistently being monitored.

The provider’s response indicated a Training plan, which includes a training and development matrix and mandatory and non-mandatory requirements has been developed and implemented, and mandatory training sessions are scheduled over the next few months. The response also stated a review and update of the staff training and development register is planned to ensure it is up-to-date and maintained.

I acknowledge the provider’s response. However, I find the workforce was not sufficiently competent or had the knowledge to effectively perform their roles. Directors stated staff are expected to be competent in their roles owing to having the relevant qualifications. In coming to my finding, I have placed weight on outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(f), which have been found non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being, effective management of high impact or high prevalence risks and consumers nearing the end of life, changes or deterioration in condition are effectively recognised or responded to promptly or timely and appropriate referrals are initiated. Deficits have also been found in the provision of care and services relating to requirements in Standards 1, 2 and 4, including provision of culturally safe care and services, assessment, planning and review and provision of services and supports for daily living. I have also considered the service’s own monitoring processes have not been effectively applied as deficits highlighted by the Assessment Team have not been identified.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied the workforce is recruited, trained, equipped and supported to deliver the outcomes required under the Quality Standards. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Some staff said they had been appointed to their role without the appropriate qualifications and experience. One staff said they had been elected into their position without any experience ‘because they were desperate for anyone’. A second staff member said, ‘I didn’t have a job interview or even an updated resume when I was hired’. An Enrolled nurse confirmed they have been rostered as a Registered nurse twice a week due to staff shortages, however, was aware of their scope of practice and request support from Clinical nurses when needed.
* Two staff members said they had not received a job description, person specification or duty statement to understand their role and responsibilities. One said they had ‘no idea’ what they were supposed to be doing and have ‘muddled along’. They provided examples of not completing the work expected because no-one had told them their responsibilities.
* Staff confirmed, and documentation showed, not all staff had received an induction or orientation. Of five staff files, only one included a completed induction checklist, three were incomplete and one did not include a checklist.
* Seven of nine staff said they had not received a formal induction or orientation, one staff who had received an orientation said it had not prepared them for their role. A care staff member said they were put straight onto the floor on their first day, despite having no caring experience and said they were unsure what to do.
* An agency staff said they were rostered as nurse in charge during their first shift, yet not provided an induction until three hours after their shift had started and five clinical staff said they were not told their duties when commencing in the role.
* Clinical management and the Directors said appropriate staff had been recruited for the roles, however, acknowledged induction and orientation processes have been lagging due to staff shortages.
* Mandatory training records showed not all staff had completed mandatory modules. Minimal evidence was provided to demonstrate other topics of education had been offered to staff and all staff confirmed there had been limited training provided, including in relation to infusion pumps, wound management, palliative care and dementia. There has been no evaluation of the training provided or auditing to check compliance with the Quality Standards or identify staff training needs.
* There has been no regular performance review and development to identify training needs and/or deficits in staff practice, no documented action plans developed and where poor practice has been recognised, it has not resulted in the provision of staff training or monitoring.

The provider’s response indicated a Training plan has been developed and implemented. The response also stated the organisation’s policies and procedures, a comprehensive suite of procedures across all Quality Standards, are available for staff, provide clear guidelines and directions and are included in mandatory training sessions.

I acknowledge the provider’s response. However, I find the service did not adequately demonstrate processes to ensure the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. Workforce induction processes have not ensured staff are prepared for their role. This was supported by staff feedback and documentation which showed induction and orientation processes are not consistently undertaken to support staff in their role. Staff have been appointed to roles without the appropriate qualifications and staff have not been consistently provided with sufficient information to inform and guide them in their roles and responsibilities. While a mandatory training program is in place, records demonstrated not all staff had completed mandatory components. Feedback from all staff indicated limited training opportunities outside of the mandatory program are provided. Staff indicated they had not been provided training in relation to infusion pumps and wound management and felt training in relation to palliative care would be of benefit to staff. Deficits have been identified relating to these areas of care. I have also considered that while the Assessment Team have identified a number of deficits relating to provision of consumer care and services, poor staff practices have not been identified by the service’s own monitoring processes, therefore, further staff training and development opportunities have not been recognised or actioned.

For the reasons detailed above, I find requirement (3)(d) in Standard 7 Human resources non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied regular assessment, monitoring or review of the performance of each member of the workforce occurs to ensure safe and quality care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Each member of the workforce has not been regularly assessed or provided an opportunity to review their performance and development, in line with the service’s process. None of the staff sampled had been invited to attend a performance review and development discussion, and none of the sampled staff files had any record of these discussions or a performance improvement action plan.
* The employee register, which records the date of last performance review and development, was outdated and did not include a list of current employees. Of the staff listed, some were overdue and others had no information recorded.

Effective processes for identifying, responding to and monitoring staff performance issues, in line with the service’s process, were not demonstrated.

* Staff A was identified by the CEO as a requiring performance review.
* Staff A’s file includes five staff letters or notes regarding performance issues from September 2021 to October 2022.
* First and final warnings were issued in response to failings in November 2021 and October 2022. No further action, outcomes and/or monitoring were noted for issues identified on four of the five occasions. While Staff A was required to submit a reflective practice about their behaviour for performance issues identified in October 2022, the service was unable to provide evidence of the reflective practice or further discussions.
* Clinical management said they had been unaware of performance issues with Staff A and only discovered the concerns when searching for information requested by the Assessment Team.
* Staff B’s file contained no information regarding performance issues, however, Clinical management provided an undated document detailing notes from a discussion regarding identified underperformance between January 2022 to January 2023. There was no further information documented, including the date of discussion, outcome or actions.
* Clinical management were aware of Staff B’s performance issues and had conducted a meeting with Staff B in February 2023. Clinical management described outcomes of the meeting and while they have been ‘keeping an eye’ on Staff B, observations or discussions have not been documented. Clinical management said Staff B continues to commit medication errors and demonstrates poor wound management and were going to set up another meeting to address continuing concerns.
* Clinical management said they have received no training in performance management.

The provider’s response indicated they acknowledge previous management have not followed the performance review and development procedure, and many probationary and two yearly reviews have not been undertaken. The response further indicated a review of related procedures has been completed and the probationary review process updated. All staff who have been employed for longer than six months will receive a new Performance review and development document to complete over the next three to five months.

I acknowledge the provider’s response. However, I find ongoing monitoring of the performance of each member of the workforce was not demonstrated. In coming to my finding, I have considered the intent of the requirement which expects the performance of all members of the workforce is to be regularly evaluated to identify, plan and support any training and development needs. Feedback from all staff and staff files sampled demonstrated regular performance review and development processes have not been undertaken, in line with the service’s processes. I have also considered poor staff performance has not been effectively managed and monitored. Staff A has had ongoing performance issues over a 14 month period, with two first and final warnings issued. Performance issues had also been identified for Staff B over a 12 month period. No further actions, outcomes and/or monitoring have been undertaken to manage performance issues for either staff member, with Clinical management indicating they had not been aware of Staff A’s performance issues prior to the Assessment Team requesting related information. I have also considered ongoing monitoring, review and evaluation of staff performance was not demonstrated as deficits in staff practice highlighted by the Assessment Team across all of the eight Quality Standards have not been identified by the service’s own monitoring processes.

For the reasons detailed above, I find requirement (3)(e) in Standard 7 Human resources non-compliant.

**In relation to requirements (3)(a), (3)(c), (3)(d) and (3)(e)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

**In relation to requirement (3)(b),** staff were mostly observed treating consumers with kindness, care and compassion and confirmed management had been swift to refuse agency staff who had not acted with respect. When prospective staff are interviewed, scenario-based questions are used to identify staffs’ values and discussion relating to the code of conduct is included in the orientation process for new staff. All consumers and representatives said most staff are kind, caring and respectful, and indicated where agency staff had occasionally been rude and gruff, management had listened to their concerns and not invited the staff member back.

For the reasons detailed above, I find requirement (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | 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

The Quality Standard is assessed as non-compliant as all five of the specific requirements have been assessed as non-compliant. The Assessment Team recommended requirement (3)(a) met and requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance not met. However, I have come to a different view to that of the Assessment Team’s recommendation of met for requirement (3)(a) and find the requirement non-compliant.

**In relation to requirement (3)(a)**

The Assessment Team were satisfied management demonstrated recent activities for engaging consumers in the development, delivery and evaluation of care and services. However, I have considered findings and evidence documented in other requirements, including Standard 1 requirement (3)(e), Standard 4 requirement (3)(c), Standard 6 requirement (3)(c) and Standard 8 requirements (3)(a) and (3)(c) which indicate consumers are not consistently engaged in the development, delivery and evaluation of care and services. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Three representatives expressed dissatisfaction with engagement processes. Feedback included, they don’t really know what is going on; newsletters are not regular and said whilst there was a lot of communication regarding COVID-19, only positive information is included, not improvement activities; and resident meetings are not productive, most feedback provided is not actioned or leads to any improvements, there is no consultation and a lack of clear direction and who’s role it is to do what.
* Care, clinical and lifestyle staff expressed dissatisfaction with how the service is run which impacts their ability to engage and support consumers to participate in the delivery and evaluation of care and services.
* Resident meetings had occurred in February 2023 and March 2023 and included a discussion of events. The April 2023 meeting was postponed. The Lifestyle coordinator said meeting minutes are distributed to all consumers and displayed on the noticeboard, however, acknowledged ‘half the time it goes missing’.
* Feedback from consumers and representatives demonstrated appropriate follow up and action of complaints is not consistently undertaken. While complaints have been raised, including through meeting forums, these have not been captured on the Complaints register to enable appropriate response and actions to occur.
* All five consumers and/or representatives indicated they had raised concerns with management or during resident meetings, however, no action had been taken and they have not seen any improvements.
* Audits and surveys have not been implemented in line with the service’s own schedule and other avenues to identify improvements.

The provider response did not include consideration of this requirement. However, I have considered the provider’s response to the Standards and requirements from where the evidence originated to support my finding in this requirement.

I find the organisation’s processes do not ensure consumers are effectively engaged in development, delivery and evaluation of care and services and are supported in that engagement. I have considered that while there are various avenues for consumers to engage in development, delivery and evaluation of care and services, feedback provided by consumers and representatives, and documentation sampled by the Assessment Team, indicate these avenues are not consistently effective with feedback provided through these avenues not resulting in improving the overall quality of care and services consumers receive. Consumers and representatives were not satisfied feedback and complaints are appropriately followed up and actioned and complaints were found to not be consistently captured, documented, monitored, analysed or trended to enable improvements to the quality of care and services to be identified and implemented. While consumers and representatives indicated they had provided feedback or raised complaints relating to specific areas of care and services, including the activity program, menus and medication management, the Assessment Team found deficits relating to these areas remain ongoing. I have also considered audits and surveys, avenues which would provide consumers the opportunity to provide feedback on the care and services delivered, have not been undertaken in line with the service’s processes. As such, I find this has not ensured consumers’ experience and quality of care and services has been considered in the development, delivery and evaluation of care and services.

For the reasons detailed above, I find requirement (3)(a) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The governing body is comprised of two members, the Directors. The service employs a CEO and a Residential services manager. A Clinical nurse and part-time Clinical nurse manager have recently appointed.
* Both the Residential services manager and CEO have resigned and are due to leave at the end of April 2023, however, both said they have been locked out of the system.
* One Director said they believe that as a governing body they are quite agile and from May 2023 have employed a new Residential services manager, are in discussions regarding a Quality role and potentially will discuss implementing a Board or Executive team or find someone independent(s) that can come to meetings. They stated their constitution is under review and there is also consideration for a different structure to the current governing body.
* The CEO said they advised the Directors of the pending legislative reforms to governing bodies, and had created a projected plan which included clinical advisory and other structures, but they were shut down in trying to roll out the new governance changes and was told to hold off.
* The CEO said they tried to implement fortnightly meetings due to the need to implement numerous changes aligned with the Quality Standards and new governance structure requirements but have only really had three proper meetings with the main conversation revolving around occupancy levels and key performance indicators related to costs.
* The Directors said they have monthly meetings with the CEO and Residential services manager to discuss the service operations and have regular conversations with the CEO outside of these meetings.
* Only four Governance and management group meeting minutes were provided for 22 November 2022, 6 December 2022, 10 January 2023 and 14 February 2023. The meeting agenda stipulates meetings are to be held fortnightly.
* An Organisational strategic business plan 2021-2025 – Gawler Grande Views was generic in nature with no dates to reflect when the document had commenced or evidence of being reviewed or updated. Outcomes listed were normal functions and/or practices of operating a residential aged care service and not reflective of strategic or upcoming legislative reforms.

The provider’s response indicated they acknowledge robust and sustainable governance structures, including accountability and responsibility, have not been consistently implemented and maintained. However, attempts were made to hold regular meetings with the previous Residential services manager and CEO, but often times they refused, were unable to meet or did not answer emails. The response further indicated that the Executive and General manager are implementing stronger governance processes, including reporting and regular governance meetings and have reviewed the governance structure.

I acknowledge the provider’s response. However, I find the organisation did not effectively demonstrate the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. In coming to my finding, I have considered that reporting processes from the service management to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services. Audits and surveys are not being undertaken in line with the service’s process, not all feedback and complaints are being captured and incidents are not being consistently reported, all of which does not enable the service and governing body to be aware of trends, deficits in care and service provision or opportunities for improvement to be identified. Systemic issues have been found in relation to assessment, planning and review, provision of care and services, human resource management and feedback and complaints processes. Governance and management group meetings have not been undertaken in line with the timeframe noted in the agenda and do not include discussions relating to all aspects of the service. While a strategic business plan is in place, the plan was aligned with normal functions and/or practices of operating a residential aged care service. I have also considered that the findings of non-compliance in relation to 29 requirements across all eight Quality Standards indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards. As such, I find such practices do not ensure the governing body is aware of whether it is meeting what consumers, the workforce and others expect for safe, inclusive and quality care and services from the organisation.

For the reasons detailed above, I find requirement (3)(b) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the service demonstrated effective organisation wide governance systems and processes in relation to all six areas of this requirement. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Information management

* The electronic system for assessment, care planning, charting, monitoring, and referrals was not consistently updated with accurate or current information.
* The majority of policies and procedures were dated July 2019. Many were generic, not reflective of current legislation, such as restrictive practices, included minimal information to guide staff practice and were not readily accessible to staff.
* Documentation sampled was often poorly annotated with missing dates, headings and a lack of clarity regarding when the information was created or what period in time the information related to.

Continuous improvement

* The PCI, last updated March 2023, did not include information relating to Standards 3, 4 or 6, and for the remaining Standards, some information was recorded but not consistently aligned to Standard(s) or requirement(s). The recorded information lacked clarity relating to issues identified, planned actions and outcomes. There was no clear tracking of progress with specific dates and timeframes for the delivery of each issue.

Financial governance

* The CEO had multiple concerns relating to the service’s financial governance, which impacted their ability to undertake the normal expectations and functions of a CEO and across aspects of care and services, including no financial or clear budgetary delegations; no access to operational financial information with all delegations and expenses required to go through head office; concerns regarding financial abuse of consumers being charged fees for services not being offered; and deficits with the provision of necessary services and supplies for provision of consumers’ care and services, including limited funding for Allied health services.
* In relation to the CEO’s feedback, the Directors indicated the CEO is able to make decisions up $2,000. In relation to the additional fees, stated this was introduced by the previous Director of care and those activities were happening at the time, however, did agree some of the services are not occurring. They stated this process would cease.
* The Directors provided a one page document relating to additional fees being charged. The document recorded 39 consumer names, however, did not include the date from which the charge commenced. The Directors said they are compiling an email to go out to these consumers which will contain and explanation and an apology.

Workforce governance

* The workforce is not consistently trained and provided with appropriate induction and orientation to the service nor sufficient oversight to guide staff knowledge and performance in relation to their roles. Staff have not received training nor competency based assessments in areas of practice where deficits have been identified and adequate monitoring is not provided to gauge staff competency and ensure performance is regularly reviewed.
* I have also considered the following evidence from Standard 7 Human resources requirement (3)(a) indicating two to four weekly meetings between the CEO, Residential services manager and the Directors include discussions relating to call bell data, incidents and risks. Minutes for February 2023 included workforce governance as an agenda item, including staff turnover, training and performance appraisals. However, comments only discuss trends in bed occupancy and the need to see the master roster.

Regulatory compliance

* The CEO raised concerns regarding the Directors lack of understanding and knowledge relating to SIRS, regulatory compliance, and overall governance principles. The Directors said they were not familiar with SIRS terminology or the five forms of restraint. Staff records and feedback showed no staff have completed training in relation to SIRS and not all staff could not adequately describe SIRS principles.
* Psychotropic registers recorded six consumers prescribed chemical restraint without appropriate consultation and consents and the Reportable incidents and escalation procedure did not reflect changes to legislation relating to restrictive practice.
* Governance and management group meeting minutes for January and February 2023 included ‘Mandatory data, incident and information reporting’ as an agenda item, however, did not record any specific discussions relating to SIRS or incident reporting.

Feedback and complaints

* Feedback from consumers, representatives, staff and management and documentation sampled indicated the Complaints register may not be an accurate representation of all feedback and complaints. Consumers and/or representatives said feedback or complaints are not always followed up or actioned in a timely manner and there is a lack of openness and transparency.
* Governance and management group meeting minutes for January and February 2023 included Customer feedback as an agenda item. Minutes of discussion were not consumer centric or evidence discussion relating to specific feedback and complaints from consumers/representatives, or the workforce.
* The Feedback and complaints policy is a one-page document with minimal information to guide staff practice. A further document outlined a process for complaints management which was not demonstrated and staff have not received training on feedback and complaints.

The provider’s response included, but was not limited to:

* Significant issues with the electronic system and reporting from the program have been identified and a meeting with program representatives has been conducted to address the issues which is progressing.
* A full review of the Quality and risk management framework has been completed and the PCI is currently being reviewed and updated.
* An experienced Residential services manager has been employed into the General manager role and an Operations manager is being recruited. A spreadsheet has been developed to better monitor staff, rosters and vacant shifts. Staffing, recruitment and turnover will be included in governance reporting.
* A procedure is in place to guide and direct management and staff in regulatory compliance. Governance structures, monitoring and reporting in relation to SIRS and restrictive practices are being embedded in governance structures.
* Acknowledge previous management have not always been responsive to concerns raised. A new Complaints log has been developed and staff training on feedback and complaints management will be undertaken over the next six months.

I acknowledge the provider’s response. However, I find effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were not demonstrated.

I find that information used by staff to guide provision of care and services was not up-to-date. Policies and procedures were generic and did not provide adequate guidance or reflect current legislation or best practice processes. Information in care plans sampled was either not up-to-date, congruent, reflective of consumers’ current care needs and preferences or did not include sufficient information to guide staff with provision of consumers’ care and services. I have also considered that data, including in relation to feedback and complaints, staff training and performance is not being effectively maintained to enable accurate reporting, trending and analysis to occur, data to be effectively monitored or improvements in the provision of care and services to be identified at an individual, site or organisational level.

I have considered that while a PCI is maintained, the PCI did not include improvement activities across all of the eight Quality Standards, information recorded lacked clarity and there was no clear monitoring of progress and timeframes for completion. Audits and surveys have not been implemented in line with the service’s own schedule and other avenues to identify improvements, such trending and analysis of feedback and complaints have not been sufficiently undertaken to enable improvement opportunities to be effectively identified. I have also considered the findings of non-compliance in relation to 29 requirements across all eight Quality Standards indicates deficiencies with the governance processes associated with continuous improvement.

I have considered financial governance systems and processes have not been effective to manage finances and resources required to deliver safe and quality care and services. While the Directors indicated the CEO had delegation to make financial decisions up to a certain amount, the CEO voiced concern relating to their ability to make such decisions. This was supported through feedback from consumers, representatives and staff who described supply shortages for items required in the provision of consumers’ care and services. Additionally, consumers have been charged fees for services which are not being provided.

In relation to workforce governance, I have considered that evidence presented relating to meeting forums with the CEO, Residential services manager and the Directors, as well as the evidence highlighted in Standard 7 requirements (3)(a), (3)(c), (3)(d) and (3)(e), demonstrates the organisation’s workforce governance systems are not effective. I find the organisation’s processes have not ensured the workforce has been sufficiently monitored or supported to ensure delivery safe and quality care and services to consumers.

Policy and procedure documents do not reflect legislative changes relating to reportable incidents and restrictive practices and the Directors and staff were not overly familiar with SIRS principles. I have also considered use of restrictive practices, specifically chemical restraint, had not been recognised, therefore, appropriate authorisations and consent, in line with legislative requirements, had not been completed. Additionally, I have also considered the findings of non-compliance in relation to 29 requirements across all eight Quality Standards indicates the organisation are not complying with their regulatory obligations.

I find the organisation did not demonstrate a best practice system for managing and responding to feedback and complaints. Feedback and complaints have not been consistently recorded or appropriate actions taken. I have also considered the findings of non-compliance in Standard 6 Feedback and complaints requirements (3)(c) and (3)(d) indicates deficiencies with the governance processes associated with feedback and complaints and that key deficits in care and services identified by the Assessment Team had not been addressed by the service even though feedback had indicated issues associated with some of these aspects of care and service delivery.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied effective risk management systems and practices relating to high impact or high prevalence risks, identifying and responding to abuse and neglect, management and prevention of incidents, or supporting consumers live the best life were demonstrated. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Quality indicator data for the quarter of October to December 2022 consisted of a list of figures and percentages. There did not appear to an overarching risk management system which captures risk and the data did not show detailed analysis, with trending against previous quarters or benchmarking. There was no data provided for the months of January, February or March 2023.
* The Assessment Team identified numerous deficits in the management of high impact or high prevalence risks, wounds, medications, weight loss, diabetes, oxygen therapy and falls.
* The training matrix listed SIRS/elder abuse, however, staff attendance was not recorded. No other training data was provided in relation to specific topics, such as falls, wounds, diabetes, weight management, or dignity of risk.
* The organisation has a Dignity of risk policy and assessment tools, however, all risks had not been identified and assessed, strategies were not documented, and staff were not aware of risk minimisation strategies. Staff were not following outlined procedures with appropriate assessments.
* Critical incident reporting procedures contained minimal information to guide staff practice. The Quality indicator data reporting dated March 2021 is not in line with current legislation, refers to physical restraint and does not reflect best practice.
* The medication incident report from January to April 2023 shows only 13 medication incidents logged. The Assessment Team identified at least 89 occasions where time-sensitive medication were administered late from March to April 2023. I have also considered evidence highlighted in Standard 3 Personal care and clinical care requirement (3)(b) where Clinical management said medication incidents will only be logged if staff tell them they have made an error.
* The Quality and risk management framework procedure indicates regular assessing and update of the risk management plan, and to undertake all scheduled activities on the Audit and survey schedule. The service provided a document entitled QA/Audit/KPI and survey schedule which was a blank template and outlined an auditing schedule, however, no completed audit documentation was provided. Clinical management were not aware of the audit schedule occurring nor were they involved.
* The Directors said clinical staff meet weekly to discuss high risk consumers. The High care resident list dated April 2023 included a review of consumers, however, listed entries often recorded minimal information and did not include date(s) identified or duration of issue(s), however, some considerations or strategies were listed.

The provider’s response indicated high risk management processes have been reviewed and updated; a documentation procedure is being developed to guide and direct Clinical management; reassessment and updating care plans of all consumers, including the Dignity of risk process, has commenced; and the QA audit and survey schedule is being reviewed and updated, as appropriate.

I acknowledge the provider’s response. However, I find effective risk management systems and practices, specifically in relation to management of high impact or high prevalence risks, identifying and responding to abuse and neglect, management and prevention of incidents, or supporting consumers live the best life were demonstrated.

The service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to medication, falls and weight management as highlighted in Standard 3 Personal care and clinical care requirement (3)(b). While four consumers highlighted have been identified with high impact or high prevalence risks, these have not been effectively identified and/or monitored to ensure timely identification, assessment and monitoring of risks to consumers’ health, safety and well-being. I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care.

In relation to identifying and responding to abuse and neglect, I have considered administration of psychotropic medications to manage consumers’ behaviours and repeated incidents of late administration of time sensitive medication have not been identified through the service and organisation’s own monitoring processes. This has resulted in appropriate safeguards not being initiated.

I have also considered staff have not demonstrated an understanding and application of incident reporting and escalation processes, specifically relating to medication incidents. Not all incidents had been identified, documented, escalated or reported. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are minimised and/or eliminated.

Staff have not consistently followed organisational policies, procedures and guidelines to ensure consumers are supported to live the best life they can. As highlighted in Standard 1 Consumer dignity and choice requirement (3)(d), risks associated with activities consumers choose to partake in had not been consistently or effectively identified through assessment processes or strategies to mitigate risks implemented. As such, I consider that this has not ensured the possibility of risks and the impact to consumers is reduced.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied aspects of the clinical governance framework for minimising the use of restraint and supporting and communicating open disclosure were effective. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* A comprehensive, contemporary understanding of restrictive practices and minimising the use of restraint, specifically chemical restraint was not demonstrated. Documentation relating to chemical restraint showed medications prescribed to manage behavioural symptoms without documented consents and/or consultation with the consumer or representative(s). Staff training records did not record any staff completion in relation to restrictive practices and policies and procedures were not reflective of current legislation or of best practice.
* Systems and processes were not supportive, transparent and consistent in communication with consumers and representatives or when things have gone wrong, including providing an apology and a clear explanation of what occurred. Staff lacked knowledge and awareness of open disclosure and training records contained no entries of staff having completed training relating to feedback, complaints or open disclosure.

The provider’s response indicated the Executive have been provided links to the Commission’s site in regard to restrictive practices and SIRS, and they have read the requirements for Approved providers and have a better understanding of the legislative requirements. The restrictive practices policy and procedure has been reviewed and updated and restrictive practice is included in mandatory training; there is a documented procedure for open disclosure, and related policies and procedures are included in the mandatory training; and the new General manager is well aware of and practices open disclosure.

I acknowledge the provider’s response. However, I find the organisation’s clinical governance framework was not effective, including in relation to minimising use of restraint and open disclosure.

I have considered the organisation’s systems to manage how restraints are used are not effective. Related policies and procedures had not been updated to align with changes to legislation which came into effect on 1 July 2021. Staff have not received training or education in relation to restrictive practices and consultation relating to use of psychotropic medications and risks involved had not been undertaken with consumers and/or representatives nor required consents obtained.

In relation to open disclosure, I find the organisation’s systems have not supported effective communication with consumers and representatives in response to incidents, feedback and complaints or that appropriate and prompt action has been taken in response to concerns raised. I have considered evidence in Standard 6 Feedback and complaints requirement (3)(c), which included feedback from consumers and representatives demonstrating appropriate follow up and action of complaints is not consistently undertaken. I have also considered staff were unfamiliar with the term open disclosure and records demonstrated staff have not received education or training relating to open disclosure principles.

I have also considered while a clinical leadership structure is in place, this has not effectively ensured the performance of the workforce is monitored and quality care and service delivery to consumers is maintained, good clinical results achieved and improvement opportunities identified. I have considered the findings of non-compliance in all five requirements in Standard 2 Ongoing assessment and planning with consumers and five of seven requirements in Standard 3 Personal care and clinical care. The findings in these Quality Standards indicates the organisation’s clinical governance framework is not effective, with deficits highlighted not being identified by the service’s or organisation’s own monitoring processes.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-compliant.

**In relation to requirements (3)(b), (3)(c), (3)(d) and (3)(e)**, I acknowledge the provider has submitted an action plan outlining actions required to address the deficits identified. However, the action plan does not include planned completion dates for the actions identified. I consider time will be required to establish efficacy, staff competency and improved consumer outcomes.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)